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Part 9
Interaction with Other Laws

Part 9 looks at the interaction between the *Guardianship and Administration Act 1986* (Vic) and other laws that deal with substituted decision making. In Chapters 22, 23 and 24 we examine the *Disability Act 2006* (Vic), the *Mental Health Act 1986* (Vic) and the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic).

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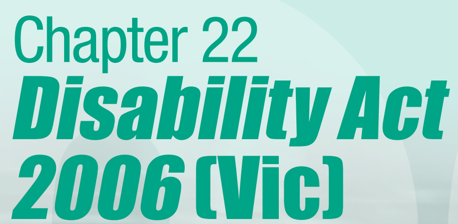

Chapter 22
Disability Act 2006 (Vic)

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Chapter 22

Disability Act 2006 (Vic)

INTRODUCTION

22.1 In this chapter, we consider the relationship between guardianship laws and the *Disability Act 2006* (Vic) (Disability Act), which provides for substitute decision making for people with a disability in some circumstances.

22.2 The terms of reference direct the Commission to report on appropriate boundaries between the *Guardianship and Administration Act 1986* (Vic) (G&A Act) and other pieces of relevant legislation, including the Disability Act.

CURRENT LAW

22.3 The Disability Act provides a framework for providing supports and services for people with disabilities throughout Victoria. It recognises the legal rights and responsibilities of people with disabilities and recognises the need for government and community supports.[1]

22.4 The Disability Act and the G&A Act overlap in a number of areas, including:

- consent to general supports and services
- consent to admission to residential institutions
- consent to restrictive interventions
- consent to compulsory treatment.

22.5 Most Disability Act provisions apply to people who have a 'disability' within the meaning of the Act. Disability is defined to include sensory, physical or neurological impairment, acquired brain injury, intellectual disability, and developmental delay. The definition specifically excludes disabilities related to ageing. It focuses on those disabilities that are likely to be permanent, and lead to reduced capacity in self-care, self-management, mobility or communication and that require significant ongoing or long-term episodic support.

22.6 The Act also includes some provisions that apply only to people with intellectual disabilities. There are specific principles for people with an intellectual disability,[2] and specific provisions about planning for services and supports,[3] admission to residential institutions,[4] and compulsory treatment.[5]

CONSENT TO SUPPORTS AND SERVICES

22.7 Services provided under the Disability Act are mainly voluntary services. They are provided in response to a request made either by the person with the disability or by someone on their behalf.[6]

22.8 The Disability Act does not deal with how a service can be requested on behalf of a person with a disability, or whether a person with a disability must consent to the request.

22.9 However, the Act does require that, whenever a person is receiving ongoing services under the Act, the disability support provider must prepare, in consultation with the person with the disability, a support plan identifying the services the person is to receive.[7] The Act sets out a range of principles that must guide this planning process, including that the person with the disability must direct it and that it must be underpinned by their right to exercise control over their own life.[8] The Act also allows a person to request assistance in this planning process[9] and requires that assistance be offered if the person has an intellectual disability.[10]

22.10 These legislative provisions effectively encapsulate the concept of supported decision making in service planning. The Act does not indicate how the service planning process should work if the person's decision-making capacity is impaired to such an extent that supported decision making might be impossible.

ADMISSION TO RESIDENTIAL INSTITUTIONS

22.11 The Disability Act also deals with the admission of people with intellectual disabilities to institutions. Only three institutions are named in the Act, but the Governor in Council can proclaim other premises as residential institutions.[11] Since the Disability Act came into operation, Plenty Residential Services has also been proclaimed as a residential institution.[12] The proclamation of Kew Residential Services has now been revoked.[13]

22.12 While the Act deals only with voluntary admission to an institution, it creates extra safeguards around these admissions, in recognition that living in an institution is quite different to living in the community.[14] The Act's criteria for admitting a person to a residential institution are that the person needs the institution's services and their admission is either:

- the best possible way of enhancing the person's independence and self-sufficiency, or
- the least restrictive option available in the circumstances, or
- necessary in order to protect either the person, or someone they live with, from serious harm.[15]

The Secretary of the Department of Human Services makes admission decisions.

22.13 The Act also allows any person to apply to VCAT for review of a decision to admit a person to an institution. VCAT may confirm the admission, if it is satisfied that the Act's criteria for admission have been met, or, if it finds that the criteria have not been met, order the Secretary to move the person from the institution within 28 days and to obtain suitable alternative accommodation for them.[16]

22.14 By providing some external review of the process, these provisions are clearly designed to provide safeguards against possible abuse or inappropriate use of the Secretary's power to admit a person to a residential institution.

USE OF RESTRICTIVE INTERVENTIONS

22.15 The Disability Act regulates the use of restrictive interventions for people with disabilities. It prohibits the use of restrictive interventions by disability service providers other than when approved under the Act.[17] A 'restrictive intervention' is an action that restricts a person's right to bodily integrity or freedom of movement. The term is defined to include chemical restraint, mechanical restraint and seclusion.[18]

22.16 The Act sets out the circumstances in which an approved disability service provider can use a restrictive intervention. These include criteria related to the protection of the person themselves, or other people, and the least restrictive alternative.[19] They also include a range of procedural requirements, including that the intervention be part of a behaviour management plan that must be developed in consultation with either the person with the disability or their guardian, and that must be lodged with the Senior Practitioner.[20]

1 *Disability Act 2006* (Vic) s 1.
2 Ibid s 6.
3 Ibid s 63.
4 Ibid s 87.
5 Ibid pt 8.
6 Ibid s 49.
7 Ibid s 54.
8 Ibid s 52(2).
9 Ibid s 53.
10 Ibid s 55.
11 Ibid s 86. The institutions named in the Act are Sandhurst, Colanda and Kew Residential Services.
12 Governor of Victoria, '*Intellectually Disabled Persons' Services Act 1986*: *Disability Act 2006* Revocation and Proclamation of Residential Institution Long Term Rehabilitation Program' in Victoria, *Victorian Government Gazette*, No 26, 28 June 2007, 1296, 1302.
13 Governor of Victoria, '*Disability Act 2006* (Vic)—Revocation of Proclamation' in Victoria, *Victoria Government Gazette*, No G 35, 28 August 2008, 2060.
14 Victoria, *Parliamentary Debates*, Legislative Assembly, 1 March 2006, 416 (Sherryl Garbutt, Minister for Community Services).
15 *Disability Act 2006* (Vic) s 87.
16 Ibid s 88.
17 Ibid s 134.
18 Ibid s 3.
19 Ibid s 140.
20 Ibid ss 141, 145.

Disability Act 2006 (Vic)

22.17 The Senior Practitioner[21] has quite extensive powers in relation to the use of restrictive interventions, including the power to direct a service provider to alter or stop its use.[22] A person with a disability can apply to the Victorian Civil and Administrative Tribunal (VCAT) for review of the inclusion of restrictive interventions in a plan.[23] The Act also gives the Public Advocate some broad watchdog powers in relation to the use of restrictive interventions.[24]

22.18 While the Act does not require the consent of the person with the disability for the use of restrictive interventions, it does require that they, or their guardian, be consulted in the preparation of the behaviour plan in which the restrictive intervention is included.[25] It also requires that an independent person be available to explain to the person with the disability that restrictive interventions are being used and that they have a right to review by VCAT.[26]

COMPULSORY TREATMENT

22.19 The Disability Act provides for compulsory treatment of people with intellectual disabilities in some circumstances.

22.20 Compulsory treatment is provided primarily when the person is presenting a significant risk to others, even though the treatment must be of benefit to the person receiving it.[27]

22.21 There are a number of different types of compulsory care arrangements under the Disability Act, which are outlined below.

Residential treatment orders

22.22 Residential treatment orders are orders made by a court where a person has been convicted of an offence and is ordered to reside in a residential treatment facility, under the supervision of the Secretary of the Department of Human Services.[28]

Security residents

22.23 Security residents are prisoners with an intellectual disability, transferred from the prison system into a residential treatment facility or residential institution at the request of the Secretary of the Department of Justice. Security residents serve their sentence under the supervision of the Secretary of the Department of Human Services.[29]

Forensic residents

22.24 Forensic residents are those who have been found by a court to be unfit to stand trial or not guilty on the ground of mental impairment and are held in a residential treatment or residential institution facility under the supervision of the Secretary of the Department of Human Services.[30]

Supervised treatment orders

22.25 Supervised treatment orders are orders issued by VCAT requiring a person with an intellectual disability who poses a significant risk of serious harm to others to be detained in a residential facility and to undergo treatment under the supervision of the Secretary of the Department of Human Services.[31] Unlike the other three compulsory care arrangements, supervised treatment orders are made after the likelihood of future harm has been assessed, rather than in response to a person's involvement with the criminal justice system.[32] A supervised treatment order prevails over a guardianship order whenever there is any inconsistency.[33]

22.26 A treatment plan must be prepared[34] and approved by the Senior Practitioner before any person can be given compulsory treatment. VCAT has a range of roles in relation to those plans[35] and to the approval of variations.[36]

22.27 In the case of a supervised treatment order, VCAT must be satisfied that:

- the person has exhibited a history of violent or dangerous behaviour
- there are no less restrictive means of reducing the risk of others being harmed by the person
- the services to be provided in the treatment plan will benefit the person and help them reduce the risk of harming others
- the person is unable or unwilling to consent voluntarily to the treatment
- it is necessary to detain the person in order to ensure they comply with the treatment plan.[37]

22.28 A supervised treatment order cannot continue for longer than one year.[38] Further compulsory treatment beyond this time cannot occur without VCAT reassessing the person's circumstances.[39]

22.29 The Senior Practitioner must oversee the implementation of the supervised treatment order.[40]

COMMUNITY RESPONSES

22.30 An issue of particular concern to some people responding to our information paper was that the Disability Act and the G&A Act do not deal with some important practices. The use of behaviour-modifying medication was an example given by the Public Advocate:

> *OPA notes that a range of restrictive interventions are currently used in relation to people with disabilities, many of which are unregulated or under-regulated. It is routine, for instance, for some pharmaceuticals to be used for purposes of modifying the behaviour of some people with cognitive impairments or mental ill health in ways that constitute restrictive interventions. Yet the administration of these pharmaceuticals is sometimes not considered by service providers to be subject to existing restrictive intervention oversight (such as is contained in Part 7 of the Disability Act).*
>
> *Indeed … the routine administration of pharmaceuticals is not even considered 'medical treatment' under the guardianship legislation, making the administration of some behaviour-modifying pharmaceuticals exempt even from the substitute consent process that applies to the medical treatment of people with cognitive impairments. While this does not technically exempt such practices from the restrictive intervention requirements of the Disability Act, OPA is certain that some libido suppressants and sedatives are being used without appropriate approval, and calls for such practices to be treated and regulated as restrictive interventions.*
>
> …
>
> *OPA calls here for all restrictive interventions that apply to people with disabilities to be brought within the regulatory mechanisms established in the Disability Act. OPA would also like to see new guardianship legislation contain a provision about the need for all restrictive interventions to be legislatively authorised and subject to review.*[41]

21 The position of Senior Practitioner is created under pt 3 div 5 of the *Disability Act 2006* (Vic). The Senior Practitioner is a clinically qualified and experienced person who is generally responsible for overseeing the use of restrictive interventions and compulsory treatment, and for the protection of the rights of people with disabilities subject to these procedures. The position is subject to the general direction and control of the Secretary: at s 23.

22 *Disability Act 2006* (Vic) s 27.

23 Ibid s 146.

24 Ibid s 144.

25 Ibid s 141.

26 Ibid s 143.

27 Ibid ss152, 191.

28 Ibid ss 151–65.

29 Ibid ss 166–79.

30 Ibid ss 180–2.

31 Ibid ss 183–201.

32 Ibid s 191.

33 Ibid s 200.

34 Ibid s 153.

35 Ibid ss 154–5.

36 Ibid ss 153(6)–(7).

37 Ibid s 191(6).

38 Ibid s 193(3)(d).

39 Ibid s 193(5), which enables a second application to be made before an order has expired; s 196 allows an order to be reviewed and varied as VCAT sees appropriate.

40 Ibid s 195.

41 Submission IP 8 (Office of the Public Advocate) 8.

Disability Act 2006 (Vic)

22.31 Some people raised concerns about the limitations of the Disability Act's provisions for compulsory treatment. As supervised treatment orders are available only for people with an intellectual disability, a guardian's consent is needed to provide similar treatment to people with other cognitive impairments. It was suggested that further safeguards are needed in order to use guardianship in this way:

> *If a person does not meet the involuntary intervention criteria of the Mental Health Act [and] the Disability Act … but still poses a serious risk to themselves or others, the guardianship regime is the alternative. In cases where guardianship is used for such purposes, there should be rigorous independent scrutiny of the way in which powers of guardianship are exercised.*[42]

22.32 The Public Advocate also raised concerns about this issue:

> *[T]here is a clear distinction between the mechanisms by which a society seeks to provide protection for an individual, and the mechanisms by which a society seeks to protect its members from dangerous people. Guardianship is one example of the former, and the Supervised Treatment Order is an example of the latter. Guardianship, in OPA's view, should never be used as a means of protecting society from dangerous individuals. Therefore, in OPA's view, the question of when guardianship might be sought, as against when a Supervised Treatment Order might be sought, is relatively clear. The law, in OPA's view, ought to reflect this clarity, and could easily do so if new guardianship legislation contained the principle that a guardianship order should only be made when this is in the interests of the represented person, and should not be made in order to protect society from the person.*[43]

22.33 The Public Advocate then went on to argue:

> *[T]he time has come now for compulsory provisions in the Disability Act to be broadened to cover other people who exhibit seriously dangerous behaviour. In addition to existing criteria, OPA submits that the requirement for the person to have an intellectual disability be replaced by a requirement that the person has a cognitive impairment. Naturally, compulsory treatment could only be ordered where expert clinical opinion suggested that treatment would benefit the person, and VCAT would need to be assured before an order could be made that an appropriate treatment regime could be devised and delivered.*[44]

22.34 In some cases, a decision must be made whether a guardianship order under the G&A Act or a supervised treatment order under the Disability Act is the most appropriate legal means of ensuring that a person with an intellectual disability who exhibits violent behaviour receives necessary services. The Senior Practitioner indicated that this choice is often difficult. He noted that a supervised treatment order is an extremely restrictive intervention and that other options, including a guardianship order in some instances, should be considered first. He suggested that while some people currently under guardianship orders would be more appropriately managed under supervised treatment orders, many psychiatrists prefer to work with the consent of a guardian when administering psychotropic or anti-libidinal medications.[45]

22.35 Victoria Legal Aid commented on the overlap of the two systems:

> *In some cases, a person with an intellectual disability lives at a facility where their liberties are significantly restricted, but they are not permanently locked in. In others, a person with an intellectual disability makes no complaint about having to live in a locked facility. In such cases, the question of whether it is necessary to 'detain' the person, and thus seek a Supervised Treatment [Order], is difficult. VLA submits that there is no obvious reform which would remove the grey area in such cases. Rather, it serves to highlight the importance of independent scrutiny of decisions about accommodation for people with intellectual disabilities, irrespective of the order to which they are subject.*[46]

PROBLEMS WITH CURRENT LAW AND PRACTICE

22.36 Two separate matters seem to contribute to the use of guardianship in situations where a person is presenting a serious risk to others. They are:

- a lack of other legislative options—some cases do not come under the provisions of either the Disability Act or the *Mental Health Act 1986* (Vic), such as when a person has an acquired brain injury
- medical practitioner preference—some psychiatrists seek a guardianship order because they prefer to act with the authority of a guardian's consent rather than under a compulsory treatment regime where they are the effective decision makers.

22.37 The first of these is primarily a legal problem, the second primarily one of practice.

LEGISLATIVE ISSUES

22.38 The lack of legislative provisions that permit compulsory treatment other than when a person has an intellectual disability or is mentally ill has meant that guardianship has become the default means of providing compulsory treatment in all other circumstances. It is important to consider whether this position should continue or whether it is appropriate to broaden the compulsory treatment provisions in the Disability Act.

22.39 The Public Advocate has suggested that new guardianship laws should provide that guardianship orders 'should not be made in order to protect society from the person'.[47] This matter requires further debate. In practice, the distinction between interventions that are intended for a person's own protection and those that are intended for the protection of others can be difficult to maintain. Sometimes a person's behaviour might involve a threat to the safety of both themselves and others.

PRACTICE ISSUES

22.40 The reported preference of some medical practitioners to rely upon the authority of a guardian rather than statutory compulsory treatment regimes when providing some forms of treatment to a person with a disability is also a matter that requires further exploration and debate.

OTHER JURISDICTIONS

22.41 In the ACT, the *Mental Health (Treatment and Care) Act 1994* (ACT) includes a number of provisions for both the involuntary treatment and detention of people with either mental illness or mental dysfunction.[48] The Act defines mental dysfunction as 'a disturbance or defect, to a substantially disabling degree, of perceptual interpretation, comprehension, reasoning, learning, judgment, memory, motivation or emotion'.[49]

42 Submission IP 43 (Victoria Legal Aid) 18.

43 Submission IP 8 (Office of the Public Advocate) 41.

44 Ibid 42.

45 Consultation with Jeffrey Chan, Senior Practitioner (16 March 2010).

46 Submission IP 43 (Victoria Legal Aid) 18.

47 Submission IP 8 (Office of the Public Advocate) 41.

48 *Mental Health (Treatment and Care) Act 1994* (ACT) pts 4, 5.

49 Ibid s 3.

22.42 These provisions allow for a range of orders, all of which are issued by the ACT Civil and Administrative Tribunal, including:

- psychiatric treatment orders that involve compulsory treatment for a person with a mental illness who is likely to do serious harm to themselves or someone else[50]
- community care orders that involve compulsory care and treatment for someone with a mental dysfunction who is likely to do serious harm to themselves or someone else[51]
- restriction orders with psychiatric treatment or community care, which can involve compulsory detention in conjunction with either psychiatric treatment or community care[52]
- both psychiatric treatment orders and community care orders, which can also include restrictions on who the person may communicate with.[53]

22.43 The breadth of these provisions means that it is unnecessary to rely on guardianship legislation to provide compulsory care and treatment to a much broader range of people, as is the case in Victoria.

POSSIBLE OPTIONS FOR REFORM

EXPANDING THE COMPULSORY TREATMENT PROVISIONS IN THE DISABILITY ACT

22.44 The Commission has previously recommended that the compulsory treatment provisions in the Disability Act extend beyond people with an intellectual disability to people with any cognitive impairments.[54] The Minister for Community Services explained the Victorian Government's response to the compulsory treatment provisions in 2006:

> *At this time these provisions relate only to people with an intellectual disability. This is because the provisions seek to regulate what is already occurring. It has been suggested that the provisions should be extended to people with an acquired brain injury. Currently, there is little evidence regarding the involvement of people with an acquired brain injury in the criminal justice system and whether there are appropriate treatment models available. It is premature for people with an acquired brain injury to be subject to compulsory treatment in the absence of this evidence. An undertaking has been made to the public advocate to commence research into this matter prior to any future inclusion of people with an acquired brain injury under these type of provisions.*[55]

Question 156 Do you agree with the Commission's previous recommendation that the compulsory treatment provisions in the *Disability Act 2006* (Vic) be extended to people with a cognitive impairment other than intellectual disability?

50 Ibid ss 28–9.

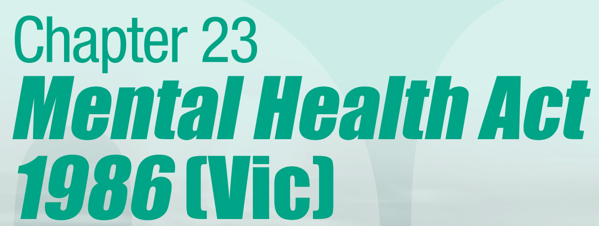
51 Ibid ss 36–36A.

52 Ibid ss 31, 36C.

53 Ibid ss 29, 36A.

54 Victorian Law Reform Commission, *People with Intellectual Disabilities at Risk: A Legal Framework for Compulsory Care* Report (2003) 113–19.

55 Victoria, *Parliamentary Debates*, Legislative Assembly, 1 March 2006, 418 (Sherryl Garbutt, Minister for Community Services).



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Mental Health Act 1986 (Vic)

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Chapter 23

Mental Health Act 1986 (Vic)

INTRODUCTION

23.1 This chapter considers the relationship between guardianship laws and the *Mental Health Act 1986* (Vic) (Mental Health Act), which creates a form of clinical guardianship by permitting a senior clinician[1] to authorise the detention[2] and treatment[3] of a person with a mental illness in some circumstances.[4]

23.2 The terms of reference direct the Commission to consider contemporaneous reviews of other substitute decision-making legislation, such as the Mental Health Act, that are of relevance to this review. In preparing this chapter, the Commission has considered the exposure draft of a Mental Health Bill released by the former Minister for Mental Health on 7 October 2010.[5]

CURRENT LAW

BACKGROUND

23.3 The current Victorian Mental Health Act is a product of the same era as the *Guardianship and Administration Act 1986* (Vic) (G&A Act). Both Acts formed part of a package of complementary legislation for people with a disability.[6] These Acts marked an end to the longstanding practice of using the same laws to respond to the needs of people with a mental illness and those with an intellectual disability. Earlier legislation—ranging from the *Mental Health Act 1959* (Vic) back to Victoria's first mental health statute, the *Lunacy Act 1867* (Vic)—had not distinguished between mental illness and intellectual disability.

23.4 One of the primary reasons for establishing the Minister's Committee on Rights and Protective Legislation for Intellectually Handicapped Persons (Cocks Committee), which produced the report that formed the basis of the G&A Act in 1980, was a growing awareness of the need for laws specially designed to meet the legal needs of people with an intellectual disability at a time of de-institutionalisation.[7] Mental health laws that centred upon civil commitment to psychiatric hospitals did not allow for 'those non-institutional residential options which can enable intellectually handicapped people to live with dignity in the community'.[8]

23.5 While a majority of the Cocks Committee supported a 'generic approach [that] would enable the benefits of guardianship and estate administration to be made available to society as a whole',[9] the Committee limited its recommendations to laws designed for people with an intellectual disability because this focus reflected both the expertise of the Committee members and the reasons for its creation.[10]

23.6 The Victorian Parliament accepted the recommendation of the majority of the Cocks Committee by passing generic legislation that enabled a guardian or administrator to be appointed for a person with 'intellectual impairment, mental illness, brain damage, physical disability or senility'.[11] However, the parliamentary debates clearly indicate that the focus of the G&A Act was people with an intellectual disability.

23.7 Interestingly, the Consultative Council on Review of Mental Health Legislation (Myers Committee), which was established in 1980 to advise on the desirability of new mental health legislation, recommended that new legislation should permit guardians to be appointed for people with a mental illness in some circumstances.[12] The Myers Committee considered guardianship appropriate for the 'many persons [who] may suffer from mental illness which requires treatment but still not be judged to constitute an immediate threat to themselves or to the community' and who 'may be incapable of caring for themselves'.[13]

23.8 The Myers Committee recommendation concerning guardianship for people with a mental illness was not specifically dealt with in either the G&A Act or the Mental Health Act. Nor was it raised in parliamentary debates—probably because the new concept of community treatment orders[14] was seen as the best way of providing mandatory treatment to people while living in the community.

CURRENT OPERATIONS

23.9 The Mental Health Act authorises health professionals to detain and involuntarily treat some people with a mental illness in defined circumstances. These actions would constitute false imprisonment and assault if not expressly permitted by law.

23.10 In order to be eligible for involuntary treatment a person must satisfy the criteria in section 8 of the Mental Health Act. In broad terms they are:

- the person appears to be mentally ill[15]
- the person requires immediate treatment
- involuntary treatment is necessary for the person's health or safety or for the protection of members of the public
- the person has refused or is unable to consent to the necessary treatment
- there is no less restrictive way of providing the treatment.

23.11 A person may receive involuntary treatment as an in-patient in a hospital or while living in the community.[16] A community treatment order may specify where the person must live.[17] While clinicians are responsible for these initial treatment and detention decisions, external accountability is provided by the Mental Health Review Board, which hears appeals from and conducts periodic external reviews of involuntary patients.[18]

23.12 The Mental Health Act establishes processes that permit clinical assessment of a person's need for involuntary treatment and detention. The Act authorises the police to apprehend people in the community in various circumstances[19] and to arrange for their transport to hospital for clinical assessment.[20] It permits a medical practitioner to conduct an initial psychiatric assessment of a person brought to a hospital and to detain that person for 24 hours,[21] as well as provide some treatment, until the authorised psychiatrist conducts an examination.[22]

23.13 If the authorised psychiatrist determines that the person satisfies the criteria for involuntary treatment, the person may be detained in hospital as an involuntary patient, or placed on a community treatment order.[23] An involuntary treatment order under the Mental Health Act is a form of clinical guardianship, because the authorised psychiatrist is given the power to determine a person's place of residence[24] and to authorise both psychiatric and non-psychiatric treatment.[25] The authorised psychiatrist is the only person who can authorise psychiatric treatment of an involuntary patient. Non-psychiatric treatment is dealt with a little differently. A guardian appointed under the G&A Act, or an agent appointed under the *Medical Treatment Act 1988* (Vic) (Medical Treatment Act), as well as the authorised psychiatrist, is able to consent to non-psychiatric treatment of a person who is an involuntary patient.[26]

23.14 The Mental Health Act contains a range of accountability and review mechanisms that seek to ensure that the powers granted to emergency workers and clinicians are used appropriately. The Act permits a person subject to an involuntary treatment order to appeal to the Mental Health Review Board at any time for review of their order.[27] The Board must also review all involuntary orders within eight weeks of being made.[28] The Board has determinative powers—it must discharge a person from an involuntary order if it is not satisfied that the relevant criteria are met.[29]

1 The senior clinician is referred to as the 'authorised psychiatrist', whose powers may be delegated to any other qualified psychiatrist: *Mental Health Act 1986* (Vic) s 96.
2 *Mental Health Act 1986* (Vic) s 12AC(2)(b).
3 Ibid s 12AD(2).
4 The criteria for involuntary treatment are set out in s 8 of the *Mental Health Act 1986* (Vic).
5 Lisa Neville MP, Minister for Mental Health, *'New Mental Health Bill Out For Public Comment'* (Press Release, 7 October 2010).
6 Most of the *Guardianship and Administration Board Act 1986* (Vic) came into operation on 14 July 1987, while most of the *Mental Health Act 1986* (Vic) commenced operation on 1 October 1987. The *Intellectually Disabled Persons Services Act 1986* (Vic) (now replaced by the *Disability Act 2006* (Vic)) was part of the same package of legislation for the benefit of people with a disability.
7 Minister's Committee on Rights and Protective Legislation for Intellectually Handicapped Persons, Parliament of Victoria, *Report of the Minister's Committee on Rights and Protective Legislation for Intellectually Handicapped Persons* (1982) 11–12.
8 Ibid 12.
9 Ibid 95.
10 Ibid 96.
11 Definition of 'disability' in *Guardianship and Administration Board Act 1986* (Vic) s 3.
12 Consultative Council on Review of Mental Health Legislation, Parliament of Victoria, *Report of the Consultative Council on Review of Mental Health Legislation* (1981) recommendations 10, 11.
13 Ibid 60.
14 *Mental Health Act 1986* (Vic) s 14.
15 Mental illness is broadly defined as 'a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory': *Mental Health Act 1986* (Vic) s 8(1A). Various conditions or activities, such as intellectual disability and use of alcohol or drugs, are expressly excluded from the definition: at s 8(2)).
16 *Mental Health Act 1986* (Vic) ss 12AC(2)–(4).
17 Ibid s 14(3)(b).
18 Ibid ss 22(1)(a)–(b).
19 Ibid ss 10–11.
20 Ibid ss 9A, 9B, 10.
21 Ibid s 12AA.
22 Ibid s 12AB.
23 Ibid s 12AC.
24 Ibid ss 12AC(2)–(4), 14(3)(b). An involuntary inpatient must be accommodated at an approved mental health service. A community treatment order may specify where the person must live, if this is necessary for the treatment of the person's mental illness.
25 *Mental Health Act 1986* (Vic) s 12AD.
26 Ibid s 85(1).
27 Ibid s 29(1).
28 Ibid s 30(1).
29 Ibid s 36(2).

Chapter 23

Mental Health Act 1986 (Vic)

23.15 Various authorisation, licensing and supervision mechanisms augment the use of the extensive powers granted to clinicians by the Mental Health Act. These provisions deal with the licensing of places where people may be involuntarily detained[30] and the qualifications and responsibilities of the person in charge of that facility.[31] Independent community visitors have the right to enter a psychiatric hospital, to talk to patients and to examine records concerning treatment.[32]

GUARDIANSHIP AND MENTAL HEALTH LAWS

23.16 Guardianship and mental health laws have operated as partly separate, but parallel, substitute decision-making regimes for the past 24 years. Throughout this period, it has been possible to appoint an administrator to manage the financial affairs of a person with a mental illness. However, it has been assumed that guardianship—both tribunal and personal appointments—should not be used as a means of authorising non-consensual psychiatric treatment or imposing restrictions upon where a person with a mental illness lives because mental health laws regulate these activities. In practice, the Mental Health Act has operated as the only means of providing substitute decision-making authority for a person with a mental illness in relation to matters of psychiatric treatment and place of residence.

23.17 In 2002, the Mental Health Act was amended in order to give the authorised psychiatrist legal primacy in relation to psychiatric treatment decisions for people who are involuntary patients.[33] In the second reading speech for the amending legislation, the Attorney-General said:

> *The Mental Health Act will be amended to explicitly clarify that decision-makers appointed under the Guardianship and Administration Act or the Medical Treatment Act do not have authority to consent, or withhold consent, to psychiatric treatment for involuntary patients.*[34]

23.18 Section 3A of the Mental Health Act provides, in effect, that a guardian cannot make psychiatric treatment decisions for a person who is an involuntary patient under the Mental Health Act.[35] However, that section does not affect a guardian's authority to make psychiatric treatment decisions for a represented person who has not become an involuntary patient. Section 3A does not prevent a guardian (with appropriate powers) from authorising a represented person's admission to a public or private mental health facility and consenting to psychiatric treatment on that person's behalf.[36] An agent (with appropriate powers) appointed under the Medical Treatment Act could also act in this way. It would be necessary, however, for clinical staff at a public or private mental health facility to accept and act upon the guardian's, or agent's, authority to take these steps.

23.19 The Public Advocate and the Chief Psychiatrist have developed a memorandum of understanding, which seeks to provide guidance to guardians and mental health professionals where their roles are uncertain or overlap.[37] This memorandum says that while guardians have 'no authority to consent or withhold consent to the provision of psychiatric treatment', they may act as an advocate in relation to mental health services, should generally be kept informed of the represented person's treatment, and can provide consent to a discharge plan.[38]

THE MENTAL HEALTH BILL

23.20 The Mental Health Bill, released as an exposure draft on 7 October 2010, does not deal directly with the interaction between mental health and guardianship laws.[39] The Bill authorises health professionals to detain and involuntarily treat some people with a mental illness in circumstances similar to those set out in the current Mental Health Act. Clause 120 of the Bill covers the same ground as section 3A of the Mental Health Act by seeking to give the authorised psychiatrist sole decision-making authority in relation to psychiatric treatment for a person who is an involuntary patient.

23.21 While the Bill changes some of the review and accountability mechanisms, none of the proposed reforms appears to have a direct bearing on the issue of whether a guardian (with appropriate powers) may authorise the admission of a represented person to a public or private mental health facility and consent to psychiatric treatment on that person's behalf.

THE FUSION DEBATE

23.22 Many commentators, both within Australia and internationally, have suggested that one body of law should govern substitute decision making for all people with impaired decision-making capacity due to disability.[40] This suggestion, which would cause guardianship and mental health legislation to merge, is known as the 'fusion' proposal.[41] The principal theme of arguments in favour of fusion is that it is discriminatory to have a separate body of law that deals with the involuntary treatment and detention of people with a mental illness when guardianship laws exist as a generic substitute decision-making regime for people with all forms of disability.[42]

23.23 The identity of the substitute decision maker is a major point of difference between guardianship and mental health laws. The Mental Health Act gives a senior clinician the power to determine the place of residence and treatment needs of some people with a mental illness, while guardianship laws provide a generic substitute decision-making regime for people with impaired capacity because of any disability, including mental illness.[43]

30 Ibid ss 94, 94A.

31 Ibid s 96.

32 Ibid ss 109–12.

33 *Guardianship and Administration (Amendment) Act 2002* (Vic) s 29. While s 12AE of the *Mental Health Act 1986* (Vic) requires the authorised psychiatrist to inform the guardian of any person who is an involuntary patient that the person has become an involuntary patient, the Act says nothing about suspension of the guardian's powers or about priority between the powers of the authorised psychiatrist and those of a guardian.

34 Victoria, *Hansard*, Legislative Assembly, 18 April 2002, 961 (Rob Hulls MP, Attorney-General).

35 These decisions are the sole province of the authorised psychiatrist: *Mental Health Act 1986* (Vic) ss 3A(2)(c), 12AD.

36 Assuming, for the purposes of this argument, that the represented person lacks capacity to make their own treatment decisions—otherwise VCAT cannot appoint a guardian and an enduring guardian cannot exercise their powers.

37 Department of Human Services (Victoria), *Memorandum of understanding between the Chief Psychiatrist and the Public Advocate: Responsibilities and roles when working with people with mental illness* (2006).

38 Ibid 5–7.

39 In some other jurisdictions attempts have been made to prioritise mental health and guardianship legislation. In New South Wales, for example, s 3C of the *Guardianship Act 1987* (NSW) provides that while guardianship may continue to operate when a person is either a voluntary or involuntary patient in a mental health facility, all of the powers in the *Mental Health Act 2007* (NSW) prevail over those in the *Guardianship Act 1987* (NSW) whenever there is inconsistency. In Tasmania, the two bodies of law have been integrated with detention decisions made under mental health laws and involuntary treatment decisions governed by guardianship law.

40 See, eg, Tom Campbell, 'Mental Health Law: Institutionalised Discrimination' (1994) 28 *Australian and New Zealand Journal of Psychiatry* 554; Genevra Richardson, 'Autonomy, Guardianship and Mental Disorder: One Problem, Two Solutions' (2002) 65 *Modern Law Review* 702; Peter Bartlett, 'The Test of Compulsion in Mental Health Law: Capacity, Therapeutic Benefit and Dangerousness as Possible Criteria' (2003) 11 *Medical Law Review* 326; John Dawson and George Szmukler, 'The Fusion of Mental Health and Incapacity Legislation' (2006) 188 *British Journal of Psychiatry* 504; John Dawson and George Szmukler, 'Why Distinguish "Mental" and "Physical" Illness in the Law of Involuntary Treatment?' in Michael Freeman (ed), *Law, Mind and Brain* (Ashgate, 2009) 173.

41 Dawson and Szmukler, 'The Fusion of Mental Health and Incapacity Legislation', above n 40. One of the authors of this proposal, Professor George Szmukler (now Professor of Psychiatry at the Institute of Psychiatry, King's College, London), is a former chair of the Victorian Branch of the Royal Australian and New Zealand College of Psychiatry and a former member of the Mental Health Review Board.

42 See, eg, Tom Campbell and Chris Heginbotham, *Mental Illness: Prejudice, Discrimination and the Law* (Aldershot, Dartmouth, 1991).

43 The word 'disability' is defined in s 3 of the *Guardianship and Administration Act 1986* to mean 'intellectual impairment, mental disorder, brain injury, physical disability or dementia'.

23.24 Guardianship laws enable a person's family member or friend to make important decisions for them when they lack capacity to do so themselves. A person with capacity may appoint a relative or friend as their enduring guardian[44] to make decisions for them when they become 'unable by reason of a disability to make reasonable judgments'.[45] When VCAT is deciding who to appoint as a guardian, it usually considers whether a family member or friend is a suitable appointment because the G&A Act directs it to consider both 'the wishes of the proposed represented person, so far as they can be ascertained'[46] and the 'desirability of preserving existing family relationships'.[47]

23.25 A guardian with appropriate powers may determine where a person—other than a person with a mental illness—will live and whether that person will have particular forms of treatment. Despite the obvious similarity with the powers that may be exercised by the authorised psychiatrist in relation to involuntary patients under the Mental Health Act, it has never been considered appropriate in Victoria for a guardian to authorise psychiatric treatment for a represented person or to authorise that person's detention in a hospital or other place of residence.

23.26 Tom Campbell argues that the existence of separate mental health legislation allows for the manifestation of 'institutional discrimination',[48] since the coercive measures permitted under the legislation are confined to people with a mental illness.[49] He suggests that this confirms and perpetuates 'mental illness prejudice'.[50] Campbell argues that a serious consequence of having separate mental health legislation is that it 'institutionalises the idea that there is something about "mental illness" itself which invites a system of control and coercion'.[51] He suggests that although issues of medical treatment and social control are conceptually and practically different, they become dangerously entangled in the context of mental illness, thereby allowing stereotyped prejudice to flourish.[52]

23.27 Stephen Rosenman argues that it is both discriminatory and therapeutically undesirable to have separate mental health laws:

> *Once they have qualified for compulsory hospitalisation, patients lose their autonomy and personal standing. Not only treatment but all facets of the patient's personal life fall completely under the power of the hospital staff. However benevolent the staff may be, patients resent staff who are at once their custodians and carers. Such resentment discourages the development of collaboration in treatment.*[53]

23.28 Rosenman suggests that using guardianship laws to provide substitute decision making for people with a mental illness who are in need of involuntary treatment would allow guardians to remain involved throughout the process and play a role that 'separates medical advice from consent'.[54]

23.29 John Dawson and George Szmukler advocate the fusion of mental health and guardianship legislation because it is both unnecessary and discriminatory to have separate laws that govern psychiatric treatment.[55] They suggest that the law should always respond to a person's incapacity to make their own decisions about medical treatment in the same way, regardless of the cause of that incapacity.

23.30 Dawson and Szmukler argue that relying on a person's incapacity as the trigger for legal intervention would 'shift the focus away from potential "risk of harm" as the central ground upon which psychiatric treatment may be imposed'.[56] They suggest that this shift is likely to have two main benefits: earlier clinical intervention for both physical and mental illnesses, and uniform application of the criminal law.[57] These authors suggest that if clinical involvement can be authorised as soon as a person lacks capacity—even though there is no imminent threat of harm—early intervention would become a real possibility at critical moments.

23.31 Szmukler has also written that this would help reduce discrimination,[58] because the current law permits the non-consensual treatment of people for a mental disorder regardless of whether they have the capacity to make treatment decisions. On the other hand, a person with a physical disorder cannot be treated non-consensually if they have capacity, even if rejecting treatment may result in death.[59]

23.32 Dawson and Szmukler also argue that a legal shift to an incapacity focus would permit all people (whether mentally ill or not) who harmed or attempted to harm somebody when they had capacity to become the responsibility of the criminal justice system, while those who lacked capacity (because of any disability) could be assisted under guardianship legislation. The shift would allow for 'consistent ethical principles [to be applied] across medical law'.[60]

23.33 Genevra Richardson suggests that discrimination against people with a mental disorder would be avoided if 'mental health care could be provided according to the same principles, including respect for patient autonomy, as those which cover all other forms of health care'.[61] She also suggests that the existence of guardianship laws further entrenches prejudice against mental illness as long as the system coexists with separate mental health legislation.[62] Richardson argues that the existence of the two systems 'encourages the perception of mental disorder as a condition apart'.[63] Where two parallel decision-making structures exist, based on two distinct sets of principles, mental disorder will be regarded as the more threatening and its pariah-status will thus be reinforced.[64]

SOME CAUTIONARY NOTES

23.34 Even the principal advocates of the fusion proposal accept that there have been some benefits in providing involuntary treatment to people with a mental illness under mental health legislation. George Szmukler, Rowena Daw and John Dawson have written:

> *A major strength of non-consensual treatment schemes that are based on incapacity principles is the respect shown for the autonomy of those patients who retain their capacity; but these schemes are, nevertheless, often weak on the regulation of emergency treatment powers, detention in hospital, and forced treatment. These are the areas, in contrast, in which civil commitment schemes are strong. The use of force, and the detention and involuntary treatment of objecting patients, is clearly authorised and regulated by mental health legislation.*[65]

23.35 The relatively few emergency intervention powers and accountability safeguards in guardianship legislation, especially when compared to the Mental Health Act, is a matter of considerable importance when considering the merits of the fusion proposal.

23.36 The G&A Act does not authorise the police (or any other public officials) to enter the premises of people who are suspected of being at risk of harm because of lack of capacity without an order from VCAT. Nor does it allow them to apprehend people in public places and convey them to hospital for further examination or treatment. The G&A Act does permit VCAT to authorise the Public Advocate to enter private premises with a member of the police force for the purposes of preparing a report about the need for a guardianship order and to order, after considering the report, that a person be apprehended for protective purposes.[66] However, this slow process of emergency intervention is poorly suited to mental health crises.

44 *Guardianship and Administration Act 1986* (Vic) s 35A(1).

45 Ibid s 35B(1).

46 Ibid s 23(2)(a).

47 Ibid s 23(2)(b).

48 Campbell, above n 40, 554.

49 Ibid.

50 Ibid.

51 Ibid 556.

52 Ibid 555.

53 Stephen Rosenman, 'Mental Health Law: An Idea Whose Time has Passed' (1994) 28 *Australian and New Zealand Journal of Psychiatry* 561, 562.

54 Ibid, 565.

55 Dawson and Szmukler, 'The Fusion of Mental Health and Incapacity Legislation', above n 40.

56 Ibid 504.

57 Ibid.

58 George Szmukler and Frank Holloway, 'Mental Health Legislation is Now a Harmful Anachronism' (1998) 22 *Psychiatric Bulletin* 662, 663-4.

59 Ibid 662.

60 Dawson and Szmukler, 'The Fusion of Mental Health and Incapacity Legislation' above n 40, 504.

61 Richardson, above n 40, 707.

62 Ibid 716.

63 Ibid.

64 Ibid.

65 George Szmukler, Rowena Daw and John Dawson, 'A Model Law Fusing Incapacity and Mental Health Legislation' (2010) 20 *Journal of Mental Health Law* 11, 12.

66 *Guardianship and Administration Act 1986* (Vic) s 27.

Mental Health Act 1986 (Vic)

23.37 There is a great need for transparent decision-making processes, and external review, when the law authorises public officers to deprive people of their liberty and their right to bodily integrity. Unlike the Mental Health Act, however, the G&A Act has few mechanisms for review of decisions to deprive a person of their liberty and provide treatment without consent. There is no means of reviewing individual decisions made by a guardian—whether appointed personally or by VCAT—acting pursuant to a guardianship order. There is limited capacity to review a decision by VCAT to appoint a guardian. It is possible to appeal on a question of law alone.[67] It is also possible to apply to VCAT for a rehearing of a decision to make a guardianship order.[68]

23.38 External review processes are a central feature of the Mental Health Act, with the Mental Health Review Board having a range of powers to review decisions made by the authorised psychiatrist. By way of contrast, using guardianship laws for the purposes of authorising treatment and place of residence for a person with a mental illness would result in the delegation of what have been seen as significant state powers—those of detention and compulsory treatment—to a single person who may be a friend or relative of the person who is the subject of the guardianship order.

23.39 The guiding considerations for guardians may also be a matter of concern should guardianship legislation become the only means of providing compulsory, but unwanted, treatment to a person with a mental illness. A guardian is required to act in the best interests of the represented person and, whenever possible, to consider that person's wishes before making any decisions.[69] This may be a very difficult undertaking if guardianship is used to authorise involuntary detention and treatment for people with a mental illness. It is inevitable that there will be instances in which the guardian is encouraged by clinical staff to make decisions contrary to the expressed wishes of the represented person. In some instances, the guardian may conclude that it is in the best interests of the represented person to accept clinical advice about treatment rather than follow the wishes of the represented person. This could be a recipe for conflict. In these circumstances, the relationship between a friend or relative who accepts appointment as a guardian and the represented person could be jeopardised.

HUMAN RIGHTS ISSUES

23.40 When evaluating the merits of the fusion proposal, it is helpful to consider the relevant provisions of both the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (the Charter) and the United Nations' *Convention on the Rights of Persons with Disabilities* (the Convention).

23.41 When mental health laws are under consideration, three relevant rights are found in sections 10, 12 and 21 of the Charter. These sections support the values of autonomy and respect for human dignity. Section 10 of the Charter stipulates that a person 'must not be subjected to medical … treatment without his or her full, free and informed consent'. Section 12 refers to the 'right to move freely within Victoria' and 'the freedom to choose where to live', while section 21 declares that '[e]very person has the right to liberty and security'.

23.42 Although a law may legitimately curtail the human rights in the Charter, a Charter right may be subject 'only to such reasonable limits as can be demonstrably justified in a free and democratic society based on human dignity, equality and freedom'.[70] Because both guardianship and mental health laws clearly limit the rights in sections 10, 12 and 21 of the Charter, in order to comply with the Charter they must pass the test set out in section 7(2), which involves consideration of both reasonableness and proportionality.

23.43 The Charter's preamble recognises that 'all people are born free and equal in dignity and rights', and one of its founding principles is that that 'human rights belong to all people without discrimination'.[71] Section 8 of the Charter recognises:

- the right of every person to recognition as a person before the law
- the equality of every person before the law
- the right of every person to equal protection of the law without discrimination, as well as equal and effective protection against discrimination.[72]

23.44 The Convention, which Australia has signed and ratified, deals with human rights in the context of legal capacity and the provision of compulsory treatment.[73] The Convention's preamble and general principles emphasise the dignity and equality of people with a disability, and their right to autonomy and freedom from discrimination.[74] Further, as part of the general obligations of states parties, article 4(1)(b) requires Australia to 'take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices that constitute discrimination against persons with disabilities'.[75]

23.45 Although some people have argued that the Convention requires the abolition of mental health laws,[76] the Australian and Victorian[77] governments have not interpreted the Convention this way. When Australia ratified the Convention, it stated:

> *Australia recognizes that every person with disability has a right to respect for his or her physical and mental integrity on an equal basis with others. Australia further declares its understanding that the Convention allows for compulsory assistance or treatment of persons, including measures taken for the treatment of mental disability, where such treatment is necessary, as a last resort and subject to safeguards.*[78]

COMMUNITY RESPONSES

23.46 The Commission received a range of responses to questions in the information paper concerning the manner in which mental health and guardianship laws should interact. Some stakeholders supported the fusion proposal, some thought it would be a retrograde step, and others suggested there be further debate about the advantages and disadvantages of allowing guardians to authorise non-consensual treatment of people who lack capacity due to mental illness and to make decisions about where they live.

23.47 The submission of Anita Smith, the President of the Tasmanian Guardianship and Administration Board, is particularly important because mental health and guardianship laws are integrated in Tasmania. Ms Smith suggests:

> *With some adjustments, I believe that guardianship legislation can take the place of mental health laws which have not kept pace with contemporary attitudes towards psychiatric disability. In Tasmania, our experience has been that mental health teams are applying for guardianship in preference to imposing mental health orders because they view them as more targeted to the issues requiring decision, more suited to promoting stability and more consistent with therapeutic principles.*[79]

67 *Victorian Civil and Administrative Tribunal Act 1998* (Vic) s 148(2).

68 *Guardianship and Administration Act 1986* (Vic) s 60A.

69 Ibid s 28.

70 *Charter of Human Rights and Responsibilities Act 2006* (Vic) s 7(2).

71 Ibid preamble.

72 Ibid ss 8(1), (3).

73 See in particular *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 999 UNTS 3 (entered into force 3 May 2008) arts 12, 15.

74 Ibid preamble (h), (n), art 3.

75 Ibid art 4(1)(b).

76 See, eg, Tina Minkowitz, 'Abolishing Mental Health Laws to Comply with the Convention on the Rights of Persons with Disabilities' in Bernadette McSherry and Penelope Weller (eds), *Rethinking Right-Based Mental Health Laws* (Hart Publishing, 2010) 151.

77 See Department of Health (Victoria), *Review of the Mental Health Act Consultation Paper—December 2008* (2008) 12–13. This paper did not directly consider whether the Convention should prohibit involuntary mental health treatment, but stated 'it is intended that Victoria will maintain a scheme for involuntary treatment under separate mental health legislation'. This has been the approach of the Department of Health (Victoria) Exposure Draft Mental Health Bill 2010 (Vic), which retains involuntary mental health treatment orders.

78 See United Nations Treaty Collection, *Chapter IV: Human Rights, 15. Convention on the Rights of Persons with Disabilities* <http://treaties.un.org/doc/Publication/MTDSG/Volume%20I/Chapter%20IV/IV-15.en.pdf>.

79 Submission IP 53 (Anita Smith).

Mental Health Act 1986 (Vic)

23.48 Psychiatric Disability Services of Victoria (VICSERV) argued that mental health and guardianship laws should be integrated into one, 'capacity-based' legislative scheme.[80] VICSERV argued that this would remove the discriminatory approach of the current laws—which treats people with a mental illness differently to others—and ensure maximum protection of human rights.[81] Similarly, the Mental Health Legal Centre has called for a single, capacity-based legislative framework for substitute decision making, rather than a diagnosis-based scheme.[82]

23.49 The Law Institute of Victoria argued that the government should consider singular, comprehensive, capacity-based legislation, and noted that the Mental Health Act review had not engaged with the threshold question of whether there is an ongoing need for mental health laws in any depth.[83]

23.50 Other submissions revealed a firm belief that mental health law should remain a distinct body of law. The Health Services Commissioner stated that mental health and guardianship laws should be complementary, but not overlap.[84]

23.51 The Public Advocate stated that there should be separate mental health and guardianship laws, but there is also some necessary overlap between these laws.[85] The Public Advocate argued that where mental health orders are in place, guardianship laws may have an ongoing role, particularly in relation to non-psychiatric treatment decisions, accommodation decisions, and 'access to persons'.[86]

23.52 Victoria Legal Aid argued that mental health laws should remain separate from guardianship laws, noting that mental health laws had developed separately from guardianship laws in many jurisdictions due to the particular issues and rights concerned.[87] Victoria Legal Aid observed that if the two areas are combined, there is a risk that 'each may lose its detailed attention to matters bearing on quality of treatment, effective processes and rights protection'.[88] Like the Public Advocate, Victoria Legal Aid and Aged Care Assessment Services noted that accommodation decisions are an important area where the two bodies of law overlap.[89]

23.53 Aged Care Assessment Services, Action for Community Living, Southwest Advocacy Organisation and two other private submissions also argued that mental health laws should remain separate from guardianship laws.[90]

GUARDIANS AND CONSENT TO PSYCHIATRIC TREATMENT

23.54 Our submissions and consultations also revealed a range of views about whether guardians should be able to consent to psychiatric treatment.

23.55 The Mental Health Legal Centre stated that, subject to appropriate safeguards, it would support guardian consent to psychiatric treatment if the decision maker was appointed by the person themselves under an advance directive document.[91] However, the Centre suggested that more research is necessary to determine if it is desirable or necessary to give VCAT appointed guardians authority to make psychiatric treatment decisions.[92]

23.56 VICSERV argued that the question of whether guardians should consent to psychiatric treatment ultimately depends on the model of decision making adopted, and would like to see a move towards a supported decision-making model and the use of advance directives.[93]

23.57 Both VICSERV and the Mental Health Legal Centre argued that the current situation, in which the authorised psychiatrist is both the substitute decision maker and the person who assesses capacity, is unacceptable.[94]

23.58 Three other submissions also supported the power of guardians to make decisions about mental health treatment in some circumstances.[95]

23.59 Victoria Legal Aid, the Public Advocate and Action for Community Living expressed concern about permitting guardians to make decisions in relation to psychiatric treatment.[96]

23.60 Victoria Legal Aid argued that neither guardians nor people appointed under powers of attorney should be allowed to consent to psychiatric treatment, preferring the current approach which limits consent to the person themselves or a medical specialist, subject to the scrutiny of an independent tribunal.[97]

23.61 The Public Advocate stated that it saw no reason to change the current prohibition on guardians consenting to psychiatric treatment, but that there could be clearer legislative guidance in relation to some 'overlap' areas, such as accommodation decisions.[98]

23.62 Action for Community Living stated that current mental health laws already provide safeguards, and people lacking capacity would not have anything to gain by extending the power to consent to guardians.[99]

23.63 The Health Services Commissioner, while opposed to giving guardians the power to consent to psychiatric treatment, argued that the guardian's views and concerns should be taken into account, and where guardians are included in treatment decisions, their consent or failure to consent should be recorded.[100]

POSSIBLE OPTIONS FOR REFORM

23.64 The Commission believes that the Charter and the Convention, which both emphasise the dignity of all individuals and promote the equal protection of the law for people with a disability, provide a useful framework within which to debate whether guardianship laws should be used to authorise the compulsory treatment and place of a residence of a person with impaired decision-making capacity due to mental illness.

23.65 It can be strongly argued that separate mental health laws discriminate against people with a mental illness when compared to other disabilities affecting capacity, because these laws deny people with a mental illness the right to have a family member or friend make important treatment and residence decisions for them when they are unable to do so. Rosenman's suggestion that permitting a guardian to make psychiatric treatment decisions for a person with impaired decision-making capacity due to mental illness is beneficial, both ethically and clinically, because it separates medical advice from consent also merits serious consideration.

23.66 Many other matters must be considered when debating whether to permit a guardian to authorise compulsory psychiatric treatment. The lack of emergency processes and comprehensive accountability mechanisms in current guardianship laws, as discussed above, suggests caution when considering whether to adopt the fusion proposal.

23.67 Guardianship is seldom used coercively in Victoria. The extent of a guardian's power to use force in relation to a represented person, or to authorise another person to do so, such as when administering an injection of medication without a specific VCAT order, remains unclear. Section 26 of the G&A Act permits VCAT to order that a guardian, or another specified person, is entitled to use force in order to ensure that the represented person complies with the guardian's decisions. The guardian or specified person is indemnified from any legal action for assault or false imprisonment if the use of force in these circumstances is reasonable and in the represented person's best interests. This relatively slow process for authorising the use of force, such as when removing a person from a place where they may be in serious danger, is poorly suited to mental health crises.

80 Submission IP 17 (Psychiatric Disability Services of Victoria) 2.

81 Ibid 3.

82 Submission IP 58 (Mental Health Legal Centre) 49.

83 Submission IP 47 (Law Institute of Victoria) 35–6.

84 Submission IP 42 (Health Services Commissioner) 9.

85 Submission IP 8 (Office of the Public Advocate) 39.

86 Ibid 40. In relation to accommodation decisions, the Public Advocate argued that the law should clarify that guardians may make accommodation decisions where the accommodation placement is not a core component of the person's psychiatric treatment, and also expressed concern about situations where represented people are discharged from a psychiatric facility without the guardian being informed. In relation to non-psychiatric treatment, the Public Advocate seeks the alignment of the definition of 'non-psychiatric treatment' under the *Mental Health Act 1986* (Vic) with the medical treatment provisions in the *Guardianship and Administration Act 1986* (Vic) and *Medical Treatment Act 1988* (Vic).

87 Submission IP 43 (Victoria Legal Aid) 17.

88 Ibid.

89 Submissions IP 43 (Victoria Legal Aid) 17, IP 39 (Aged Care Assessment Services of Victoria) 7.

90 Submissions IP 5 (Southwest Advocacy Association) 7, IP 7 (Stephanie Mortimer) 28, IP 16 (Mark Feigan) 18, IP 39 (Aged Care Assessment Services of Victoria) 7, IP 50 (Action for Community Living) 11.

91 Submission IP 58 (Mental Health Legal Centre) 50–1.

92 Ibid.

93 Submission IP 17 (Psychiatric Disability Services of Victoria) 3–4.

94 Consultation with Mental Health Legal Centre (7 April 2010); Submission IP 17 (Psychiatric Disability Services of Victoria) 4.

95 Stephanie Mortimer supported the power of guardians to make decisions in relation to psychiatric treatment, in consultation with a psychiatrist: Submission IP 7 (Stephanie Mortimer) 7. BENETAS supported the consolidation of all substitute decision-making laws, including by allowing guardians to consent to psychiatric treatment in certain clearly defined circumstances such as urgent treatment: Submission IP 21 (BENETAS) 2. Mark Feigan argued that while guardians should not be required to consent to psychiatric treatment, they should be able to refuse consent: Submission IP 16 (Mark Feigan) 19.

96 Submissions IP 8 (Office of the Public Advocate) 41, IP 43 (Victoria Legal Aid) 17, IP 50 (Action for Community Living) 12.

97 Submission IP 43 (Victoria Legal Aid) 17.

98 Submission IP 8 (Office of the Public Advocate) 41.

99 Submission IP 50 (Action for Community Living) 12.

100 Submission IP 42 (Health Services Commissioner) 10.

Mental Health Act 1986 (Vic)

23.68 There is a strong body of opinion in Victoria that guardianship powers should only be used for the benefit of the represented person and not for the protection of the public. The Public Advocate has said that guardianship 'should never be used as a means of protecting society from dangerous individuals'.[101]

THE RELATIONSHIP BETWEEN GUARDIANSHIP AND MENTAL HEALTH LAWS

23.69 There are three broad options when considering the relationship between guardianship and mental health laws.

Option A: No change

23.70 Under this option, it would remain impossible for a person to appoint an enduring guardian or for VCAT to appoint a guardian to make decisions about psychiatric treatment and place of residence for a person with impaired decision-making capacity due to mental illness. The Mental Health Act would continue to be the sole source of authority to provide compulsory psychiatric treatment and to impose restrictions upon liberty by requiring a person to be a patient in a hospital or to live at a specific place in the community.

Option B: Fusion of guardianship and mental health laws

23.71 This option would bring about the complete fusion of mental health and guardianship law. There would no longer be a Mental Heath Act. Guardianship legislation would become the sole legal mechanism under which medical treatment, hospital confinement and place of residence decisions would be made for all people with impaired decision-making capacity due to any disability.

23.72 Szmukler, Daw and Dawson have recently published a model law, based on the United Kingdom's *Mental Capacity Act 2005* (UK), which would govern the non-consensual treatment of all people without capacity to consent to their own treatment.[102] The authors point out that their scheme applies to all people with impaired capacity, 'whether this is due to schizophrenia, Alzheimer's Disease, a learning disability, a confusional state due to infection, a cerebrovascular accident, a head injury, or any other impairment'.[103]

23.73 Other jurisdictions have been attracted to the fusion proposal. In September 2009, the Northern Ireland Health Minister announced the government's intention to merge mental health and mental capacity legislation by 2014.[104] In 2009, the ACT published a review of its mental health legislation in which it identified three options for the framework of new laws.[105] One of those options is a mental capacity statute that would bring about the fusion of mental health and guardianship legislation.

Option C: Limited use of guardianship for non-consensual psychiatric treatment (preferred)

23.74 This option would allow guardianship to be used as a mechanism for authorising psychiatric treatment and place of residence in some circumstances. The Mental Health Act and guardianship legislation would operate as parallel mechanisms, under which a third person would be permitted to authorise psychiatric treatment and determine the place of residence for a person with a mental illness. Under this option, an enduring guardian (with appropriate powers) would be able to authorise all forms of treatment and place of residence decisions for a represented person with a mental illness when that person does not have the capacity to make their own decisions about these matters. The powers of the enduring guardian would prevail over those of an authorised psychiatrist under the Mental Health Act, except in cases of emergency when there is a serious risk of immediate harm to the represented person or others and insufficient time to contact the enduring guardian with the recommendation that their powers be exercised for the represented person's benefit.

23.75 Under this option, it would also be possible for VCAT or the Mental Health Review Board to appoint a guardian, who is a family member or friend of a person with impaired decision-making capacity due to mental illness, to make psychiatric treatment and place of residence decisions for the represented person. The tribunal would be able to make this decision if it believes that it would enhance the dignity and promote the wellbeing of that person for these decisions to be made by a trusted family member or friend. In these circumstances, the powers of the enduring guardian would prevail over those granted to an authorised psychiatrist under the Mental Health Act.

23.76 The Commission prefers Option C, but acknowledges that this proposal represents a marked change in the way in which psychiatric treatment and place of residence decisions are made for people with impaired capacity due to mental illness. Option C represents a step down the long path of ensuring that people with a mental illness enjoy equal protection of the law. At this stage, the Commission believes that Option B is a step too far because of the need for comprehensive emergency procedures when dealing with mental health crises.

23.77 In order to be workable, Option C would require widespread support from consumers, carers and clinicians. Many matters of detail—such as the accountability mechanisms for guardians and the means of resolving disagreements between clinicians and guardians—would need to be considered. The Commission invites debate about the merits of Option C.

Question 157 Do you agree with the Commission's proposal (Option C) that it should be possible, in some circumstances, for guardianship to be used as a mechanism for authorising psychiatric treatment and place of residence decisions for a person who is unable to make their own decisions due to mental illness?

101 Submission IP 8 (Office of the Public Advocate).

102 Szmukler, Daw and Dawson, above n 65.

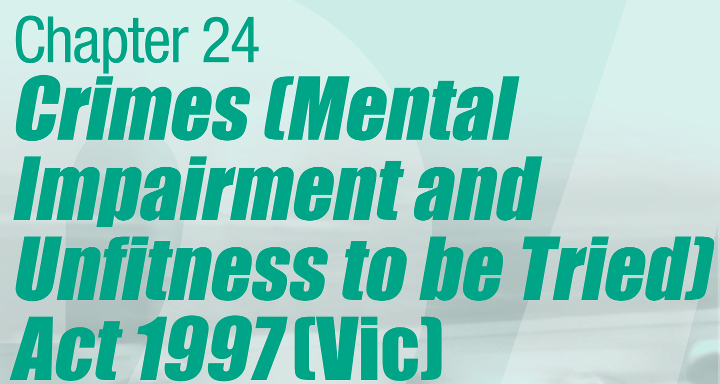
103 Ibid 11.

104 Northern Ireland Department of Health, Social Sciences and Public Safety (Press Release, 10 September 2009).

105 ACT Health, Mental Health Policy Unit, *The Framework of Mental Health and Related Legislation in the ACT: An Options Paper* (November 2009).

Chapter 24

Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic)



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Chapter 24

Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic)

INTRODUCTION

24.1 This chapter considers the relationship between guardianship laws and the *Crimes (Mental Impairment and Unfitness to be Tried Act 1997* (Vic) (CMIUT Act).

24.2 We consider whether there is, or should be, a role for a guardians in the following situations:

- proceedings under the CMIUT Act
- assisting people detained under the CMIUT Act during the period of their detention.

CURRENT LAW

24.3 The CMIUT Act deals with situations where a person charged with a criminal offence is found unfit to stand trial or not guilty because of mental impairment.

24.4 A finding that a person is unfit to stand trial concerns their mental capacity at the time of the trial, whereas the defence of mental impairment is concerned with a person's mental state at the time the alleged offence occurred.

24.5 The key principle in the CMIUT Act is that 'restrictions on a person's freedom and personal autonomy should be kept to the minimum consistent with the safety of the community'.[1]

UNFITNESS TO STAND TRIAL

24.6 A person may be found unfit to stand trial if their mental processes are disordered or impaired and because of it they are, or at some time during the trial will be unable to:

- understand the nature of the charge
- enter a plea to the charge and to exercise the right to challenge jurors or the jury
- understand the nature of the trial (namely that it is an inquiry as to whether the person committed the offence)
- follow the course of the trial
- understand the substantial effect of any evidence that may be given in support of the prosecution, or
- give instructions to their legal practitioner.[2]

24.7 If the issue of unfitness is raised, an investigation will be conducted in order to determine whether the person is fit to stand trial.[3] If the person is found fit to stand trial, the trial is commenced or resumed in accordance with usual criminal procedures.[4] If the person is likely to become fit within the next twelve months, the trial is adjourned for a specified period and the defendant will be either granted bail, remanded in custody in an 'appropriate place' or remanded in custody in prison.[5]

24.8 If a person is unfit to stand trial and they are unlikely to become fit within the next twelve months, then a special hearing must be held within three months.[6]

SPECIAL HEARING

24.9 A special hearing determines whether the person:

- is not guilty of the offence
- is not guilty of the offence because of mental impairment
- committed the offence charged or an offence available as an alternative.[7]

24.10 Because the defendant has been found unfit to stand trial, they are unable to enter a plea; the special hearing is conducted as if the person has pleaded not guilty.[8]

MENTAL IMPAIRMENT

24.11 A person is not guilty because of mental impairment if, at the time of the alleged offence, they had a mental impairment that meant they:

- did not know the nature and quality of what they were doing, or
- did not know that what they were doing was wrong.[9]

EFFECT OF FINDING THAT A PERSON COMMITTED THE OFFENCE OR IS NOT GUILTY BECAUSE OF MENTAL IMPAIRMENT

24.12 If a person is found to have committed the offence or is not guilty because of mental impairment, they must either be released unconditionally[10] or placed under a supervision order.[11]

SUPERVISION ORDER

24.13 A supervision order can mean one of three things:

- a custodial supervision order for custody in prison[12]
- a custodial supervision order for custody in an 'appropriate place'[13]
- a non-custodial supervision order releasing the person on certain conditions.[14]

24.14 Custody in an 'appropriate place' for a person with a mental illness means an approved mental health service.[15] The person becomes a 'forensic patient' under the *Mental Health Act 1986* (Vic).[16] The Victorian Institute of Forensic Mental Health (Forensicare) is responsible for managing all forensic patients. At present, all forensic patients under custodial supervision orders are detained in Thomas Embling Hospital, a 118-bed secure hospital.[17] Forensic patients on non-custodial supervision orders or those on extended leave from Thomas Embling Hospital are managed on an out-patient basis by the Community Forensic Mental Health Service of Forensicare.[18]

24.15 An appropriate place for a person with an intellectual disability would be a residential institution[19] or residential treatment facility.[20] The person is a 'forensic resident' under the *Disability Act 2006* (Vic).[21]

1 *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 39. This principle must be applied when deciding whether to make, vary or revoke a supervision order, to remand a person in custody, to grant a person extended leave or to revoke a grant of extended leave under the Act.

2 Ibid s 6(1). Memory loss is not in itself sufficient to make a person unfit to stand trial: at s 6(2).

3 Ibid pt 2.

4 Ibid s 12(1).

5 See ibid ss 11(4)(b), 12(2).

6 Ibid s 12(5).

7 Ibid ss 15, 17. A finding that a person committed the offence is a 'qualified finding of guilt', it does not constitute a basis in law for any conviction for the offence to which the finding relates and constitutes a bar to further prosecution in respect of the same circumstances: at s 18(3).

8 Ibid s 16(2).

9 Ibid s 20(1).

10 Ibid ss 18(4)(b), 23(b).

11 Ibid ss 18(4)(a), 23(a). If the Magistrates' Court finds a person not guilty because of mental impairment of a summary offence or an indictable offence heard and determined summarily, the Magistrates' Court must discharge the person: at s 5(2). We note that a specialist 'mental health list' is being piloted at the Melbourne Magistrates' Court. It is aimed at better addressing the needs and rights of people with a mental impairment. The Department of Justice (Victoria), *Justice Mental Health Strategy* (2010) 36 indicates that in the future it is possible that the mental impairment defence and/or unfitness to be tried matters may be integrated into the Magistrates' Court specialist mental health list.

12 Ibid s 26(2)(a)(ii). The court may only make a custodial supervision order for custody in prison if it is satisfied that there is no practicable alternative in the circumstances: at s 26(4).

13 Ibid s 26(2)(a)(i). Section 3(1) defines an appropriate place as (a) an approved mental health service; or (b) a residential treatment facility; or (c) a residential institution. A court may only make a custodial supervision order for custody in an appropriate place if it has received a certificate made under s 47 stating that the facility necessary for the order is available: at s 26(3).

14 Ibid s 26(2)(b).

15 Ibid s 3(1) defines an 'approved mental health service' to have the same meaning as in the *Mental Health Act 1986* (Vic). Section 3(1) of the *Mental Health Act 1986* (Vic) provides that 'approved mental health service' means premises or a service (a) proclaimed to be an approved mental health service under s 94, including the Victorian Institute of Forensic Mental Health; or (b) declared to be an approved mental health service under s 94A.

16 *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 3 (1); *Mental Health Act 1986* (Vic) s 3(1).

17 Victorian Institute of Forensic Mental Health, *Annual Report 2008–2009* (2009) 8. The Department of Justice, (Victoria), above n 11, 19 identifies access to forensic mental health beds at Thomas Embling Hospital as a key issue. In 2008–09, 4% of patients at Thomas Embling Hospital were forensic patients detained under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic): see Victorian Institute of Forensic Mental Health, *Annual Report 2008-2009* (2009) 24.

18 Submission IP 48 (Victorian Institute of Forensic Mental Health) 3.

19 *Disability Act 2006* (Vic) s 86. The institutions named in the Act are Sandhurst, Colanda and Kew Residential Services. Since the Disability Act came into law, Plenty Residential Services has also been proclaimed as a residential institution: see Governor of Victoria, '*Intellectually Disabled Persons' Services Act 1986*: *Disability Act 2006*—Revocation and Proclamation of Residential Institution Long Term Rehabilitation Program' in Victoria, *Victoria Government Gazette*, No G 26, 28 June 2007, 1302. Further, the proclamation of one of these residential institutions—Kew Residential Services—has now been revoked: see Governor of Victoria, '*Disability Act 2006* (Vic)—Revocation of Proclamation' in Victoria, *Victoria Government Gazette*, No G 35, 28 August 2008, 2060. Although the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) allows for placement within any of these facilities, the Department of Human Services considers that the only appropriate option within disability services is the Long Term Residential Program at Plenty Residential Services: see Department of Human Services (Victoria), *Disability Services Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 Practice Guidelines* (2007) 31.

20 The Intensive Residential Treatment Facility within the Disability Forensic Assessment and Treatment Service is deemed to have been proclaimed as a residential treatment facility under the *Disability Act 2006* (Vic) s 151(6). It provides assessment and treatment in a secure facility for a small number of adults with an intellectual disability who have met the criteria for admission under s 152 of the *Disability Act 2006* (Vic).

21 *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 3(1); *Disability Act 2006* (Vic) s 3(1).

Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic)

REVIEW AND APPEAL OF SUPERVISION ORDERS

24.16 A person may appeal to the Court of Appeal against a supervision order concerning them. A number of other designated people, such as the Director of Public Prosecutions, can also appeal to the Court of Appeal against a supervision order if they consider it in the public interest to do so.[22]

24.17 Supervision orders are made for an indefinite period.[23] However, the court must set a 'nominal term' for the supervision order.[24] The court must make a major review of the supervision order at least three months before the end of the nominal term and after that, at least every five years.[25]

24.18 The rules of evidence do not apply to a major review. Instead, the hearing is conducted in a more informal, quasi-inquisitorial way.[26] The court 'may inform itself in relation to any matter in such manner as it thinks fit'.[27] In practice, much of the information that the court considers, at least in relation to forensic patients, is independent psychiatric testimony about the person's psychiatric and psychological functioning.[28]

24.19 An application can be made to vary a custodial supervision order, or vary or revoke a non-custodial supervision order by:

- the person subject to the order
- a person having custody, control, care or supervision of the person
- the Director of Public Prosecutions or the Attorney-General.[29]

COMMUNITY RESPONSES

24.20 In our information paper, we asked what role guardians should have for people who may be affected by the CMIUT Act. Only a small number of people responded to this question.

24.21 Some submissions suggested that the role of guardians for people affected by the CMIUT Act should be the same as the role for any other person who needs or has a guardian.[30]

24.22 The Public Advocate considered that:

> *guardians should only have a role under the Crimes (Mental Impairment and Unfitness to be Tried) Act where a guardianship-type decision needs to be made (regarding, for instance, accommodation or health care). Aside from this, guardians should have no specific role in relation to this Act. OPA may, in certain circumstances, have an advocacy role in relation to a person who is subject to this legislation.*[31]

24.23 The Health Services Commissioner submitted that '[g]uardians should be engaged as partners in treatment and care for the represented person'.[32]

24.24 Forensicare made a detailed submission in which it considered the role of guardians under the CMIUT Act at two points: first, in judicial proceedings under the Act and secondly in assisting people detained under the Act during their detention.

24.25 Forensicare argued that a guardian should not have a role in judicial proceedings under the CMIUT Act, because the Act contains a number of mechanisms designed to provide protection and 'to advance the rights and interests of mentally ill offenders during the course of judicial proceedings under the [CMIUT Act]'.[33]

24.26 The mechanisms it identifies are:

- a relaxation of the rules of evidence in hearings to make the hearing a quasi-inquisitorial inquiry (although we note that this relaxation of procedure only applies to hearings once the person is already under a supervision order; it does not apply to 'special hearings' held when a person is unfit to stand trial. In a special hearing, the rules of evidence apply)[34]
- the person's entitlement to be legally represented
- special hearings for people who are unfit to stand trial
- the ability to raise fitness to stand trial at any time
- the principle in the CMIUT Act that must be applied by the court that 'restrictions on a person's freedom and personal autonomy should be kept to the minimum consistent with the safety of the community'.[35]

24.27 In light of these safeguards, Forensicare considered that:

> *The appointment of a guardian to make decisions in relation to any such proceeding is … unnecessary and superfluous. Accordingly, Forensicare is in agreement with the decision of In the Matter of R (unreported, VCAT, Deputy President Sandra Davis, 13 October 1999) (see also PL (Guardianship) [2007] VCAT 2485) which held that there is no self-evident role for a guardian in legal proceedings under the [CMIUT Act].*[36]

24.28 It suggested that advocates (provided by the Office of the Public Advocate) may have an important role to play in assisting people who are involved in legal proceedings under the CMIUT Act:

> *[W]hile the decision-making role of a guardian in [CMIUT Act] proceedings is considered unnecessary, the provision of an advocate may be helpful in assisting forensic patients in the navigation of the legal process, including the attainment of legal representation and the communication of instructions to the legal representative.*[37]

24.29 The majority of forensic patients detained at Thomas Embling Hospital do not have a guardian or administrator appointed in an ongoing role.[38] Forensicare argued that there is a role for guardians in assisting people detained under the CMIUT Act. People detained as forensic patients under the CMIUT Act have significant decision-making power removed from them, in many cases for long periods of time. For example, the authorised psychiatrist may consent to treatment for a mental illness and may also provide treatment for non-psychiatric medical complaints.[39]

24.30 Forensicare considered that, in some situations, the appointment of a guardian would be beneficial, noting

> *the potential for the appointment of guardians to provide an important check on the way in which the broader day-to-day treatment and management of forensic patients is undertaken (beyond the confines of the judicial process), ensuring that the interests and wishes of forensic patients are taken into account. Examples of instances where the independent oversight of a guardian may be useful include the timing of leave applications and applications for reduced CMIA supervision, and decisions regarding the appropriateness of accommodation placements on discharge (such as aged care residential services or continuing care units).*[40]

22 Ibid s 28A.

23 Ibid s 27(1). When it makes a supervision order, the court may direct that the matter be brought back to the court for review at the end of the period specified by the court: at s 27(2).

24 Ibid s 28.

25 Ibid s 35(1). The court must vary a custodial supervision order to a non-custodial supervision order, unless satisfied that the safety of the person subject to the order or members of the public will be seriously endangered as a result of the release of the person on a non-custodial supervision order: at s 35(3)(a)(i). If it is a non-custodial supervision order, it may confirm the order, vary the conditions of the order or revoke the order: at s 35(3)(b).

26 Ibid s 38.

27 Ibid s 38(1). This relaxation of the rules of evidence also applies to a number of other hearings specified in s 38(1). It does not apply to 'special hearings': at s 16(2)(d).

28 Submission IP 48 (Victorian Institute of Forensic Mental Health) 3. If a person is under a supervision order, a report must be made and filed with the court at intervals of not more than 12 months for the duration of the order, detailing (a) treatment, therapy or counselling that the person has undergone, or any services that the person has received, since the making of the order or the last report; and (b) any changes to the prognosis of the person's condition or the person's behavioural problems and the plan for managing the condition or problems. The purpose of the report is to assist the court in determining any application or review for the person to whom the report relates: ibid ss 41(3), (3A). See also s 40, which details the matters the court must consider in deciding whether to make, vary or suspend an order, or order release or a significant reduction in the degree of supervision.

29 *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 31.

30 Submissions IP 7 (Stephanie Mortimer) 4, IP 8 (Office of the Public Advocate) 39 and IP 43 (Victoria Legal Aid) 17.

31 Submission IP 8 (Office of the Public Advocate) 39.

32 Submission IP 42 (Office of the Health Services Commissioner) 9.

33 Submission IP 48 (Victorian Institute of Forensic Mental Health) 4.

34 *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 16(2)(d).

35 Submission IP 48 (Victorian Institute of Forensic Mental Health) 3–4.

36 Ibid 4. The submission refers to the decisions of *In the Matter of R* (unreported, VCAT, Deputy President Sandra Davis, 13 October 1999) and *PL (Guardianship)* [2007] VCAT 2485. These decisions determined that the G&A Act does not provide for substitute decision making in criminal matters and the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) does not confer power on VCAT to appoint a substitute decision maker in the context of proceedings under that Act.

37 Submission IP 48 (Victorian Institute of Forensic Mental Health) 4.

38 Ibid 4.

39 Ibid 5.

40 Ibid 5.

Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic)

24.31 It indicated that, at times, it has sought the appointment of a guardian but this has been resisted by the Public Advocate 'on the basis that, in relation to involuntary patients under the *Mental Health Act 1986* (Vic), it is less restrictive for the authorised psychiatrist to act on their behalf'.[41] Forensicare told us that:

> *This position has been informed by OPA's broad interpretation of the definition of treatment under section 3 of the Mental Health Act 1986 (Vic). In particular, OPA has advised Forensicare in the past that decisions related to accommodation placement on discharge from Thomas Embling Hospital fall within the boundaries of treatment. This interpretation raises some disquiet and places Forensicare in a difficult position in regards to the preservation of the therapeutic relationship, particularly where a forensic patient objects to the accommodation proposal. In such instances, a guardian may provide valuable independent oversight of the appropriateness of the proposal, benefiting both Forensicare and, ultimately, the court when adjudging the issue. Here, the potential for the guardian to give evidence before the court may provide valuable judicial assistance and ensure that the interests of the forensic patient remain at the forefront of the decision-making process.*[42]

POSSIBLE OPTIONS FOR REFORM

24.32 People who are subject to the CMIUT Act and have guardianship needs should be treated no differently to other people. The Commission does not believe that guardians should have a special role in relation to people subject to the CMIUT Act. In many cases, a person detained under the CMIUT Act will retain capacity to make some decisions, while other decisions will be made for them under the provisions of the CMIUT Act. In appropriate cases, a guardian may be appointed to make decisions, but this does not include substitute decision making about legal proceedings under the CMIUT Act.

24.33 The Commission agrees with the view expressed by both the Public Advocate and Forensicare that, in some cases, an advocate may be needed for people subject to the CMIUT Act. This need may arise during legal proceedings or during a period of detention under the CMIUT Act.[43]

24.34 In most cases, an advocate could provide the assistance required by people detained under the CMIUT Act that Forensicare has identified.

24.35 An area of concern is the fact that if a person is found not guilty because of mental impairment and placed on a custodial supervision order, there is no requirement to review the order for a very long period of time (for example, the nominal period for murder is 25 years). In addition, after a major review occurs, the order may be confirmed and not reviewed for another five years.[44] There may be a role for an advocate to see people detained under a custodial supervision order regularly to assist and support them in determining if they should apply for a review to vary the order. An advocate could also assist the person when making any application for a review.

24.36 In some cases, a person subject to proceedings or detained under the CMIUT Act may not have easy access to an advocate.

24.37 The Commission believes that it might be desirable to provide people detained under the CMIUT Act with an advocate at particular times. Those times include:

- at regular intervals during a period that a person is detained on a custodial supervision order
- during a special hearing under the CMIUT Act to assist the person in navigating the legal process
- during hearings such as major reviews of a supervision order, or applications to vary a custodial supervision order
- when decisions about accommodation placements after discharge are being made.

24.38 The most obvious agency to meet these advocacy needs is the Public Advocate. In the past, the Public Advocate has provided advocacy to some people involved in CMIUT proceedings.[45] The Public Advocate's role in providing advocacy services is currently unclear and in Chapter 20 we suggest that this role should be set out in legislation and appropriately resourced.

Question 158 Do you believe that an advocate should be made available to a person subject to the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) at particular times?

Question 159 Do you believe that the Public Advocate should be given a formal role as an advocate for people involved in proceedings or detained under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic)?

41 Ibid 5.

42 Ibid 5–6.

43 The Department of Justice (Victoria), above n 11, 19 identifies the limited capacity of community legal and advocacy service centres to provide the specialist advice and support that is sometimes required as a key issue for people with a mental impairment who come into contact with the criminal justice system.

44 *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) s 35(1)(b).

45 For example, in *PL (Guardianship)* [2007] VCAT 2485 (10 December 2007) [14], reference is made to the provision of advocacy services to PL by the Office of the Public Advocate to help him apply to Victoria Legal Aid for legal representation.

Appendices

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Appendix A INFORMATION PAPER CONSULTATIONS

CONSULTATIONS		
1	The Victorian Advocacy League for Individuals with Disability Inc (VALID) Western Regional Client Network	2 March 2010
2	VALID Northern Regional Client Network	3 March 2010
3	State Trustees Limited	9 March 2010
4	Council on the Ageing (COTA) Victoria	9 March 2010
5	Office of the Public Guardian, Alberta Canada	16 March 2010
6	Jeffrey Chan—Senior Practitioner at DHS	16 March 2010
7	Office of the Public Advocate	16 March 2010
8	John Billings	17 March 2010
9	Australian Bankers' Association (Sydney—phone)	18 March 2010
10	Fiona Smith	18 March 2010
11	Seniors groups roundtable (Aged and Community Care Victoria; COTA Victoria; Seniors Information Victoria; Seniors Rights Victoria; Elder Rights Advocacy; National Seniors (Victoria); Housing for the Aged Action Group)	26 March 2010
12	Julian Gardner	26 March 2010
13	Roundtable with people with disabilities, carers and advocates in Morwell (in partnership with Gippsland Disability Resource Council)	29 March 2010
14	Roundtable with service providers in Morwell (in partnership with Gippsland Disability Resource Council)	29 March 2010
15	NIDUS Personal Planning Resource Centre and Registry, British Columbia	31 March 2010
16	Respecting Patient Choices Team—Austin Hospital	6 April 2010
17	Mental Health Legal Centre	7 April 2010
18	Roundtable with mental health consumers (in partnership with Mental Health Legal Centre Inc (MHLC) and Victorian Mental Illness Awareness Council (VMIAC))	7 April 2010
19	Roundtable with carers in Hastings (in partnership with Carers Australia (Victoria))	8 April 2010
20	Roundtable with trustee organisations (ANZ Trustees Ltd; Equity Trustees Ltd; Trust Company Ltd (in partnership with Trustee Corporations Association))	9 April 2010
21	Ruth Vine—Chief Psychiatrist, Department of Health	9 April 2010
22	Law Institute Victoria	13 April 2010
23	FTL Judge and Papaleo	14 April 2010
24	Mental Illness Fellowship Victoria	14 April 2010
25	Roundtable with carers, people with disabilities and service providers in Ballarat (in partnership with Grampians Disability Advocacy)	15 April 2010
26	Alzheimer's Australia (Victoria)	19 April 2010
27	Villamanta Disability Rights Legal Service	19 April 2010
28	VAILD Southern Regional Client Network	20 April 2010
29	David Green	21 April 2010

CONSULTATIONS		
30	Action on Disability within Ethnic Communities (now Advocacy Disability Ethnicity Community)	21 April 2010
31	Roundtable with carers and service providers in Shepparton (in partnership with Regional Information & Advocacy Council (RIAC))	22 April 2010
32	Roundtable with service providers in Mildura (in partnership with RIAC)	27 April 2010
33	Roundtable with carers and people with disabilities in Mildura (in partnership with RIAC)	27 April 2010
34	Mallee Family Care Mildura	28 April 2010
35	Oasis Aged Care Mildura	28 April 2010
36	Principal Aged Care Mildura	28 April 2010
37	Centrelink (Canberra—phone)	30 April 2010
38	Roundtable with people with aquired brain injuries (in partnership with Brain Injury Matters)	3 May 2010
39	Roundtable with Federation of Community Legal Centres—Elder Law Group	3 May 2010
40	Roundtable with Self Advocacy Resource Unit (SARU)	4 May 2010
41	Margaret Ryan and Max Jackson	4 May 2010
42	Roundtable with Disability Advocacy Resource Unit (DARU)	5 May 2010
43	Victorian Aboriginal Legal Service	6 May 2010
44	Roundtable with metropolitan carers (in partnership with Carers Australia (Victoria))	6 May 2010
45	Family members—guardians and administrators	7 May 2010
46	Tony and Heather Tregale	7 May 2010
47	Mary Dight	7 May 2010
48	State Trustees client	7 May 2010
49	Roundtable with Royal District Nursing Service	10 May 2010
50	Spectrum Migrant Resource Centre	12 May 2010
51	Aged and Community Care Victoria	12 May 2010
52	Forum with Gippsland Carers Association	25 May 2010
53	VCAT Members	2 June 2010

Appendix B INFORMATION PAPER SUBMISSIONS

SUBMISSIONS		
1	Carers Australia (Victoria)	28 May 2010 (revised)
2	Anonymous	13 October 2009
3	Stephanie Mortimer	13 January 2010
4	Confidential	29 March 2010
5	Southwest Advocacy Association	12 April 2010
6	Mark Lacey	21 April 2010
7	Stephanie Mortimer	27 April 2010
8	Office of the Public Advocate (Victoria)	7 May 2010
9	Royal District Nursing Service	7 May 2010
10	Gippsland Carers Association Inc.	10 May 2010
11	Tony & Heather Tregale	11 May 2010
12	Katherine Haggarty	11 May 2010
13	Anonymous	11 May 2010
14	Anthony J Walsh	13 May 2010
15	Confidential	13 May 2010
16	Mark Feigan	13 May 2010
17	Psychiatric Disability Services Of Victoria (VICSERV)	13 May 2010
18	BMC Ministries Inc.	13 May 2010
19	Scope (Vic) Ltd	13 May 2010
20	Dying With Dignity Victoria Inc	13 May 2010
21	BENETAS	13 May 2010
22	Epworth Foundation	13 May 2010
23	Mental Illness Fellowship Victoria	14 May 2010
24	St Kilda Legal Service	14 May 2010
25	Eve Kinnear	14 May 2010
26	The Alfred	14 May 2010
27	Marillac	14 May 2010
28 a, b	People with Disability Australia (PWD)	14 May 2010
29	Australian Association of Social Workers (AASW)	14 May 2010
30	Victorian Aboriginal Legal Service (VALS)	14 May 2010
31	Pamela Faulkner	14 May 2010
32	NSW Guardianship Tribunal	14 May 2010
33	Trustee Corporations Association of Australia	14 May 2010
34	Anonymous	14 May 2010

SUBMISSIONS		
35	Loddon Campaspe Community Legal Centre	14 May 2010
36	Royal College of Nursing Australia	14 May 2010
37	Victorian Equal Opportunity and Human Rights Commission (VEOHRC)	14 May 2010
38	Dr John B Myers	14 May 2010
39	Aged Care Assessment Services of Victoria (ACAS)	14 May 2010
40	Australian & New Zealand Society for Geriatric Medicine	14 May 2010
41	Anonymous	14 May 2010
42	Office of the Health Services Commissioner	17 May 2010
43	Victoria Legal Aid (VLA)	18 May 2010
44	Australian Bankers' Association (ABA)	19 May 2010
45	Victoria Police	19 May 2010
46	Troy Huggins	20 May 2010
47	Law Institute of Victoria Ltd (LIV)	21 May 2010
48	Victorian Institute of Forensic Mental Health	24 May 2010
49 a, b	Council on the Ageing (COTA) Victoria and Seniors Rights Victoria	24 May 2010
50	Action for Community Living	26 May 2010
51	Confidential	28 May 2010
52	Spectrum Migrant Resource Centre	28 May 2010
53	Anita Smith	31 May 2010
54	PILCH Homeless Persons' Legal Clinic	31 May 2010
55	The Australian Psychological Society Ltd	31 May 2010
56	JacksonRyan Partners	15 June 2010
57	Alfred Hospital Ethics Committee and General Ethical Issues Sub-Committee	23 September 2010
58	Mental Health Legal Centre (MHLC)	20 October 2010
59	State Trustees Limited	1 November 2010
60	Guardianship Board of South Australia	3 November 2010

Consultation Paper Questions to Guide Submissions

PART 2: THE DIRECTION OF NEW LAWS

CHAPTER 4: STRUCTURE OF NEW LAWS

1. Do you have any general comments about the matters identified by the Commission as influencing the need for change? Are there any other important matters that should affect the content of future guardianship laws?

CHAPTER 5: PRINCIPLES OF NEW LAWS

2. Do you agree with the Commission's draft statement of purpose for new guardianship laws?
3. Do you agree with the Commission's draft general principles for new guardianship laws?
4. Are there principles you think should be added or removed from these general principles?

CHAPTER 6: CLEAR AND ACCESSIBLE LAWS

5. Do you agree with the Commission's proposal that Victoria's various substitute decision-making laws be consolidated into one single Act?
6. Do you agree with the Commission's proposal that the term 'medical decision maker' or 'health decision maker' should replace 'person responsible' in legislation? If so, which one do you prefer?
7. Do you agree with the Commission's proposal that the term 'guardian' should be replaced with 'adult guardian'?
8. Do you agree with the Commission's proposal that the term 'administrator' should be replaced with 'financial guardian'?
9. Should the terminology used for powers of attorney be better integrated with the terminology for guardianship and administration? What terms should be used?
10. Do you have any specific ideas about how to better target education about guardianship laws towards:
    - people with disabilities
    - family, friends and carers of people with disabilities
    - CALD groups
    - Indigenous communities
    - older people
    - young people
    - health and community sector professionals
    - lawyers?
11. Should the Public Advocate play a greater role in producing community education materials and educating the community about substitute decision making? What other bodies could play a role?
12. Would an educational and awareness campaign assist the community to better understand and make use of guardianship laws?
13. What type of data do you think needs to be collected and made available and from what bodies?

PART 3: SUPPORTED DECISION MAKING

CHAPTER 7: SUPPORTED DECISION MAKING

14. Do you agree with the Commission's proposal to introduce new supported decision-making arrangements?
15. Do you agree with any or all of the proposed roles of supporters and co-decision makers?
16. What steps would need to be taken in order to ensure that these appointments operated fairly and efficiently?
17. Do you agree that the Public Advocate should not be a 'supporter' or a 'co-decision maker'?
18. Do you think that the Public Advocate should play a role in training supporters and co-decision makers, and monitoring supported decision-making arrangements?
19. Should the Public Advocate establish and coordinate a volunteer support program to assist people who do not have family or friends willing and able to take on these roles?
20. Should 'supporter' or 'co-decision-maker' arrangements apply to financial matters, or be limited to personal decision making?
21. Do you agree with the suggested training and monitoring roles for the Public Advocate? Are there any other functions the Public Advocate should perform in relation to supporters?
22. What safeguards do you think are necessary to protect supported people from abuse?

PART 4: PERSONAL APPOINTMENTS

CHAPTER 8: PERSONAL APPOINTMENTS

23. Should all enduring powers be activated at the same time? If so, when should this occur?
24. Should parents and carers of children with disabilities be able to file a document with VCAT that states their wishes about future guardianship or administration arrangements?
25. Should these wishes be a factor VCAT is required to consider when it appoints a substitute decision maker or supporter?
26. Should the number of enduring appointments be reduced from three to two by removing the option of appointing an agent under the *Medical Treatment Act 1988* (Vic) and by requiring people to use an enduring guardianship appointment for medical treatment matters?
27. Should there only be one type of appointment with a range of possible powers?
28. Should an online registration system be created for enduring powers?
29. Which organisation should hold the register?
30. Should registration be voluntary or compulsory?
31. If registration is compulsory, what effect should this have on unregistered appointments?
32. When is the best time for registration to occur?
33. Who should have access to the register? What safeguards could be put in place to protect an individual's privacy while allowing appropriate people to access it?
34. Should it be necessary to notify a public authority and/or various other people when a power of attorney is activated?
35. Should a donor be able to specify that certain people should be notified when a power of attorney is activated? Who should be notified and why?
36. How might notification work in a situation where a person's capacity is fluctuating?
37. Should a donor also be able to specify that people/bodies should not be notified when a power of attorney is activated?

CHAPTER 9: DOCUMENTING WISHES ABOUT YOUR FUTURE

38. Do you think that the law concerning instructional medical directives should be set out in legislation?
39. Do you think it should be possible to make statutory instructional directives about things other than medical treatment?
40. What types of things should it be possible to include in an instructional directive?
41. Should the wishes expressed in a document making a personal appointment be binding, or should they merely be matters that the personally appointed decision maker must consider?
42. If the wishes are merely one of the matters that the personally appointed decision maker must consider, should that person be required to provide written reasons for departing from them?
43. If the wishes are binding upon the personally appointed decision maker, should it be possible to override them in some circumstances? Do you think VCAT should perform this role and (if so) in what circumstances?
44. Should the same rules apply to both enduring guardians and enduring attorneys (financial)? If not, in what circumstances should they differ?
45. Should there be sanctions for overriding an instructional directive in a way that does not comply with the law? What should these sanctions be?
46. Should there be an electronic registration system for advance directives?
47. Should registration extend to medical and lifestyle instructional directives?
48. Should registration be voluntary or compulsory?
49. Are there issues that arise in relation to the registration of advance directives that differ from those that are relevant when considering the registration of personal appointments?

Consultation Paper Questions to Guide Submissions

PART 5: VCAT APPOINTMENTS

CHAPTER 10: VCAT APPOINTMENTS AND WHO THEY ARE FOR

50. Do you agree with the Commission's proposal that disability should no longer be a separate criterion for the appointment of a substitute decision maker, but that it should be necessary for VCAT to find that a person is incapable of making their own decisions because of a disability before it can appoint a guardian or an administrator?

51. Do you agree with the Commission's suggestions for capacity principles (Option A) and a legislative definition of incapacity (Option B) in order to provide legislative guidance on how to determine when a person is unable to make their own decisions? Are there additional or other ways to provide this guidance?

52. Do you agree with the Commission's proposal (Option B) that new guardianship laws should allow VCAT to appoint a guardian or an administrator for a person when it is satisfied that the person is unable to make their own decisions because of a disability—and is unlikely to regain or achieve that capacity—and might have some future need for a guardian or an administrator?

CHAPTER 11: AGE

53. Do you agree with the Commission's proposal (Option C) to lower the age limit of the *Guardianship and Administration Act 1986* (Vic) to 16 and to raise the age limit of the *Children, Youth and Families Act 2005* (Vic) to 18?

54. Is there a risk that young people may not have access to the same services that are currently available if the Commission's proposal is adopted? What could be done to manage this risk?

CHAPTER 12: THE DISTINCTION BETWEEN GUARDIANSHIP AND ADMINISTRATION

55. Should the current distinction between guardianship and administration be retained? If so, do you agree with any of the options (A (i)–(v)) described by the Commission?

56. Do you agree with any of the suggested ways to manage the overlap between the powers of guardians and administrators? Are there any other ways to manage this overlap?

57. Should new guardianship laws guide VCAT about how to choose between family members and the Public Advocate when appointing a guardian or between family members and State Trustees (or some other professional administrator) when appointing an administrator? If not, how could this issue of recognising existing family relationships be addressed?

CHAPTER 13: POWERS OF GUARDIANS AND ADMINISTRATORS

58. Do you agree with the Commission's proposal (Option A (iii)) that new guardianship laws should contain comprehensive lists of the decision-making powers that can and cannot be given to a guardian and an administrator?

59. If yes to Q 58, what decisions should a guardian be able and unable to make?

60. If yes to Q 58, what decisions should an administrator be able and unable to make?

61. Do you believe that any of the other options are a better way of dealing with the decision-making powers that a guardian or an administrator could or could not be given?

62. Should it be possible for VCAT to order that a guardian or an administrator have the power to make decisions about any of the following matters:
    - whether a represented person should continue to hold a driver licence
    - a will by the represented person
    - organ donation by the represented person?

63. Should new guardianship legislation extend or clarify the provisions in section 50A of the *Guardianship and Administration Act 1986* (Vic) which permit an administrator to make small gifts on behalf of a represented person in limited circumstances?

64. Should new guardianship legislation alter or clarify the anti-ademption provisions in section 53 of the *Guardianship and Administration Act 1986* (Vic)?

65. Should new guardianship legislation enable State Trustees to be given the same powers as those of other administrators?

66. Who should conduct litigation on behalf of a represented person?

67. Should it be possible for a court or tribunal to order that an administrator or guardian who conducts litigation on behalf of a represented person is personally liable for some or all of the costs of that litigation?
68. Should new guardianship laws permit VCAT to authorise a guardian, or other person, to use some force to ensure that a represented person complies with the guardian's decisions?
69. If yes to Q 68, do you agree with the additional safeguards proposed by the Commission?

PART 6: STATUTORY APPOINTMENTS

CHAPTER 14: AUTOMATIC APPOINTMENTS—THE PERSON RESPONSIBLE

70. Do you agree with the Commission's proposal (Option B) that the hierarchy for automatic appointees, as currently set out in section 37 of the *Guardianship and Administration Act 1986* (Vic), should be retained?
71. What alterations (if any) should be made to the list?
72. Do you think new guardianship legislation should require an automatic appointee to take a substituted judgment approach to decision making?
73. Do you think that new guardianship legislation should contain additional measures for scrutinising the decisions made by automatic appointees? If so, what should those measures be?

CHAPTER 15: INFORMAL ASSISTANCE—ADMISSION INTO CARE

74. Do you think there should be specific laws about people being admitted to and remaining in residential care facilities in situations where they do not have capacity to consent to those living arrangements but are not objecting to them?
75. If yes, do you agree with the Commission's Option E that new guardianship legislation should extend the automatic appointments scheme to permit the 'person responsible' to authorise living arrangements in a residential care facility in these circumstances if there are additional safeguards?
76. If the automatic appointment scheme is expanded to cover these circumstances, do you agree with any or all of the possible safeguards suggested by the Commission? Are there any other safeguards that should be introduced?
77. If the automatic appointment scheme is expanded to cover these circumstances, should the hierarchy of automatic appointees be changed?
78. If the automatic appointment scheme is expanded to cover these circumstances, what residential facilities should fall within the scheme?

CHAPTER 16: MEDICAL TREATMENT

79. Do you think that the definition of medical treatment should be broadened?
80. Should a broader definition include the prescription and administration of pharmaceutical drugs?
81. Should it include paramedical procedures, such as physiotherapy? Should it include complementary health procedures, such as naturopathy and Chinese medicines? What else should it include?
82. Do you think a distinction should be made between minor and other medical procedures when a person is unable to consent? If yes, how should the distinction be made between minor and other procedures?
83. Do you agree that minor medical procedures should not require substituted consent if certain safeguards are met? Do you agree with the safeguards suggested?
84. Do you believe the law should retain the requirement that a medical or dental practitioner must notify the Public Advocate where a person responsible does not consent or cannot be identified or contacted and the practitioner still wishes to carry out the procedure? If not, are there any other safeguards that might be more appropriate in these circumstances?
85. Do you believe the process for obtaining substituted consent to participation in medical research procedures should be the same as the process for obtaining substituted consent for medical treatment?
86. If the process is the same, what factors should the person responsible be required to consider before giving substituted consent to participation in a medical research procedure?

Consultation Paper Questions to Guide Submissions

PART 7: RESPONSIBILITY AND ACCOUNTABILITY UNDER THE LAW

CHAPTER 17: RESPONSIBILITIES

87. Does the law need to provide more guidance about the relationship between the wishes a person expresses at the time a decision is made, and any past wishes, views, beliefs and values the person has expressed?
88. Does the law currently strike the right balance between following the wishes of the person, including those that involve risk or danger, and other important considerations such as the right of a person to be protected from harm?
89. Do you think there should be a general set of decision-making principles that should apply to all types of substituted and supported decisions?
90. Do you agree with the Commission's proposal (Option C) that substituted judgment should be the paramount consideration for decision makers? Or, do you think that substituted judgment should be just one guiding principle to consider?
91. Is substituted judgment relevant to supported decision making?
92. Do you agree that new guardianship laws should specifically require substitute decision makers to act honestly and respond appropriately to conflicts of interest?
93. Do you agree that new guardianship laws should specifically require guardians and administrators to treat the represented person and important people in their life with courtesy and respect at all times?
94. Should new guardianship laws contain the same decision-making principles for financial decisions and personal decisions?
95. If no, how could financial decision makers be guided to balance the need for sound financial management with the principle of substituted judgment where these considerations might conflict?
96. Should there be separate and distinct principles for medical decision making? If so, what should these principles be?

CHAPTER 18: CONFIDENTIALITY

97. Do you agree with the Commission's proposal that new guardianship legislation should authorise all substitute decision makers, including automatic appointees, to have access to confidential and private information about the represented person on a 'need to know' basis?
98. Do you believe that new guardianship legislation should contain a provision similar to section 101 of the *Guardianship Act 1988* (NSW) for dealing with misuse of confidential or private information?

CHAPTER 19: ACCOUNTABILITY AND REVIEW OF SUBSTITUTE DECISION MAKING

99. Do you think that private guardians and attorneys should be required to lodge periodic reports about their activities with a public official?
100. Should people exercising substitute decision-making powers be required to provide periodic declarations of compliance with their responsibilities?
101. Who should receive and monitor the declarations?
102. Do you think that substitute decision makers should declare an oath or sign a statement agreeing to comply with their responsibilities before they undertake their roles?
103. Should there be random audits of the way substitute decision makers perform their responsibilities?
104. Who should carry out these random audits?
105. Should VCAT be able to order administrators and financial attorneys to repay funds that have been misused?
106. Is there a need for more specific penalties for substitute decision makers who misuse or abuse their powers?
107. If yes, what types of conduct should warrant a specific penalty?
108. Should penalties for substitute decision makers who misuse or abuse their powers be increased?
109. Should penalties be the same, regardless of whether the substitute decision makers have been personally appointed or appointed by VCAT?

110. Should civil penalties be introduced for substitute decision makers who misuse or abuse their powers?
111. Do you agree with the Commission's proposal (Option B) that new guardianship laws should permit merits review of decisions made by the Public Advocate as a guardian and by State Trustees as an administrator?
112. Who should be entitled to apply for merits review of a guardian's or administrator's decision?
113. What should constitute a 'reviewable decision'?
114. Are there any additional steps that need to be taken to limit trivial, vexatious or repeated applications for merits review of a guardian's or administrator's decision?
115. Should merits review of decisions by administrators be treated differently to merits review of decisions by guardians?
116. Who should conduct merits review of decisions of public guardians and administrators?
117. Should VCAT have the discretionary power to appoint a guardian or administrator on the condition that they complete any training requirements specified in the order?

PART 8: IMPLEMENTING AND REGULATING NEW LAWS

CHAPTER 20: THE PUBLIC ADVOCATE

118. Do you believe the Public Advocate's investigation function should extend beyond cases concerning guardianship and administration?
119. Do you think the Public Advocate's investigatory powers should be clarified so that she can require people and organisations to provide her with documents and attend her offices to answer questions?
120. Do you think the Public Advocate should have the power to enter private premises with a warrant issued by a judicial officer when there are reasonable grounds for suspecting that a person with a disability who has been neglected, exploited or abused is on those premises?
121. Do you think it is necessary to protect the anonymity of people who provide the Public Advocate with information about the possible abuse, neglect or exploitation of people with a disability?
122. Should the Public Advocate be able to take civil penalty proceedings against people who have allegedly breached guardianship legislation?
123. Do you support clarifying the Public Advocate's individual and systemic advocacy functions in guardianship legislation?
124. Do you think that the legislation should include principles to guide the Public Advocate when undertaking her advocacy functions?
125. Do you think that the Public Advocate's functions in relation to community advocacy are necessary?
126. Do you agree that the Public Advocate should continue to be both the guardian of last resort and an advocate?
127. Should the Public Advocate be responsible for training and supporting private guardians?
128. Should the Public Advocate be responsible for monitoring the activities of all or some private guardians?
129. If so, how should any monitoring activities be performed?
130. Do you think the Public Advocate should play a role in designing a register of personal appointments?
131. Do you think the Public Advocate should be given responsibility for monitoring the activities of personally appointed substitute decision makers?
132. If so, what functions and powers should be given to the Public Advocate to undertake this responsibility?
133. Do you think the Public Advocate should be given any responsibilities to deal with possible misuses of power by a person who is automatically appointed by legislation to make decisions for another person?
134. Do you think the Public Advocate should be required to report annually to Parliament?

Consultation Paper Questions to Guide Submissions

CHAPTER 21: VCAT

135. Should the Guardianship List be supported by a body such as the New South Wales Guardianship Tribunal's Coordination and Investigation Unit so that it can take a more active role in preparing cases for hearing?
136. Should the Public Advocate be funded to undertake this role?
137. Do you agree with any of the options proposed by the Commission to improve legal assistance and advocacy support for people in Guardianship List matters at VCAT?
138. Should VCAT be required to consider making supported and co-decision-making orders before appointing a substitute decision maker?
139. Do you think that new guardianship legislation should specify a maximum period for all guardianship and administration orders?
140. If so, what should that maximum period be?
141. Following the expiry of an order, should it be possible for VCAT to reassess or make a new guardianship or administration order in the absence of the parties, with their consent?
142. Should VCAT advise a person who provides them with confidential information that the information may be made available to the proposed represented person and other parties?
143. Should a person who provides VCAT with confidential information be responsible for requesting and justifying the need to keep the information confidential?
144. Should VCAT Guardianship List files remain open to the public, with some restrictions about who can gain access, or should the files be closed to the public, with only the parties having a right of access?
145. Should the period in which an application for a rehearing can be made be extended beyond the current 28-day limit?
146. Should VCAT be required to inform parties of the right to seek a rehearing?
147. Should a represented person be requested to opt out of, rather than opt in to, a reassessment hearing?
148. Should a represented person be entitled to at least one unscheduled reassessment of the order during the period of the order?
149. Should the legislation allow guardians and administrators to seek a VCAT order to enforce decisions they make which a third party refuses to accept?
150. Should multi-member panels, with members drawn from a range of backgrounds, be the standard practice for initial guardianship and administration applications?
151. Do you have any views about how VCAT Guardianship List hearings should be conducted?
152. Do you have any ideas about how to achieve better attendance of the represented person at VCAT hearings?
153. Do you have any ideas about how to make the Guardianship List more accessible to Indigenous people?
154. What can be done to make the Guardianship List more accessible to users who come from culturally and linguistically diverse backgrounds?
155. What can be done to make the Guardianship List more accessible to users in regional areas?

PART 9: INTERACTION WITH OTHER LAWS

CHAPTER 22: *DISABILITY ACT 2006* (VIC)

156. Do you agree with the Commission's previous recommendation that the compulsory treatment provisions in the *Disability Act 2006* (Vic) be extended to people with a cognitive impairment other than intellectual disability?

CHAPTER 23: *MENTAL HEALTH ACT 1986* (VIC)

157. Do you agree with the Commission's proposal (Option C) that it should be possible, in some circumstances, for guardianship to be used as a mechanism for authorising psychiatric treatment and place of residence decisions for a person who is unable to make their own decisions due to mental illness?

CHAPTER 24: *CRIMES (MENTAL IMPAIRMENT AND UNFITNESS TO BE TRIED) ACT 1997* (VIC)

158. Do you believe that an advocate should be made available to a person subject to the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) at particular times?
159. Do you believe that the Public Advocate should be given a formal role as an advocate for people involved in proceedings or detained under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic)?