Chapter 24
Mental Health Act

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Chapter 24

INTRODUCTION

24.1 The Commission has been asked to consider how guardianship laws should interact with other statutory regimes that authorise different forms of substitute decision making for people with impaired ability to make their own decisions.

24.2 This chapter considers the relationship between guardianship laws and the Mental Health Act 1986 (Vic), which creates a form of clinical guardianship by permitting a senior psychiatrist to authorise the detention and treatment of a person with a mental illness in some circumstances.

24.3 The terms of reference direct the Commission to consider contemporaneous reviews of other substitute decision-making legislation that are relevant to this review. In preparing this chapter, the Commission considered the review of the Mental Health Act that commenced in 2008 and which led to the exposure draft of a Mental Health Bill released on 7 October 2010.

24.4 The Department of Health received more than 200 submissions in response to the exposure draft of the Bill. In 2011, further roundtable meetings were held and an expert advisory group was reconvened. The Victorian Government announced that it anticipated introducing a revised Bill into the Victorian Parliament in 2012, with the aim of new mental health legislation commencing in 2013.

CURRENT LAW

BACKGROUND

24.5 The current Victorian Mental Health Act was enacted at the same time 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. 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 Victoria’s first mental health statute, the Lunacy Act 1867 (Vic), to the Mental Health Act 1959 (Vic)—had been the primary source of substitute decision-making authority for all people with impaired decision-making capacity.

24.6 As indicated in earlier chapters, one of the primary reasons for establishing the Cocks Committee, which produced the report that formed the basis of the G&A Act, was the creation of new laws to meet the legal needs of people with an intellectual disability at a time of de-institutionalisation. The existing mental health legislation—the Mental Health Act 1959 (Vic)—was not designed to ‘enable intellectually handicapped people to live with dignity in the community’.

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1 This person 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(d).
3 Ibid ss 12AD(2), 85(1)(a)(iv).
4 The criteria for involuntary treatment are set out in ibid s 8.
7 Ibid.
8 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.
10 Ibid 12.
24.7 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’, 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.

24.8 The Victorian Parliament accepted the Cocks Committee’s recommendation for generic laws by passing legislation that enabled a guardian or administrator to be appointed for any person with impaired decision-making ability because of a ‘disability’. ‘Disability’ was originally defined to mean ‘intellectual impairment, mental illness, brain damage, physical disability or senility’, but was amended in 1999 to mean ‘intellectual impairment, mental disorder, brain injury, physical disability or dementia’.

24.9 Interestingly, the Myers Committee, which was established in 1980 to advise about the desirability of new mental health legislation, recommended that guardians should be appointed for people with a mental illness in some circumstances. 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’.

24.10 This recommendation was not adopted in either the G&A Act or the Mental Health Act. Nor was it raised in parliamentary debates—perhaps because the new concept of community treatment orders was seen as the best way of providing mandatory treatment to people while living in the community.

CURRENT OPERATIONS

24.11 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.

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

- The person appears to be mentally ill.
- The person requires immediate treatment that can be obtained compulsorily.
- 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 adequate treatment.
24.13 A person may receive involuntary treatment as an in-patient in a hospital or while living in the community.23 A community treatment order may specify where the person must live.24 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 patients25
- the Chief Psychiatrist, who has general clinical responsibility for patients receiving treatment under the Mental Health Act26
- community visitors, who have the power to inspect mental health services, speak to patients and report to the Minister.27

24.14 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 circumstances28 and to arrange for their transport to hospital for clinical assessment.29 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,30 as well as provide treatment until the authorised psychiatrist31 conducts an examination.32

24.15 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.33 An involuntary treatment order under the Mental Health Act is a form of clinical guardianship because the authorised psychiatrist has the power to determine a person’s place of residence34 and to authorise both psychiatric and non-psychiatric treatment.35

24.16 The authorised psychiatrist is the only person who can authorise psychiatric treatment for an involuntary patient. Non-psychiatric treatment is dealt with a little differently. A guardian appointed by the Victorian Civil and Administrative Tribunal (VCAT), an enduring guardian appointed by a person with capacity, or an agent appointed under the Medical Treatment Act 1988 (Vic), as well as the authorised psychiatrist, can provide substitute consent to non-psychiatric treatment of a person who is an involuntary patient.36

24.17 The Mental Health 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.37 The Board must also review all involuntary orders within eight weeks of being made.38 The Board has determinative powers that are not discretionary—it must discharge a person from an involuntary order if it is not satisfied that the relevant criteria are met.39
24.18 Various authorisation, licensing and supervision mechanisms accompany the extensive powers granted to clinicians by the Mental Health Act. There are provisions dealing with the licensing of places where people may be involuntarily detained and the qualifications and responsibilities of the person in charge of that facility. Independent community visitors have the right to enter a psychiatric hospital to talk to patients and to examine records concerning treatment.

GUARDIANSHIP AND MENTAL HEALTH LAWS

24.19 Guardianship and mental health legislation have operated as partly separate, but parallel, substitute decision-making regimes for the past 25 years. Throughout this period, it has been possible for a tribunal to appoint an administrator to manage the financial affairs of a person with a mental illness or for a person with capacity to appoint an enduring guardian or an enduring attorney to make substitute decisions for them at times of incapacity about any matters other than psychiatric treatment.

24.20 It has been assumed that guardianship 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 only mental health laws can regulate these activities. In practice, the Mental Health Act has been the sole means of providing substitute decision-making authority for both psychiatric treatment and place of residence decisions for a person who lacks capacity because of a mental illness. The reasons for this significant exception to the scope of a guardian’s powers do not appear to have been clearly articulated and debated.

24.21 Despite the longstanding practice of not using guardianship laws to authorise psychiatric treatment for people with a mental illness, the Mental Health Act was amended in 2002 in an attempt to give the authorised psychiatrist clear legal primacy in relation to psychiatric treatment decisions for people who are involuntary patients. 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.

There was no explanation of the reasons for this amendment to the Mental Health Act.

24.22 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. However, that section does not affect a guardian’s authority to make psychiatric treatment decisions—other than those concerning psychosurgery and electroconvulsive therapy—for a represented person who does
not have the capacity to make their own decisions about the matter and who is not an involuntary patient. For example, 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.\textsuperscript{50} An agent (with appropriate powers) appointed under the Medical Treatment Act could also act in this way. It would be necessary 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. The Commission is unaware of any circumstances in which a guardian’s powers have been used to authorise psychiatric treatment for a represented person in a public or private mental health facility.

\textbf{24.23} The Public Advocate and the Chief Psychiatrist\textsuperscript{51} have developed a memorandum of understanding that seeks to provide guidance to guardians and mental health professionals where their roles are uncertain or overlap.\textsuperscript{52} 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.\textsuperscript{53}

\section*{THE MENTAL HEALTH BILL}

\textbf{24.24} 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.\textsuperscript{54} 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.

\textbf{24.25} 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.

\section*{THE FUSION PROPOSAL}

\textbf{24.26} 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.\textsuperscript{55} This suggestion, which would cause

\begin{itemize}
  \item \textsuperscript{50} 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.
  \item \textsuperscript{51} The Chief Psychiatrist has overall responsibility for the medical care and welfare of people receiving treatment or care for mental illness under the Mental Health Act 1986 (Vic) s 105.
  \item \textsuperscript{52} 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).
  \item \textsuperscript{53} Ibid 5–7.
  \item \textsuperscript{54} Some attempts have been made in other Australian jurisdictions 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, 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 partially integrated with detention decisions made under mental health laws and involuntary treatment decisions governed by guardianship law: see Mental Health Act 1996 (Tas) ss 32, 52.
\end{itemize}
guardianship and mental health legislation to merge, has become widely known as the ‘fusion’ proposal.56 The primary argument 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 all people who lack capacity because of a disability.57

24.27 The identity of the substitute decision maker is one of the major points 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 that permits VCAT to appoint a person’s family member or friend58 to make important decisions for them when they lack capacity to do so themselves. A person with capacity may also appoint a relative or friend as their enduring guardian59 to make decisions for them when they become ‘unable by reason of a disability to make reasonable judgments’.60

24.28 A guardian with appropriate powers may determine where a person who lacks capacity—other than a person with a mental illness—will live and whether that person will have particular forms of treatment recommended by health professionals. Despite the obvious similarity between the treatment and residence powers of a guardian and those of an authorised psychiatrist when dealing with involuntary patients, it has never been considered appropriate in Victoria for a guardian to make psychiatric treatment or place of residence decisions for a person with a mental illness who does not have the capacity to make their own decisions.

24.29 Tom Campbell argues that the existence of separate mental health legislation allows for the manifestation of ‘institutional discrimination’,61 since the coercive measures permitted under the legislation are confined to people with a mental illness.62 He suggests that this confirms and perpetuates ‘mental illness prejudice’.63 Campbell argues that separate mental health legislation ‘institutionalises the idea that there is something about “mental illness” itself which invites a system of control and coercion’.64 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.65

56 John Dawson and George Szumukler, ‘The Fusion of Mental Health and Incapacity Legislation’ (2000) 188 British Journal of Psychiatry 504. One of the authors of this proposal, Professor George Szumukler (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. It appears that the term ‘fusion’ was chosen because of its prominent use in the very lengthy debate among some lawyers, particularly in NSW, about whether the UK Judicature Acts 1873–75 (and later Australian equivalents) caused the fusion or merger of the separate bodies of law known as the common law and equity. Those in favour of the ‘fusion’ argument in that debate are often cast as the progressives (see, eg, Michael Kirby, ‘Equity’s Australian Isolationism’ (2008) 8(2) Queensland University of Technology Law Journal 444).


58 The Public Advocate is appointed to undertake the role of a guardian when no other suitable person is available: see Guardianship and Administration Act 1986 (Vic) s 23(4).

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

60 Ibid s 35B(1).

61 Ibid.

62 Ibid.

63 Ibid.

64 Ibid 556.

65 Ibid 555.
24.30 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.66

24.31 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’.67

24.32 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 compulsory psychiatric treatment.68 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.

24.33 Dawson and Szmukler argue that there are individual and community benefits in moving to a system that relies on the incapacity of a person with mental illness as the trigger for legal intervention. This step would ‘shift the focus away from potential “risk of harm” as the central ground upon which psychiatric treatment may be imposed’.69 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.70

24.34 Szmukler has also written that this step would help reduce discrimination,71 because the current law permits the non-consensual treatment of people with 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.72

24.35 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. They suggest that the shift would allow for ‘consistent ethical principles [to be applied] across medical law’.73

24.36 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’.74 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.75 Richardson argues that the existence of the two systems

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67 Ibid 565.
69 Ibid.
70 Ibid.
72 Ibid 662.
73 Dawson and Szmukler, The Fusion of Mental Health and Incapacity Legislation’ above n 68, 504.
75 Ibid 716.
‘encourages the perception of mental disorder as a condition apart’.76 Where two parallel decision-making structures exist—based on two distinct sets of principles—mental disorder will be seen as the more threatening and its pariah status will be reinforced.77

Some cautionary notes
Emergency intervention in mental health laws
24.37 Even the principal advocates of the fusion proposal accept that there have been some benefits in using mental health legislation to provide involuntary treatment to people with a mental illness, especially because of the availability of emergency intervention and detention powers. 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.78

24.38 The relatively few emergency intervention powers 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.

24.39 Unlike the Mental Health Act,79 the G&A Act does not authorise police officers (or any other public officials), without an order from VCAT, to enter the premises of and arrange assistance for people who might be at risk of serious harm because of lack of capacity. Nor does it allow the police to apprehend people in public places and convey them to hospital for further examination or treatment.80 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.81 This slow process of emergency intervention is poorly suited to mental health crises.

Additional safeguards in mental health laws
24.40 There is clearly a great need for transparent decision-making processes and appropriate external review when the law authorises public officers to deprive people of their liberty and to provide them with compulsory psychiatric treatment. Unlike the Mental Health Act, 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 current means of reviewing individual decisions made by either tribunal-appointed or personally appointed guardians.82

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76 Ibid.
77 Ibid.
79 Mental Health Act 1986 (Vic) s 10.
80 Ibid s 10(1).
81 Guardianship and Administration Act 1986 (Vic) s 27.
82 In Chapter 19, the Commission recommends the introduction of merits review for individual guardianship decisions of the Public Advocate and financial decisions of State Trustees and other professional administrators.
Chapter 24

Mental Health Act

24.41 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. In contrast, using guardianship laws to authorise 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 whose decisions are not easily reviewed.

Decision-making principles in guardianship laws

24.42 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 decisions. This may be very difficult if guardianship is the only mechanism that can be 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 preferable 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.

COMMUNITY RESPONSES

RESPONSES TO THE INFORMATION PAPER

24.43 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 people 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 psychiatric treatment for people who lack capacity due to mental illness and to make decisions about where they live.

24.44 The views of Anita Smith—the President of the Tasmanian Guardianship and Administration Board and the chair of the Australian Guardianship and Administration Council—were particularly influential because there has been some integration of mental health and guardianship laws in Tasmania. Ms Smith suggested:

> 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.84

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83 Guardianship and Administration Act 1986 (Vic) s 28. The Commission recommends that the ‘best interests’ obligation be replaced by a duty to promote the ‘personal and social wellbeing of the represented person’ with ‘substituted judgment’ being the paramount consideration; see Chapter 17.

84 Submission IP 53 (Anita Smith).
Psychiatric Disability Services of Victoria (VICSERV) argued that mental health and guardianship laws should be integrated into one, ‘capacity-based’ legislative scheme.\(^{85}\) VICSERV argued that this would remove the discriminatory approach of the current laws—that treat people with a mental illness differently to others—and ensure maximum protection of human rights.\(^{86}\) Similarly, the Mental Health Legal Centre called for a single, capacity-based legislative framework for substitute decision making, rather than a diagnosis-based scheme.\(^{87}\)

The Law Institute of Victoria argued that the Victorian Government should consider single, comprehensive, capacity-based laws, 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.\(^{88}\)

**RESPONSES TO THE COMMISSION’S PROPOSALS IN THE CONSULTATION PAPER**

In the consultation paper, the Commission identified three broad options when considering the relationship between guardianship and mental health laws. The three options are:

- **Option A: No change**—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 who becomes an involuntary patient under the Mental Health Act.

- **Option B: Fusion of guardianship and mental health laws**—this option would bring about the complete fusion of mental health and guardianship law. The Mental Health Act would cease to exist and guardianship legislation would become the sole substitute decision-making regime for all people with impaired decision-making capacity due to a disability.

- **Option C: Limited use of guardianship for non-consensual psychiatric treatment**—this option would allow guardianship to be used as a mechanism for authorising psychiatric treatment and place of residence decisions in some circumstances. The Mental Health Act and guardianship legislation would operate as parallel mechanisms, permitting a third person 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 lacks capacity to make their own decisions. The powers of the enduring guardian would prevail over those of an authorised psychiatrist under the Mental Health Act, except in cases of emergency.

In the consultation paper, the Commission indicated a preference for Option C, but observed that many details—such as the accountability mechanisms for guardians and the means of resolving disagreements between clinicians and guardians—required consideration. The Commission invited debate about the merits of Option C.

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85 Submission IP 17 (Psychiatric Disability Services of Victoria).
86 Ibid.
87 Submission IP 58 (Mental Health Legal Centre).
88 Submission IP 47 (Law Institute of Victoria).
24.49 Many organisations provided detailed responses to the Commission’s proposal, supporting or opposing the options outlined. Some organisations and community members thought there should be further inquiry into the interaction of mental health and guardianship laws before any changes are implemented.  

**Views in support of Option A (no change)**

24.50 A number of organisations expressed support for retaining separate mental health and guardianship laws.  

24.51 Some concerns were raised that allowing psychiatric treatment decisions to be dealt with under guardianship legislation would result in the loss of the external scrutiny and accountability that exists under current and proposed mental health legislation. Victoria Legal Aid argued that the introduction of sufficient protection into guardianship legislation would probably render proceedings more costly for people to access.  

24.52 Some people were concerned about friends or family members making psychiatric treatment decisions for a person diagnosed with a mental illness. They also referred to the potential for conflict and loss of trust between the people involved. One submission suggested that family members might not want to undertake the responsibility of the position, while another noted that family members might feel pressured to accept an appointment.  

24.53 One person noted that mental health laws are different to other substitute decision-making laws because they often require representatives to make decisions that are contrary to the wishes of the represented person. The Public Advocate noted that these situations might compromise the role of supporters.  

24.54 There were also concerns that adoption of Options B or C would reduce the responsibility of authorised psychiatrists who would propose treatment but not carry the same degree of responsibility for it.  

24.55 Further, the Public Advocate argued that any changes to the current arrangements could fracture the distinction between voluntary and involuntary treatment. The Law Institute of Victoria argued that the proposal would create a two-tiered system for those with and without enduring guardians, and that any use of guardians for psychiatric treatment decisions is likely to introduce unnecessary complexity into the system.  

**Views in support of Option B (fusion)**

24.56 Some organisations and individuals were strongly in favour of complete fusion of mental health and guardianship laws. The Mental Health Legal Centre argued this is...

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89 For eg, Submission CP 66 (Victorian Equal Opportunity and Human Rights Commission), CP 78 (Mental Health Legal Centre and CP 78 (Mental Health Legal Centre—Appendix 1: Consumer Views).  
90 For eg, Submissions CP 73 (Victoria Legal Aid) and CP 77 (Law Institute of Victoria).  
91 For eg, consultation with NSW Public Guardian (16 March 2011); Submissions CP 19 (Office of the Public Advocate), CP 73 (Victoria Legal Aid) and CP 77 (Law Institute of Victoria).  
92 Submission CP 73 (Victoria Legal Aid).  
93 Roundtable with mental health consumers (in partnership with Mental Health Legal Centre and Victorian Mental Illness Awareness Council) (5 April 2011).  
94 Consultation with Anita Smith (21 February 2011).  
95 Consultation with Associate Professor Nicholas Tonti-Filippini (3 May 2011). Also Submission CP 27 (Catholic Archdiocese of Melbourne).  
96 Consultation with Associate Professor Nicholas Tonti-Filippini (3 May 2011).  
97 Submission CP 19 (Office of the Public Advocate).  
98 Ibid.  
99 The Public Advocate noted that it and many other organisations and individuals are calling for greater safeguards in the realm of involuntary psychiatric treatment: Ibid.  
100 Submission CP 77 (Law Institute of Victoria).  
101 For eg, Submissions CP 47 (Dr Michael Murray), CP 59 (Carers Victoria), CP 78 (Mental Health Legal Centre and CP 78 (Mental Health Legal Centre—Appendix 1: Consumer Views).
a more consistent approach to mental health that does not treat people with mental illness differently from other members of the community. The Mental Health Legal Centre noted that its consumers were keenly questioning the need for separate mental health laws which, on their face, reinforced the different and discriminatory way in which they were treated as a result of their diagnosis.

24.57 The Mental Health Legal Centre noted that there was a strong feeling among consumers that the Commission’s proposal of limited use of guardians for non-consensual psychiatric treatment represented a ‘compromise of the rights of people labelled with a mental illness’. Consumers raised concerns about the extent to which, in practice, substitute decision makers might step in prematurely in situations that might not meet the threshold for substitute decision making under the involuntary treatment provisions of the Mental Health Act.

24.58 Carers Victoria was in favour of fusion, arguing that it would potentially address some of the intractable problems of the current Mental Health Act. These problems include the potential conflict of interests created by an authorised psychiatrist being responsible for providing treatment advice, assessing capacity to consent and acting as a substitute decision maker for a person with a mental illness who lacks capacity. Furthermore, the fact that incapacity to consent to treatment is equated with a refusal to consent to treatment, means that people with capacity to consent are unable to refuse treatment for mental illness. Carers Victoria argued that the potential inability to refuse psychiatric treatment is not only discriminatory, but that it also underpins the disempowering experience of the mental health system as reported by people with a mental illness.

Views in support of Option C (greater overlap)

24.59 Some organisations and individuals supported the Commission’s proposal that it should be possible, in some circumstances, to use guardianship as a mechanism for authorising psychiatric treatment and place of residence decisions for a person who lacks capacity to make their own decisions due to mental illness. Some groups indicated that their support for the Commission’s proposal was contingent on the provision of rigorous safeguards against misuse of powers and external accountability.

24.60 A number of organisations and consumers thought there should be further inquiry into the interaction of mental health and guardianship laws before making any changes. Other organisations thought it was premature to comment on the Commission’s proposal until the Victorian review of mental health legislation is finalised.

24.61 Other organisations sought more detail on the Commission’s proposals to allow them to comment more fully.
Chapter 24

Mental Health Act

THE COMMISSION’S VIEWS AND CONCLUSIONS

APPOINTMENT OF AN ENDURING PERSONAL GUARDIAN TO MAKE PSYCHIATRIC TREATMENT DECISIONS

24.62 Victorian law permits anyone with capacity to appoint someone—such as a family member or close friend—to make medical treatment decisions for them if they lose capacity at some time in the future.112 Appointments of is this nature are usually final and binding113—even for end of life decisions—except when dealing with psychiatric treatment. An authorised psychiatrist has exclusive powers to prescribe and authorise psychiatric treatment for an involuntary patient under the Mental Health Act, even though that person has validly appointed an enduring guardian to make psychiatric treatment decisions for them.

24.63 It is self-evident that the existing law and practice concerning authorisation of non-consensual psychiatric treatment for people with a mental illness treats people with a mental illness differently to others who experience impaired decision-making capacity because of disability. Whether that different treatment amounts to unjustifiable discrimination against people with a mental illness as some commentators suggest,114 or whether it constitutes a special measure115 for the benefit of people with a mental illness, is a matter for ongoing debate.

24.64 There are clinical issues to consider, as well as legal ones, when considering why psychiatric treatment decisions are currently an exception to the law that governs all other forms of substitute decision-making for medical treatment. Psychiatrist Stephen Rosenman has suggested that permitting a guardian to make psychiatric treatment decisions is beneficial—both ethically and clinically—because it separates medical advice from consent to treatment.116 This observation is particularly important at a time when mental health policy promotes participation by a person with a mental illness and their family in decisions about treatment and care.117

24.65 The Commission believes it is time to give people a choice about the person who will make psychiatric treatment decisions for them in some circumstances when they are unable to do so themselves. It should be possible for a person with capacity (a principal) to appoint another consenting person to be their enduring personal guardian118 to make psychiatric treatment (and any other medical treatment decisions) for them when they lack capacity to make their own decisions. In some instances, the psychiatric treatment powers of an enduring personal guardian should prevail over the powers of the authorised psychiatrist if the principal becomes an involuntary patient under the Mental Health Act. Without this change, the law will continue

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112 This can be through the appointment of an agent under section 5A of the Medical Treatment Act 1988 (Vic) or the appointment of an enduring guardian with health care powers under pt 4 div 5A of the Guardianship and Administration Act 1986 (Vic).

113 However, an application may be made to VCAT to suspend or revoke the authority of an agent or enduring guardian. See Medical Treatment Act 1988 (Vic) s 5C, Guardianship and Administration Act 1986 (Vic) s 352. Where an agent or enduring guardian withholds consent to medical treatment a medical practitioner may proceed if they provide adequate notice to the agent or guardian, notify the Public Advocate, and await a prescribed period of time: Guardianship and Administration Act 1986 (Vic) ss 42L, 42M. If an agent has completed a valid refusal of treatment certificate, a medical practitioner may only proceed with the treatment if VCAT suspends or revokes the agent’s authority (and thereby suspends or revokes the refusal of treatment certificate): see Medical Treatment Act 1988 (Vic) ss 5C, 5D.


115 ‘Special measures’ are generally seen as an acceptable departure from the principle that people are entitled to equal protection of the law and should not be subject to discrimination on the ground of an irrelevant attribute: see Charter of Human Rights and Responsibilities Act 2006 (Vic) s B(4); Equal Opportunity Act 2010 (Vic) s 12.

116 Rosenman, above n 66, 562.

117 See, eg, Mental Health Act 1986 (Vic) s 6A.

118 In Chapters 5 and 10, the Commission recommends replacing the term ‘enduring guardian’ with ‘enduring personal guardian’.
to deal with substitute decision-making for psychiatric treatment in way that is not consistent with the approach to taken to substitute decision-making for all other forms of medical treatment, other than the few matters that are ‘special procedures’ under the G&A Act.119

24.66 Some people who have experienced mental illness will have well-formed views about the types of treatment they are willing and unwilling to accept when they lack capacity to make their own decisions. Respect for human dignity suggests that when they are clearly capable of exercising capacity to plan for the future, they should be entitled to appoint another willing and capable person to make treatment decisions when they cannot do so themselves.

24.67 The role of an enduring personal guardian with these powers will not be easy. In some instances, a potential enduring personal guardian might decline the role before an appointment is made, while in others a guardian who has accepted an appointment might decide that the role is too onerous because of the strain it places on their relationship with the principal. The enduring personal guardian should be permitted to resign in these circumstances.

Principles of the Mental Health Act

24.68 Beneficence and a desire to protect the community from harm were major policies implemented by the Mental Health Act when it was first enacted in 1986. The significance of these policies is demonstrated by the criteria that must be satisfied when deciding whether a person is eligible for involuntary psychiatric treatment. The central criterion is that, because of a person’s mental illness, involuntary treatment ‘is necessary for his or her health or safety’ or ‘for the protection of members of the public’.120

24.69 Over time, new policies—such as respect for autonomy and the desirability of patient participation in treatment decisions—have influenced the content of amendments to the Mental Health Act. In 1995, the Act was amended to include principles of treatment and care. Two of the many principles listed in the Act are that ‘the provision of treatment and care for people with a mental disorder should promote and assist self-reliance’ and that ‘every effort that is reasonably practicable should be made to involve a person with a mental disorder in the development of an ongoing treatment plan’.121

24.70 Two of the important objectives of the current review of the Mental Health Act are to:

- provide greater opportunity and support for patients to participate, as far as they are able, in their treatment and care
- deliver a more patient-centred, rights-orientated, least restrictive and recovery-focused approach to treatment and care for people with serious mental illness.

It will be a significant challenge for those people who are designing new mental health laws to give practical effect to these principles so that they become more than mere statements of aspiration.

24.71 The Commission believes that these important objectives can be advanced by allowing people with a mental illness to participate in their own treatment and care by giving them the same rights as everyone else with a disability that affects their decision-making ability. A person with capacity should be permitted to appoint another person as their enduring personal guardian with the power to make decisions

119 ‘Special procedures’ are discussed in Chapter 13.
120 Mental Health Act 1986 (Vic) s 8(1)(c).
121 Ibid ss 6A(d), (j).
about psychiatric treatment for them when they lack the capacity to make their own decisions. In some instances, the psychiatric treatment powers of the enduring personal guardian should continue to operate even when the principal becomes an involuntary patient under the Mental Health Act.

24.72 When the reason for a person becoming an involuntary patient is their own wellbeing rather than public safety, the psychiatric treatment powers of an enduring personal guardian should prevail over the treatment powers of an authorised psychiatrist, other than in exceptional circumstances. This change to the way in which guardianship and mental health laws interact would be an important way of giving real substance to the values of autonomy, dignity and participation which are now central aspects of disability policy.122

24.73 There is still too much to learn about the causes of mental illness and the effects of the various drugs that are used to alleviate the symptoms of those illnesses to allow beneficence to be the dominant public policy—and psychiatrists to be the only substitute decision makers—when people with a mental illness lack the capacity to make their own treatment decisions. There are no objective tests to confirm a diagnosis of many mental illnesses123 and our understanding of why various drugs used in psychiatry alleviate symptoms is still developing.124 Some drugs have serious side effects.125 It should be possible for a person with capacity to appoint a trusted family member or friend to make treatment decisions for them when they are unable to do so, just as they can appoint someone to make all other treatment decisions for them.

24.74 The Commission’s proposals concerning the circumstances in which an enduring personal guardian can be authorised to consent to psychiatric treatment for a person without capacity who is an involuntary patient are one means of seeking to strike a new balance between beneficence and autonomy when dealing with non-consensual psychiatric treatment. While no other Australian jurisdiction has taken the step of permitting an enduring guardian to make decisions about psychiatric treatment when the principal becomes an involuntary patient, Tasmania allows a guardian appointed by a tribunal to make treatment decisions in these circumstances.

24.75 The broader debate about the complete fusion of mental health and guardianship law is important and will probably continue for some time in Australia if the experience in the United Kingdom is any guide.126 The Commission encourages further discussion about this fundamental change to the way in which authority is given for some people to receive mental health services.

HUMAN RIGHTS ISSUES

The Charter of Human Rights and Responsibilities

24.76 Victoria’s 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) both emphasise the dignity of all people and promote the equal protection of the law for people with a disability. As such, the Commission believes they provide a useful framework within which to consider whether guardianship laws should be used to authorise the compulsory treatment of a person with impaired decision-making capacity due to mental illness.

122 See Chapters 4 and 5 of this report in which the changing policy environment is discussed.
125 Ibid.
24.77 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’, while section 21 declares that ‘[e]very person has the right to liberty and security’.

24.78 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’.127 Because both guardianship and mental health laws clearly limit the rights in sections 10 and 21 of the Charter, they must pass the test set out in section 7(2), which involves consideration of both reasonableness and proportionality, in order to comply with the Charter.

24.79 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’.128 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.129

The Convention on the Rights of Persons with Disabilities

24.80 The Convention, which Australia has signed and ratified, deals with human rights in the context of legal capacity and the provision of compulsory treatment.130 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.131 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’.132

24.81 Most importantly for present purposes, article 12 of the Convention requires states parties to ‘recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life’, and to take ‘appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity’.133

24.82 Although some people have argued that the Convention requires the abolition of mental health laws,134 the federal135 and Victorian136 governments have not interpreted it this way. When Australia ratified the Convention, it stated:

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127 Charter of Human Rights and Responsibilities Act 2006 (Vic) s 7(2).
128 Ibid preamble.
129 Ibid ss 8(1), (3).
131 Convention on the Rights of Persons with Disabilities, preamble (h), (n), art 3.
132 Ibid art 4(1)(b).
133 Ibid arts 12(2), (3).
136 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.
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.\[137\]

### Special measures

24.83 Those who suggest that a group of people who share an attribute (such as a mental illness) should be treated differently usually bear the onus of proving that the different treatment is a ‘special measure’ for the benefit of that group.\[138\] This approach seems appropriate when considering whether an enduring personal guardian should be unable to make decisions about the principal’s psychiatric treatment when the principal is an involuntary patient under the Mental Health Act.

24.84 The arguments in favour of continuing to give the authorised psychiatrist legal primacy when making psychiatric treatment decisions for an involuntary patient under the Mental Health Act and for denying an enduring guardian any role in these decisions are difficult to identify because this issue has not been openly debated. The 2006 memorandum of understanding between the Chief Psychiatrist and the Public Advocate about substitute consent to treatment and other decisions for a person with a mental illness does not explain the reasons for the preferred use of Mental Health Act powers. Similarly, there was no parliamentary discussion of policy considerations when the Mental Health Act was amended in 2002 to give the authorised psychiatrist sole responsibility in relation to psychiatric treatment decisions for involuntary patients.\[139\]

24.85 It is likely that clinical preference for early treatment and administrative expediency are the most significant reasons in favour of retaining the authorised psychiatrist as the only person who can authorise psychiatric treatment for a person who is an involuntary patient under the Mental Health Act. These reasons do not seem strong enough to maintain an argument that the current inability of an enduring guardian to make psychiatric treatment decisions for an involuntary patient is a ‘special measure’ that justifies different treatment of people with a mental illness.

### Early intervention

24.86 The treatment principles in the current Mental Health Act refer to the need for ‘timely and high quality treatment and care in accordance with professionally accepted standards’.\[140\] This goal could be enhanced by allowing an enduring personal guardian to make psychiatric treatment decisions. As Dawson and Szmukler have argued, early intervention is more likely to occur if clinical involvement can be authorised as soon as a person lacks capacity rather than awaiting an event that triggers the involuntary treatment processes of the Mental Health Act.\[141\]

### Administrative expediency

24.87 While administrative expediency is not a matter that should be dismissed lightly, it does not justify giving an authorised psychiatrist sole decision-making power about psychiatric treatment for a person who is an involuntary patient. It is important that authorised psychiatrists have clear and workable choices when dealing with a person

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138 See, eg, Equal Opportunity Act 2010 (Vic) s 12(6); Gerhardy v Brown (1985) 159 CLR 70.
139 Section 3A of the Mental Health Act 1986 (Vic) was inserted into that Act by section 29 of the Guardianship and Administration (Amendment) Act 2002 (Vic).
140 Mental Health Act 1986 (Vic) s 6A(a).
who is seriously mentally ill and who is unable to make their own decisions about psychiatric treatment. The Commission believes that this outcome can be achieved without retaining the Mental Health Act as the only vehicle for substitute decision making for psychiatric treatment and by permitting a properly authorised enduring personal guardian to make psychiatric treatment decisions for a principal in some circumstances. Other branches of medicine have adapted over time to the need to seek consent from a substitute decision maker when a person is unable to consent to their own treatment.

The extent of an enduring personal guardian’s authority

24.88 Many important matters arise when considering the extent to which an enduring personal guardian should be authorised to consent to psychiatric treatment for a person with a mental illness. The lack of emergency intervention processes and accountability mechanisms in guardianship laws suggests a measured and staged approach when recommending an expanded role for guardians in psychiatric treatment decisions.

24.89 Guardianship powers are seldom used coercively in Victoria. The extent of an enduring personal guardian’s authority to use force in relation to a principal, or to permit another person to do so—such as when injecting medication—without a specific order from VCAT 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 principal 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.\(^\text{142}\) 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.

24.90 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”.\(^\text{143}\) The Commission agrees with this statement.\(^\text{144}\)

24.91 In some circumstances, protection of the public rather than beneficence is the primary reason for causing a person to become an involuntary patient under the Mental Health Act. As noted earlier, an authorised psychiatrist has a choice when considering the criteria that must be satisfied before confirming that a person should become an involuntary patient. The authorised psychiatrist can decide that involuntary treatment is required because of a person’s mental illness, either “for his or her health or safety” or “for the protection of members of the public”.\(^\text{145}\) The extent to which people become involuntary patients in order to protect the public from harm is unknown.

24.92 In keeping with the general principle that guardianship should not be used coercively to protect the public, the Commission does not believe that the psychiatric treatment powers of an enduring personal guardian should prevail over those of an authorised psychiatrist when a person becomes an involuntary patient in order to protect the public from harm. In these instances, a public official who operates under appropriate

\(^{142}\) Guardianship and Administration Act 1986 (Vic) s 26(2).

\(^{143}\) Submission IP 8 (Office of the Public Advocate).

\(^{144}\) See further discussion in Chapter 12.

\(^{145}\) Mental Health Act 1986 (Vic) s 8(1)(c).
accountability requirements for the exercise of their powers should make decisions about compulsory psychiatric treatment rather than a private individual appointed by the person who receives the treatment. Those public officials can properly represent the interests of the state by requiring one person to have compulsory psychiatric treatment for the benefit of others in the community.

24.93 The most significant practical challenge with this proposal is to distinguish between instances where the primary reason for causing a person to become an involuntary patient is their own wellbeing and those where the primary reason is protection of the public.

24.94 The Commission believes that authorised psychiatrists can be given appropriate assistance with this task through guidelines developed by the Chief Psychiatrist in consultation with the Public Advocate. While those guidelines will assist authorised psychiatrists to distinguish between those cases where involuntary treatment is given to protect the public rather than primarily for the wellbeing of the person concerned, the success of this approach to striking a new balance between competing interests will probably be determined by the views of authorised psychiatrists. Even though it would be possible for an authorised psychiatrist who wishes to retain sole decision-making authority for psychiatric treatment to record in every case that a person has become an involuntary patient ‘for the protection of members of the public’, the Commission believes that professionalism and integrity of clinicians working in the state’s hospitals should prevent this outcome.

24.95 Given the manner in which psychiatric hospitals and community treatment facilities operate, the Commission does not believe it is appropriate to allow an enduring personal guardian to make decisions about a principal’s detention in a hospital or compulsory residence in a community facility. The authorised psychiatrist must continue to have exclusive authority to determine occupancy as demand for these ‘beds’ often outstrips supply. If an enduring personal guardian had compulsory residence powers there would be potential for conflict and possible harm to the represented person if the enduring personal guardian authorised compulsory residence in a hospital or community facility and the authorised psychiatrist did not believe this step to be an appropriate use of limited resources.

RECOMMENDATIONS

Power of an enduring personal guardian to make psychiatric treatment decisions

416. New guardianship legislation should expressly permit a person with capacity (the principal) to appoint an enduring personal guardian to make decisions about psychiatric treatment for the principal when they are unable to do so because of impaired decision-making capacity, including when the principal is an involuntary patient or a person subject to an involuntary treatment order under the Mental Health Act 1986 (Vic).

417. It should be possible for the principal to give an enduring personal guardian decision-making powers in relation to psychiatric treatment that prevail over the powers of the authorised psychiatrist under the Mental Health Act 1986 (Vic) when the principal is either an involuntary patient or is subject to an involuntary treatment order and ‘involuntary treatment of the person is necessary for [the principal’s] health or safety’ and the authorised psychiatrist reasonably believes that there is no significant risk posed by the person to the public.
418. The Chief Psychiatrist should develop guidelines, in consultation with the Public Advocate, for use by authorised psychiatrists when determining whether the primary reason for taking action under the *Mental Health Act 1986* (Vic) is that ‘involuntary treatment of the person is necessary for [the principal’s] health or safety’.

419. Sections 3A(2)(c), 3A(2)(d) and 12AD of the *Mental Health Act 1986* (Vic) should be amended so that in the circumstances set out in recommendation 417, an enduring personal guardian with psychiatric treatment powers is able to make treatment decisions for the principal’s mental illness when they are an involuntary patient or are subject to an involuntary treatment order and the powers of the enduring personal guardian prevail over the powers of the authorised psychiatrist under the Mental Health Act.

**Tribunal power to appoint a personal guardian to make psychiatric treatment decisions**

24.96 The Commission believes that, ordinarily, only an enduring personal guardian with appropriate powers should be permitted to make psychiatric treatment decisions that prevail over the powers of an authorised psychiatrist when the principal becomes an involuntary patient. It should not be possible for a tribunal to appoint a guardian with this power, other than in the very limited circumstances discussed below.

24.97 The highly personal nature of psychiatric treatment decisions produces a need for deep trust and understanding between the principal and the person who makes these decisions for them. Allowing only personally appointed enduring personal guardians to make psychiatric treatment decisions that prevail over those of the authorised psychiatrist is the best way of securing this outcome.

24.98 The Commission anticipates that some people who have experienced mental illness will seek to appoint an enduring personal guardian with psychiatric treatment powers. It is important that people with this experience are confident that well-meaning family members and friends are not ‘imposed’ upon them as guardians by a tribunal appointment.

24.99 If it is clear that when a person had capacity they intended, but failed, to appoint an enduring personal guardian with psychiatric treatment powers, the tribunal should have the power to appoint a personal guardian to make psychiatric treatment decisions that prevail over the powers of an authorised psychiatrist when that person becomes an involuntary patient. The tribunal would need strong evidence of the person’s clear intention to appoint a particular person as their enduring personal guardian with psychiatric treatment powers before exercising this power.

24.100 Because a person’s unrealised wish to appoint an enduring personal guardian with psychiatric treatment powers is likely to become evident during reviews and appeals conducted by the Mental Health Review Board, it is appropriate that the Board have the same power as the tribunal to appoint a personal guardian in these circumstances.
RECOMMENDATIONS

Tribunal power to appoint a personal guardian to make psychiatric treatment decisions

420. A person with an interest in the affairs of a person who is an involuntary patient or is subject to an involuntary treatment order under the Mental Health Act 1986 (Vic) can apply to the tribunal for an order to appoint a personal guardian with the power to make decisions about psychiatric treatment for the person in the circumstances set out in recommendation 417.

421. The tribunal can appoint a personal guardian with prevailing psychiatric treatment powers in the circumstances set out in recommendation 417 if satisfied that:
   (a) the criteria for appointing a personal guardian are otherwise satisfied
   (b) there is no enduring personal guardian with prevailing powers
   (c) an appropriate person (other than the Public Advocate) is willing and able to perform the role of personal guardian with prevailing powers
   (d) the represented person expressed the wish to make this appointment when they had capacity.

422. The Mental Health Review Board can, on the application of an interested person or on its own motion, appoint a personal guardian with prevailing psychiatric treatment powers when conducting an appeal or review involving an involuntary patient or a person subject to an involuntary treatment order if satisfied that:
   (a) the criteria for appointing a personal guardian are otherwise satisfied
   (b) there is no enduring personal guardian with prevailing powers
   (c) an appropriate person (other than the Public Advocate) is willing and able to perform the role of personal guardian with prevailing powers
   (d) the represented person expressed the wish to make this appointment when they had capacity.

WITNESSING REQUIREMENTS FOR THE APPOINTMENT OF AN ENDURING PERSONAL GUARDIAN

24.101 Two important issues associated with the proposal that it should be possible for a person to appoint an enduring personal guardian with psychiatric treatment powers are the capacity of the principal at the time of the appointment and the willingness and preparedness of the enduring personal guardian for the role. The Commission believes that both of these issues can be dealt with by introducing special witnessing requirements for the appointment of an enduring personal guardian with psychiatric treatment powers.

24.102 In Chapter 10, the Commission proposes some changes to witnessing requirements for all enduring appointments in order to strengthen the process and generate more confidence in the integrity of these appointments. The Commission recommends that two adults, one of whom is authorised to witness an affidavit, should witness enduring appointments.

24.103 Because it is likely that questions will sometimes be raised about a person’s capacity at the time of appointing an enduring personal guardian with psychiatric treatment powers, it is important that there be an expert, independent evaluation of the principal’s capacity at the time of the appointment. A medical practitioner is a suitable
and reasonably accessible person to undertake this evaluation. While some people might see this recommendation as unnecessarily paternalistic, it is a practical means of responding to later disputes about a person’s capacity at the time they made the appointment.

24.104 The role of an enduring personal guardian with psychiatric treatment powers will be very challenging in some circumstances. The principal may behave very differently when they do not have capacity to make their own treatment decisions to how they behave at other times. The enduring personal guardian could face a conflict between the instructions or wishes of the principal and advice from clinicians about treatment.

24.105 While the Commission believes that an enduring personal guardian can fulfil their role by applying the substitute decision-making principles set out in Chapter 17, it is highly desirable that both the principal and the potential enduring personal guardian consider the challenges they might face if the principal loses capacity and the enduring personal guardian is asked to make psychiatric treatment decisions.

24.106 A medical practitioner is a suitable and reasonably accessible person to advise both the principal and the proposed enduring personal guardian about the possible consequences of making the appointment.

**RECOMMENDATIONS**

**Witnessing requirements for the appointment of an enduring personal guardian**

423. An appointment of an enduring personal guardian with the power to make decisions about psychiatric treatment for the principal in the circumstances set out in recommendation 417 should comply with additional witnessing requirements in order to be valid. Instead of the witnessing requirements that apply to all other enduring appointments, the document should be witnessed by a medical practitioner who certifies that they:

(a) assessed the principal shortly before witnessing the document and believe that the principal had the capacity to appoint an enduring personal guardian with the power to make decisions about psychiatric treatment for the principal when they are unable to do so because of impaired decision-making capacity

(b) explained to the principal and the enduring personal guardian the possible consequences of giving the enduring personal guardian powers which prevail over those of the authorised psychiatrist in the circumstances set out in recommendation 417.

**CHALLENGING PSYCHIATRIC TREATMENT DECISIONS BY AN ENDURING PERSONAL GUARDIAN**

24.107 The Commission’s proposal concerning a person’s ability to appoint an enduring personal guardian with psychiatric treatment powers seeks to strike a new balance in principle between beneficence and autonomy when dealing with non-consensual treatment for mental illness. There will be occasions, however, when it should be possible for a public body to consider whether the balance struck in a particular instance is appropriate.
24.108 It is possible that an enduring personal guardian with psychiatric treatment powers will reject all clinical advice about treatment and, by doing so, jeopardise the principal’s wellbeing. In these circumstances, an authorised psychiatrist, or a person with an interest in the affairs of the principal, should be permitted to apply to a tribunal to consider the psychiatric treatment decisions made by the enduring personal guardian and for it to decide whether that person should continue to exercise powers in relation to psychiatric treatment which prevail over those of an authorised psychiatrist.

24.109 In view of the context in which challenges to the psychiatric treatment decisions of an enduring personal guardian are likely to arise, it is desirable that both VCAT and the Mental Health Review Board have jurisdiction to deal with these applications. In some instances, there might be a disagreement between the authorised psychiatrist and the enduring personal guardian about the precise nature of the treatment that should be given to the principal. The Mental Health Review Board will often be the preferable venue for cases of this nature because of its expertise in dealing with matters of psychiatric treatment.

24.110 While both tribunals should be able to set aside the psychiatric treatment powers of an enduring personal guardian, this step should be taken in exceptional circumstances only. The Commission believes that it should be possible to set aside the powers of an enduring personal guardian when that person is making psychiatric treatment decisions that are harmful to the principal and that the principal would have found unacceptable if they had capacity to make them.

24.111 A decision by the Mental Health Review Board to set aside the psychiatric treatment powers of an enduring personal guardian would ordinarily result in the authorised psychiatrist becoming the sole decision maker in relation to matters of psychiatric treatment when the principal is an involuntary patient under the Mental Health Act.

24.112 The Mental Health Review Board should be permitted to set aside the psychiatric treatment powers of an enduring personal guardian only when it is satisfied that:

- the criteria in section 8(1) of the Mental Health Act apply to the principal
- decisions made by the enduring personal guardian about psychiatric treatment for the principal have been or are likely to be harmful to the personal health and wellbeing of the principal
- those decisions are likely to have been unacceptable to the principal if they had the capacity to make decisions about treatment for mental illness
- decisions likely to made by the authorised psychiatrist about psychiatric treatment for the principal are likely to promote the personal health and wellbeing of the principal.

24.113 A decision by VCAT to set aside the appointment of an enduring personal guardian with psychiatric treatment powers might result in the need for a new guardian or result in the authorised psychiatrist becoming the sole decision maker in relation to matters of psychiatric treatment if the principal is an involuntary patient under the Mental Health Act. VCAT should be permitted to set aside the appointment of an enduring personal guardian with psychiatric treatment powers only when it is satisfied that:

- decisions made by the enduring personal guardian about psychiatric treatment for the principal have been or are likely to be harmful to the personal health and wellbeing of the principal
- those decisions are likely to have been unacceptable to the principal if they had the capacity to make decisions about treatment for mental illness.
**RECOMMENDATIONS**

**Challenging psychiatric treatment decisions by an enduring personal guardian**

424. An authorised psychiatrist should be permitted to apply to the Mental Health Review Board for an order setting aside the appointment of an enduring personal guardian with the power to make decisions about psychiatric treatment in the circumstances set out in recommendation 417 so that the involuntary psychiatric treatment order powers of the authorised psychiatrist can be invoked.

425. Upon hearing an application by the authorised psychiatrist in these circumstances, the Mental Health Review Board may set aside the power of an enduring personal guardian to make decisions about psychiatric treatment in the circumstances set out in recommendation 417 when satisfied that:

(a) the criteria in section 8(1) of the *Mental Health Act 1986* (Vic) apply to the principal

(b) decisions made by the enduring personal guardian about psychiatric treatment for the principal have been or are likely to be harmful to the personal health and wellbeing of the principal

(c) those decisions are likely to have been unacceptable to the principal if they had the capacity to make decisions about treatment for mental illness

(d) decisions likely to made by the authorised psychiatrist about psychiatric treatment for the principal are likely to promote the personal health and wellbeing of the principal.

426. An authorised psychiatrist, or any other person with an interest in the affairs of the principal, should be permitted to apply to VCAT for an order setting aside the appointment of an enduring personal guardian with the power to make decisions about psychiatric treatment for the principal in the circumstances set out in recommendation 417.

427. Upon hearing an application in the circumstances set out in recommendation 417, VCAT may set aside the appointment of an enduring personal guardian with the power to make decisions about psychiatric treatment in the circumstances set out in recommendation 417 when satisfied that:

(a) decisions made by the enduring personal guardian about psychiatric treatment for the principal have been or are likely to be harmful to the personal health and wellbeing of the principal

(b) those decisions are likely to have been unacceptable to the principal if they had the capacity to make decisions about treatment for mental illness.

428. If VCAT sets aside the appointment of an enduring personal guardian with the power to make decisions about psychiatric treatment in the circumstances set out in recommendation 417 it may appoint another suitable person as the personal guardian or it may decline to make any further appointment, thereby permitting the authorised psychiatrist to invoke their treatment powers under the *Mental Health Act 1986* (Vic) if the authorised psychiatrist chooses to do so.