THE FUSION PROPOSAL: A NEXT STEP?

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A. Introduction

While Australia is highly likely to have rights-based laws governing the involuntary treatment of people with a mental illness into the foreseeable future, debate about the precise nature of that legal regime will continue.

Support for the fusion of Australian mental health and guardianship laws appears to be gaining ground as expert commentators in many countries question the need for two separate bodies of law that deal with what seem to be the same, or similar, legal issues. 1 Those issues may be broadly characterised as authorising the medical treatment and, in some instances, the containment of people who are unable, or unwilling, to consent to these actions because of impaired capacity resulting from disability.

At present mental health legislation deals with the detention and involuntary treatment of people with a mental illness, while Australian guardianship laws provide a generic substitute decision-making regime for people with impaired capacity because of any disability, including mental illness. Despite the breadth of guardianship laws, they are generally unavailable for use in the circumstances covered by the civil commitment provisions in mental health statutes.

The case for continuing to treat people with a mental illness differently to the way in which we deal legally with others who have impaired decision-making capacity must be able to withstand scrutiny at a time when human rights, such as the equal protection of the law, are at the forefront of our thinking.2

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Like the separate rules of common law and equity prior to the advent of legislation, modern Australian mental health and guardianship laws have generally operated as parallel bodies of law, providing quite different substitute decision-making regimes for people unable to make their own decisions because of disability. In some Australian jurisdictions attempts have been made to integrate the two bodies of law, while in others one body of law expressly defers to the other. In Victoria the two sets of laws have co-existed in silence until quite recently, the general assumption having been that mental health laws govern most substitute decision-making for people with a mental illness, and that guardianship laws have a limited role to play.

The purpose of this paper is, first, to examine the Australian history of mental health and guardianship laws in order to explain why we have these two separate bodies of law. Secondly, to describe the current operation of mental health and guardianship laws in Victoria and New South Wales, the two most populous Australian jurisdictions. Thirdly, to identify some of the arguments for and against the fusion of mental health and guardianship laws and, fourthly, to consider the feasibility of a 'legal trial' which would not bring about fusion but would permit these two bodies of substitute decision-making law to operate concurrently for people with a mental illness over a reasonable period of time. The 'legal trial' would permit consumers, clinicians and carers to evaluate which system better caters for the legal needs of people with a mental illness when they lack capacity to make decisions for themselves. The ultimate outcome may be evidence based law reform.

B. The history of Australian mental health and guardianship laws

The history of mental health law

Australia has traditionally looked to England for guidance when preparing mental health laws. Until the 1980s our Mental Health Acts were little more than local versions of

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1 In England this step came about in the 1870s (the Judicature Acts 1873-1875). Victoria followed in the 1880s (Supreme Court (Judicature) Act 1883 (Vic)). In NSW this step was not taken until the 1970s (Supreme Court Act 1970 (NSW) ss 57-63; Law Reform (Law and Equity) Act 1972 (NSW)).

2 There are still some prominent Australian lawyers who dispute the assertion that the common law and equity have been fused (see RP Meagher, JD Heydon and MJ Leeming, Meagher, Gummow and Lehane’s Equity, Doctrines and Remedies, 4th ed (Butterworths LexisNexis, Sydney, 2002) xi)). For a more modern view, see M Kirby, ‘Equity’s Australian Isolationism’ (W A Lee Equity Lecture, 19 November 2008, QUT, Brisbane): http://www.michaelkirby.com.au/images/stories/speeches/2000s/vol65+/2008/2323-W_A_Lee_Equity_Lecture_2008_(final).doc

3 In Tasmania, for example, decisions about detention in hospital are made by the Mental Health Tribunal (see s 52 Mental Health Act 1996 (Tas)), while decisions about involuntary treatment for mental illness are made by the Guardianship and Administration Board (see s 32 Mental Health Act 1996 (Tas)).

4 Section 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 whenever there is inconsistency. Section 7 of the Mental Health Act permits a guardian to admit a person under guardianship to a mental health facility as a voluntary patient.

5 In Victoria a guardian may be a substitute decision-maker in relation to non-psychiatric treatment for a voluntary patient (Mental Health Act 1986 (Vic), s 85). While Victorian law does not specifically prevent the use of guardianship laws to provide involuntary psychiatric treatment for a person with impaired capacity, there are strong indications in the legislation that this step should not be taken (see eg Mental Health Act 1986 (Vic), s 3A).
English statutes. Since that time some important differences, such as the Australian emphasis upon involuntary treatment in the community, have emerged.

Early English mental health laws were concerned with the protection of private property. While those statutes, which date from the reign of Edward I during the late 13th century, had a protective purpose, they also contributed to the royal income. As feudal lords had abused people of unsound mind, the sovereign intervened, as *parens patriae*, to protect their lands. The monarch had the prerogative power to manage the lands of these people and to share in the profits for doing so. People of unsound mind became wards of the sovereign, and the sovereign could determine where they were to live and what could be done to them.8

Medieval law made no specific provision for mentally ill people without interests in land. It was not until the 18th century that legislation dealt with the detention of mentally ill persons who had no property. The *Vagrancy Act* 1744 permitted justices to order that ‘pauper lunatics’ be locked up and chained in a secure place. This move reflected concerns of the day that insane people would interfere with the property of others unless they were placed in institutions.

Legislative interest in the actual care and treatment of people with a mental illness commenced three decades later, in 1774, with the passage of the *Madhouses Act*. This Act sought to regulate private asylums in response to complaints about appalling conditions.10 For the first time legislation introduced a system for licensing and inspecting madhouses which, historians suggest, was ineffectual.11

During the 19th century, various legal procedures and bureaucracies were established in England with the aims of protecting people in private asylums and safeguarding people who were at risk of being committed to these institutions. Certification procedures involving medical practitioners were introduced, provision was made for public mental health hospitals and a Lunacy Commission was established.12 There were strongly competing views then, as now, about the processes to be followed when determining who could be admitted to an institution as an involuntary patient:

\[\text{M]edical men (sic)... desired early and easy treatment of persons afflicted with mental disease, and at the same time demanded protection against the risks they ran in certifying persons as lunatics; lawyers... attached more weight to the liberty of the person than to the possibility of a cure by facility for compulsory confinement.}\]

The English *Lunacy Act* of 1890 was a legislative response to the unsatisfactory care provided to people in mental health facilities. At the time, the asylum was essentially custodial rather than curative, often acting as a dumping ground for the socially

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10 Lithiby, above n 8, 54.
11 See e.g. Glover-Thomas, above n 9, 7.
12 Ibid.
undesirable as well as the mentally ill. According to Glover-Thomas, these conditions led to the emergence of a pessimistic attitude towards medical judgement and a fear that the sane might also be subjected to wrongful confinement. The Act established a formalised legal structure, with involuntary detention and treatment procedures being heavily regulated.

The Act remained in force for 40 years, strongly influencing the shape of both English and Australian mental health laws ever since. As the well-known Australian psychiatrist Dr John Ellard has observed, most subsequent Australian mental health acts have been little more than local revisions of the Lunacy Act of 1890.

While there have been pendulum swings in the precise content of Australian mental health laws, their legal purpose has remained the same. Mental health acts authorise conduct that would otherwise be unlawful: loss of liberty and loss of the right to choose whether to accept medical treatment. They also establish administrative machinery to facilitate and review these authorisations. Examples include the powers given to police officers to take people to psychiatric hospitals for assessment and the requirement that magistrates or tribunals review the cases of involuntarily detained people.

**History of guardianship laws**

The history of Australian guardianship laws is very different to that of mental health laws. Since the 1980s, Australia, together with some Canadian provinces and New Zealand, has been a world leader in the development of laws which permit the appointment of a substitute decision-maker when people with a disability are incapable of making their own decisions about important personal or financial matters.

While Australian statutory guardianship laws are a relatively recent phenomenon, guardianship laws date back to the time of the Roman Empire. The law of the Roman XII Tables prescribed that ‘if a person is a fool, let this person and his goods be under the protection of his family or paternal relatives, if he is not under the care of anyone’.

These ancient principles of caring for the vulnerable underpinned the concept of guardianship that developed in medieval English law. However, English (and subsequently Australian) law ‘evidenced a preoccupation with estate administration at the

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14 Glover-Thomas, above n 9, 16.
15 Ibid 3.
expense of guardianship’. Until the early 16th century, royal officials acted as agents of the Crown in handling petitions and appointing tutors or guardians.

In the 17th century this jurisdiction passed to the Courts of Chancery. These courts could appoint a guardian, known as a ‘committee’, to look after the property and the person of the ward. The courts also relied on juries to determine whether the wards would be deemed ‘idiots’ or ‘lunatics’, and the juries sometimes used their discretion to avoid financially ruinous findings of idiocy. Lunacy was preferred to idiocy because if the latter were found, the ward’s assets were forfeited to the crown.

The jury system was abolished in the 19th century when responsibility for decision-making reverted to judges and court officials. The English Lunacy Act of 1890 consolidated this shift and provided a framework for regulating the personal and property affairs of people with a mental illness and those who were intellectually disabled. As previously noted, many of the Australian colonies copied this legislation. Lunacy powers were plenary. They fell within the jurisdiction of the state Supreme Courts and were exercised by Masters in Lunacy.

In England, the Mental Deficiency Act 1913 and later the Mental Health Act 1959 allowed mentally ill and intellectually disabled people to be taken into guardianship. The legislation gave the guardian the power to make decisions as though the subject of the order was under the age of 14 and the guardian was their father. Because reliance on confinement in hospitals was strong, however, guardianship laws were rarely used.

The English Mental Health Act 1983 defined and confined the powers of a guardian. This legislation gave the guardian three specific powers: first, to require the person to reside at a specified place; secondly, to require the person to attend at places and times for the purpose of medical treatment, education, occupation or training; and, thirdly, to require that a doctor or some other specified individual have access to the person under guardianship.

The guardianship powers in the 1983 Act were seldom used for a number of reasons, including the fact that guardians were not actually empowered to authorise compulsory treatment or detention at specified places in the community. A report of the English Law Commission in 1995 led to the enactment of the Mental Capacity Act 2005 which provides a substitute decision-making regime that promotes autonomy and is based on a ‘best interests’ approach. This legislation is broadly similar to contemporary Australian guardianship statutes.

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22 Carney and Tait, above n 18, 10.
23 Carney, above n 20, 206.
24 Carney and Tait, above n 18, 10.
25 Ibid 11.
26 Ibid.
27 Carney and Tait, above n 18, 11.
28 Bartlett and Sandland, above n 16, 488.
29 Glover-Thomas, above n 7, 75.
30 Mental Health Act 1983 s 8(1). See Bartlett and Sandland, above n 16, 488.
31 Bartlett and Sandland, above n 16, 489.
In Australia, personal guardianship was little used until the 1960s because of the focus on institutionalisation. The legal powers of a guardian were seldom needed because the institution itself made decisions about matters such as treatment, lifestyle and education.\(^{33}\) Even when deinstitutionalisation began, Australian courts were rarely asked to exercise their powers to appoint guardians because of the expense involved.\(^{34}\) As Carney observed, ‘superior courts were almost inaccessible due to their financial cost, the lack of public familiarity, and the absence of psychological comfort’.\(^{35}\) Moreover, the use of ‘trial leave’, which later became formalised as ‘community treatment orders’, allowed psychiatrists to direct the treatment of people with a mental illness outside of an institution without the use of guardianship powers.\(^{36}\)

Once guardianship law was substantially reformed in the late 20\(^{th}\) century, it became popular as a means of providing a substitute decision-making regime for people with an intellectual disability who were moving from institutions to the community.\(^{37}\) South Australia was the first jurisdiction to enact new laws,\(^{38}\) while Victoria\(^{39}\) and NSW\(^{40}\) followed within a decade.

In 1982 a Victorian ministerial committee (the Cocks Committee) examined the traditional guardianship system and identified deficiencies in the law.\(^{41}\) The Committee found the law to be uncertain and inflexible, referring to the absence of guidelines for selecting and discharging guardians, and to the fact that the plenary nature of guardianship led to an extraordinary loss of autonomy. The Cocks Committee also took issue with the cumbersome process for appointing a guardian, and with the absence of a process for reviewing the continuing need for a substitute decision-maker.\(^{42}\) It supported steps taken in South Australia to establish a Guardianship Board with the power to make various decisions for people with intellectual disability.\(^{43}\)

The committee recommended setting up a ‘one stop shop’ where both personal and property matters could be handled.\(^{44}\) The aim was for guardianship to operate as a ‘last resort’ option under legislation which promoted autonomy and self-sufficiency, encouraged the appointment of family members rather than representatives of the state as substitute decision-makers, and resulted in limited and reviewable orders.\(^{45}\) Other Australian states soon enacted similar laws, which have been constantly developed and refined ever since.\(^{46}\)

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\(^{33}\) The statutory powers of appointment, vested in state Supreme Courts, were very similar to those in the 1913 and 1959 English *Mental Health Acts*. See eg *Public Trustee Act* 1958 (Vic), ss 32 and 39.  
\(^{35}\) Carney and Tait, above n 18, 13.  
\(^{36}\) Ibid.  
\(^{37}\) Ibid 15.  
\(^{38}\) *Mental Health Act* 1976 (SA).  
\(^{39}\) *Guardianship and Administration Board Act* 1986 (Vic).  
\(^{40}\) *Disability Services and Guardianship Act* 1987 (NSW).  
\(^{41}\) Cocks Committee, *Report of the Minister’s Committee on Rights and Protective Legislation for Intellectually Handicapped Persons* (Melbourne, Vic Gov Pr, 1982).  
\(^{42}\) Ibid 24-25.  
\(^{43}\) Ibid 12.  
\(^{44}\) Ibid 28-30.  
\(^{45}\) Carney and Tait, above n 18, 19.  
C. Current Australian mental health and guardianship laws

Mental health laws

The legal purpose of mental health laws

As has been noted, the primary legal purpose of all contemporary mental health laws is to authorise activities which would otherwise be unlawful: the detention and involuntary treatment of some people who have a mental illness. These actions would constitute false imprisonment and assault if not expressly permitted by law.

These laws exist because we have decided that some people with a mental illness should be required to accept treatment for their own good, or for the protection of others. The law permits them to be involuntarily detained in a hospital, or required to interact with community mental health services, while the compulsory treatment regime is implemented.

Current Australian mental health laws are influenced by notions of beneficence, by a concern to protect the community from harm, and by the desire to ensure that liberty is not lightly lost. The legislation seeks to strike a balance between reducing the risk of harm and protecting the core value of liberty. The concern with liberty transcends the interests of people with a mental illness. This is not a modern phenomenon. Mental health laws have always sought to ensure that people are not lightly deprived of their freedom, or their property, because of mistaken judgments about mental illness.

The process provisions

Mental health laws include many provisions that are designed to facilitate actions which may ultimately result in a person’s compulsory treatment and loss of liberty once various clinical assessments have been made. They permit emergency intervention by the police and first instance clinical decision-making. They proceed on the assumption that some people will actively resist clinical intervention. The statutes create processes for use when apprehending people in the community, transporting them to hospital, undertaking medical examinations, and deciding whether to authorise involuntary treatment and detention.

The usual trigger for the operation of mental health laws is a ‘street level’ judgement that clinical intervention is required because a person is at risk of harm to themselves or others because of mental illness. A person’s capacity, or lack of it, to consent to any

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47 Police officers (and others) are given the power to cause a person who appears to be mentally ill and at risk of harm to be medically examined (see Mental Health Act 1986 (Vic) ss 10, 12; Mental Health Act 2007 (NSW) ss 20-22).

48 The terms ‘mental illness’ and ‘mentally ill person’ are similarly defined in the NSW and Victorian statutes (see Mental Health Act 2007 (NSW) s 4; Mental Health Act 1986 (Vic) s 8(1A)). The Victorian Act provides that a ‘a person is mentally ill if he or she has a mental illness, being a medical condition that is characterised by a significant disturbance of thought, mood, perception or memory’. Both Acts also contain lists of disqualifying factors, such as political opinion and sexual preference, which cannot of themselves be used to indicate that a person has a ‘mental illness’ (see Mental Health Act 2007 (NSW) s 16; Mental Health Act 1986 (Vic) s 8(2)).
interference with their liberty or freedom to choose medical treatment is not a primary consideration. 49

Modern mental health laws contain comprehensive ‘process provisions’ which permit emergency intervention when there is a risk of harm. These powers parallel, and in some respects surpass, 50 those possessed by police officers to apprehend and detain people suspected of engaging in serious criminal activities.

The following powers are found in most modern Australian mental health laws:

- police officers may apprehend a person in the community suspected of being at serious risk of harm because of mental illness and cause them to be examined by a medical practitioner 51
- police officers may forcibly enter the premises of a person suspected of being at serious risk of harm because of mental illness, apprehend that person and cause them to be examined by a medical practitioner 52
- police officers may transport a person to a hospital for examination 53
- a medical practitioner at a psychiatric hospital may conduct a psychiatric assessment of a person brought to that hospital and cause the person to be detained at the hospital until a second opinion may be sought from a psychiatrist 54
- a psychiatrist at a psychiatric hospital may subject a person to a psychiatric assessment and cause a person to be detained at the hospital and given psychiatric treatment without the consent of that person. 55

Once ‘full’ involuntary patient status 56 has been confirmed by the use of these processes, a person experiences absolute loss of liberty and total loss of power to refuse psychiatric treatment. Mental health laws impose a form of clinical guardianship, with the senior psychiatrist at a hospital having the power to authorise involuntary treatment. 57

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49 The NSW legislation does not even require the medical practitioners involved in causing a person to become an involuntary patient, or the external reviewing authorities (Magistrates and the Mental Health Review Tribunal), to consider the person’s capacity to consent to treatment. The criteria are mental illness (or mental disorder) and risk of serious harm (Mental Health Act 2007 (NSW) ss 14-15). In Victoria the medical practitioners involved in causing a person to become an involuntary patient and the external reviewing authority (the Mental Health Review Board) must be satisfied that ‘the person has refused or is unable to consent to the necessary treatment for the mental illness’ (Mental Health Act 1986 (Vic) s 8(1)(d)).

50 For instance, section 10(2) of the Mental Health Act 1986 (Vic) permits a police officer to forcibly enter premises, without a warrant, when the police officer has reasonable grounds for believing, amongst other things, that a person who appears to be mentally ill is likely to cause serious harm to themselves or some other person. Compare the general police power to enter premises and arrest a person suspected of crime: Crimes Act 1958 (Vic) s 459A.

51 See eg Mental Health Act 1986 (Vic) ss 10(1), 10(4); Mental Health Act 2007 (NSW) s 22.
52 See eg Mental Health Act 1986 (Vic) ss 10(2); Mental Health Act 2007 (NSW) s 21.
53 See eg Mental Health Act 1986 (Vic) ss 9A, 9B; Mental Health Act 2007 (NSW) s 22.
54 See eg Mental Health Act 1986 (Vic) ss 12, 12AA; Mental Health Act 2007 (NSW) s 27.
55 See eg Mental Health Act 1986 (Vic) ss 12AC, 12AD; Mental Health Act 2007 (NSW) ss 27, 29 and 84.
56 It is also possible in both Victoria and NSW to use these processes to cause a person to be placed on a community treatment order which does not result in the loss of liberty experienced by involuntary inpatients (see Mental Health Act 1986 (Vic) ss 12; Mental Health Act 2007 (NSW) s 51).
57 See eg Mental Health Act 1986 (Vic) s 12AD; Mental Health Act 2007 (NSW) s 84.
Accountability and review mechanisms

Modern mental health laws contain a range of accountability and review mechanisms which seek to ensure that the powers granted to emergency workers and clinicians are used properly and with good cause. Various authorisation or licensing mechanisms deal with recording information, the places where people may be involuntarily detained, and the qualifications and responsibilities of the person in charge of that facility. Provisions of this nature deal with the following matters:

- prescribed forms to be used when exercising the various powers granted by the legislation
- the licensing of premises that are permitted to receive involuntary patients
- the appointment of a senior psychiatrist at each licensed facility
- the responsibilities of that senior psychiatrist.

Modern mental health laws also contain an array of checks and balances designed to ensure that there is merits review of a decision to deprive a person of their liberty and to require them to accept treatment without consent. Those review mechanisms include the following matters:

- the senior psychiatrist, or delegate, must review any decision made by an admitting medical officer to detain a person as an involuntary patient
- a tribunal must review any decision to detain a person as an involuntary patient
- a person detained as an involuntary patient has the right to appeal to a tribunal at any time for review of their detention
- some forms of psychiatric treatment must be approved by a tribunal before they may be used
- independent community visitors have the right to enter a psychiatric hospital, to talk to patients and to examine records concerning treatment.

Guardianship laws

The legal purpose of guardianship laws

Modern Australian guardianship laws provide for the appointment of substitute decision-makers for people who do not have the capacity to make their own decisions about important matters such as where they will live, whether they should have a particular

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58 See eg Mental Health Act 1986 (Vic) s 9; Mental Health Act 2007 (NSW) s 19.
59 See eg Mental Health Act 1986 (Vic) s 94; Mental Health Act 2007 (NSW) s 109.
60 See eg Mental Health Act 1986 (Vic) s 96; Mental Health Act 2007 (NSW) s 111. In NSW the ‘medical superintendent’ does not have to be, but is usually, a psychiatrist.
61 See eg Mental Health Act 1986 (Vic) s 96(2); Mental Health Act 2007 (NSW) s 124.
62 See eg Mental Health Act 1986 (Vic) s 12AC; Mental Health Act 2007 (NSW) s 27.
63 See eg Mental Health Act 1986 (Vic) s 30; Mental Health Act 2007 (NSW) s 34. In NSW a magistrate conducts the initial ‘tribunal’ review.
64 See eg Mental Health Act 1986 (Vic) s 29; Mental Health Act 2007 (NSW) s 44.
65 See eg Mental Health Act 1986 (Vic) s 57; Mental Health Act 2007 (NSW) s 94.
66 See eg Mental Health Act 1986 (Vic) s 112; Mental Health Act 2007 (NSW) s 131.
form of medical treatment, and how their financial affairs should be managed. These laws permit a tribunal to appoint a suitable person, such as a relative or friend, as a guardian to make personal or ‘lifestyle decisions’ for a person incapable of making their own decisions as a result of disability, and, similarly, to appoint such a person as an administrator (or financial manager) to make financial decisions. A public official is available for appointment as a guardian or administrator of last resort.

Australian guardianship laws also encourage forward planning and, in some circumstances, informal decision-making. These laws aim to promote the autonomy of people with impaired decision-making capacity and they seek to discourage default decision-making by professionals, such as medical practitioners, except in relation to life-threatening emergencies or relatively minor matters.

As we have seen, the primary purpose of modern Australian guardianship laws was originally to establish a substitute decision-making regime for people with an intellectual disability who no longer fell within mental health legislation and were no longer required or able to live in psychiatric hospitals. These laws established a ‘light touch’ substitute decision-making regime with strong emphasis upon promoting the autonomy of people to make their own decisions whenever possible. This was achieved by granting the guardian only those substitute decision-making powers which were clearly necessary, and through encouraging the use of informal decision-making processes whenever possible.

Much has changed since these statutes were first enacted in the 1980s. Appointment of a guardian by a tribunal is no longer the preferred way of providing a substitute decision-maker for people who are incapable of making their own decisions and who are in need of another person to make decisions on their behalf. The legislation now establishes a tiered approach to substitute decision-making. It encourages forward planning with a guardian appointed by tribunal being the final option when a substitute decision-maker is required. The preferred approach is for people to appoint their own substitute decision-maker. The legislation permits a person who is over the age of 18 and has capacity to appoint an enduring guardian to make decisions on their behalf when they are incapable of doing so. In Victoria, there is also an overlapping power to appoint a person as an agent for the specific purpose of making future medical treatment decisions.

The legislation also creates a default substitute decision-making regime in the area of medical treatment. It declares that a range of people automatically become substitute decision-makers when a person becomes incapable of consenting to most types of medical

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67 There is a separate branch of most guardianship legislation which deals with the management of financial affairs. For example, in Victoria, Part 5 of the Guardianship and Administration Act 1986 (Vic) deals with ‘Administration Orders’. In NSW, Part 3A of the Guardianship Act 1987 (NSW) deals with ‘Financial Management Orders’. These parts of the legislation are not discussed in this paper as they are beyond the scope of the matters under consideration.

68 In Victoria the Public Advocate and in NSW the Public Guardian.

69 See eg Guardianship and Administration Act 1986 (Vic) Part s 4; Guardianship Act 1987 (NSW) s 4.

70 Medical practitioners have statutory default decision-making power in relation to these matters: see eg Guardianship and Administration Act 1986 (Vic) s 42L; Guardianship Act 1987 (NSW) s 37.

71 See the ‘objects’ or ‘general principles’ sections in the Acts: Guardianship and Administration Act 1986 (Vic) s 4; Guardianship Act 1987 (NSW) s 4.

72 See eg Guardianship and Administration Act 1986 (Vic) Part 4 Division 5A; Guardianship Act 1987 (NSW) Part 2.

73 Medical Treatment Act 1988 (Vic) s 5A.
treatment.74 These statutorily appointed default decision-makers, such as a person’s spouse or primary carer, are permitted to make most treatment decisions for a person who lacks the capacity to do so.75

The outer limits of the powers that may be given to and exercised by a guardian are not particularly clear. While a guardian may be given the power to consent to medical treatment on behalf of a represented person,76 the power of a guardian to authorise the detention of a person in a hospital or a community residence is uncertain.

The extent of a guardian’s powers is best determined by considering the legislative description of the powers of a plenary guardian. Both the NSW and Victorian statutes use the drafting device of referring to powers set out in other bodies of law to describe the powers of a plenary guardian. In the Victorian Act the powers are those ‘which the plenary guardian would have if he or she were a parent and the represented person his or her child’.77 In NSW, as well as having ‘custody of the person’, the plenary guardian ‘has all of the functions …that a guardian has at law or in equity’.78 It is highly unlikely that the drafters of these provisions considered whether guardianship powers could be used to authorise the detention in either a hospital or a community setting of a person who was actively resisting deprivation of their liberty.

The use of guardianship has changed quite markedly over the past two decades and it is now the primary substitute decision-making regime for people with all forms of disability other than mental illness.79 People who are unable to make their own decisions because of disabilities generally associated with the ageing process have become the major users of guardianship laws.

Process provisions

The trigger for the operation of guardianship laws is a determination by any interested person that somebody is in need of a substitute decision-maker because they appear to lack capacity to make an important decision.80 While that lack of capacity must be the result of a disability, the term ‘disability’ is so broadly defined that it is difficult to imagine circumstances in which it does not cover a person who lacks capacity to make an important decision.81 In practice, a friend or relative, health worker or other person involved in the care of people with a disability will usually make an application to a tribunal for the appointment of a guardian when there is a perceived need for a substitute decision-maker.

74 The nature of the incapacity is set out in the legislation. The person must be incapable of understanding the general nature and effect of the proposed treatment, or incapable of indicating whether he or she consents to that treatment (see eg Guardianship and Administration Act 1986 (Vic) s 36(2); Guardianship Act 1987 (NSW) s 33(2)).
75 See eg Guardianship and Administration Act 1986 (Vic) Part 4A; Guardianship Act 1987 (NSW) Part 5.
76 Guardianship and Administration Act 1986 (Vic) s 24(2)(d).
77 Guardianship and Administration Act 1986 (Vic) s 24 (1); Guardianship Act 1987 (NSW) s 40.
78 Guardianship Act 1987 (NSW) s 21(1).
79 Section 1 of the Guardianship and Administration Act 1986 (Vic) provides as follows: ‘The purpose of this Act is to enable persons with a disability to have a guardian or administrator appointed when they need a guardian or administrator’.
81 See eg Guardianship and Administration Act 1986 (Vic) s 22; Guardianship Act 1987 (NSW) s 14.
82 See eg Guardianship and Administration Act 1986 (Vic) s 3; Guardianship Act 1987 (NSW) s 3(2).
Guardianship statutes do not contain any of the process provisions for emergency intervention found within mental health laws. Guardianship legislation does not permit 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. Nor does it allow them to apprehend people and cause them to be medically assessed in order to determine whether a guardianship order should be made, and to convey them to hospital for further examination or treatment. In practice, informal steps are usually taken when emergency action is required because few people who lack capacity actively resist that intervention.

**Accountability and review mechanisms**

Guardianship laws contain relatively few mechanisms which permit review of any decisions made by a guardian or the decision by a tribunal to make a guardianship order. In NSW, it is possible to appeal from a tribunal decision to appoint a guardian on a question of law alone and, with leave, on the merits of the decision. 83 It is also possible to request for the tribunal to review a guardianship order. 84 In Victoria, there is a right to appeal on a question of law alone, 85 and it is possible to apply to the tribunal for a re-hearing of a decision to make a guardianship order. 86

In both jurisdictions there is no capacity to review individual decisions made by a private guardian acting pursuant to a guardianship order. In NSW, it is possible to review individual decisions made by the statutory guardian of last resort, the Public Guardian, 87 but, other than in this circumstance, the broad powers of a guardian may be exercised without any opportunity for external review of individual decisions. While this issue is a matter of on-going debate, any new mechanism for external review of individual decisions by a guardian is likely to be labour and resource intensive.

**D. Fusion of mental health and guardianship laws**

*Arguments in favour of fusion*

The fusion of mental health and guardianship laws would cause guardianship to become the only legal means of providing substitute decision-making for people who lack the capacity to make their own decisions because of any disability, including mental illness. Professors John Dawson and George Szumukler, two of the most prominent advocates of the fusion proposal, describe how the law would operate:

This scheme would not rely on any specific reference to ‘mental disorder’. Instead, it would rely squarely on the criterion of incapacity to make necessary treatment decisions, but it would still authorise both a person’s detention and their involuntary treatment…Under it [the fusion proposal], the incapacity of a

83 Guardianship Act 1987 (NSW) s 67A; Administrative Decisions Tribunal Act 1998 (NSW) s 118B.
84 Guardianship Act 1987 (NSW) s 25.
85 Victorian Civil and Administrative Tribunal Act 1998 (Vic) s 148(2).
86 Guardianship and Administration Act 1986 (Vic) s 60A.
87 Administrative Decisions Tribunal Act 1998 (NSW) s 80A.
person to consent would be the fundamental criterion governing all involuntary health interventions, and that criterion would be applied to both detention and involuntary treatment, of both ‘physical’ and ‘mental’ conditions.

…[W]e are not advocating the intermediate (or hybrid) legal position now followed in many parts of North America and continental Europe that involves the application of different legal criteria to the detention and involuntary treatment decisions. Under that approach, mental disorder and threat of harm criteria may be applied to a person’s detention, while incapacity criteria may be applied to their treatment. That approach has the significant disadvantage that it can lead to a position wherein a person may be lawfully detained in a psychiatric facility on the basis of their mental disorder, but they cannot be treated if they retain or regain their capacity to consent to psychiatric treatment. 88

In practical terms, fusion would mean that when a person loses capacity because of mental illness, decision-making responsibility about matters such as treatment and detention would shift from a public official (as is now the case under mental health laws) to the family member or friend who had been appointed as the guardian, or to the statutory guardian of last resort (as occurs under guardianship legislation). This change may promote the dignity and autonomy of a person who loses capacity because of mental illness, as in many instances the substitute decision-maker would be a close and trusted person rather than an unfamiliar doctor at a psychiatric hospital.

The principal theme that runs through the arguments in favour of fusion is that it is discriminatory to have a separate body of law which deals with the involuntary treatment and detention of people with a mental illness when statutory guardianship laws exist as a generic substitute decision-making regime for people with all forms of disability. 89

Professor Tom Campbell argues that the existence of such separate legislation allows for the manifestation of ‘institutional discrimination’ 90 since the coercive measures permitted under the legislation are confined to people with a mental illness. 91 He also suggests that ‘mental illness prejudice’ 92 is confirmed and perpetuated through the existence of separate mental health legislation. According to Campbell:

By having separate mental health legislation empowering the detention and treatment of persons with mental illness, these prejudices are legitimated and channelled so that compulsion is used disproportionately and unreasonably against this section of the population. 93

Campbell argues that a serious consequence of having separate legislation is that it ‘institutionalises the idea that there is something about “mental illness” itself which invites a system of control and coercion’. 94 He suggests that although issues of medical treatment and social control are conceptually and practically different, they become

88 Dawson and Szmukler, above n 1 (2009), 174-175 (emphasis in original).
91 Ibid.
92 Ibid.
93 Ibid 556.
94 Ibid.
dangerously entangled in the context of mental illness, thereby allowing stereotyped prejudice to flourish. The stereotyping stems from ignorance, he contends, because public opinion wrongly attributes ‘the anti-social characteristics of psychopaths’ to people with a mental illness.

This ignorance, according to Campbell, has led to the widespread assumption that all people with a mental illness are dangerous, which is reinforced by legislation that permits preventative detention of mentally ill people in anticipation of dangerous conduct. Campbell does not take issue with the notion of preventative detention, but argues that the rules should apply equally to everyone regardless of whether or not they have a mental illness.

Dr 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.

Rosenman suggests that guardianship laws be used to provide substitute decision-making for people with a mental illness in need of involuntary treatment. He believes that this shift would allow guardians to remain involved throughout the process and thus play a role ‘which separates medical advice from consent’.

Dawson and 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. 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.

Dawson and Szmukler argue that reliance on 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’. 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. These authors suggest that if clinical involvement may 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. Szmukler has written elsewhere that this would also help
reduce discrimination\textsuperscript{103} because the current law permits the non-consensual treatment of people for a mental disorder regardless of whether or not 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 the rejection of treatment may result in death.\textsuperscript{104}

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 while retaining capacity to be controlled through the criminal justice system, while those who lacked capacity (whether mentally ill or not) could be managed under involuntary treatment legislation. The shift would allow for ‘consistent ethical principles [to be applied] across medical law’.\textsuperscript{105}

Professor 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.’\textsuperscript{106}

Richardson also suggests that the existence of guardianship laws in Australia further entrenches prejudice against mental illness so long as this system coexists with separate mental health legislation.\textsuperscript{107} Richardson argues that the existence of the two systems ‘encourages the perception of mental disorder as a condition apart’:\textsuperscript{108}

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.\textsuperscript{109}

\textbf{Arguments against fusion:}

There are a many arguments which may be raised in opposition to the suggestion that mental health and guardianship laws should merge. First, it may be argued that mental health laws are ‘special measures’ which promote the interests of people with a mental illness rather than unfairly discriminate against them. ‘Special measures’ do not infringe the equal protection and non-discrimination provisions in domestic and international human rights charters.\textsuperscript{110}

It may be argued that separate mental health laws are ‘special measures’ that implement a policy of beneficence towards people with a mental illness. Mental illness is different to

\textsuperscript{104} Ibid.
\textsuperscript{105} Dawson and Szmukler, above n 102, 504.
\textsuperscript{107} Ibid 459.
\textsuperscript{108} Ibid.
\textsuperscript{109} Ibid.
\textsuperscript{110} Section 7(4) of the Victorian \textit{Charter of Human Rights and Responsibilities Act 2006} provides that: ‘Measures taken for the purposes of assisting or advancing persons or groups of persons disadvantaged because of discrimination do not constitute discrimination’. Article 5.4 of the \textit{Convention on the Rights of Persons with Disabilities} contains similar language.
most other forms of disability because it is sometimes accompanied by a lack of awareness of impairment of functioning. A person with a mental illness, unlike someone with most physical disorders, may be unaware of any disturbance of functioning which may be alleviated by treatment. This difference may be used to justify separate, interventionist mental health laws that are designed to promote the well-being of people with mental illness who are unable to perceive their own need for treatment.\textsuperscript{111} It has been argued that ‘in the tussle between autonomy and coercion, a short period of coercion may be a precursor to a long period of autonomy’.\textsuperscript{112}

Secondly, it may be argued that the safeguards which have slowly developed over time about the use of coercive powers may be jeopardised if guardianship rather than mental health laws were used to authorise the detention and involuntary treatment of a person with a mental illness. The use of guardianship laws for these purposes would result in the delegation of what have been seen as significant state powers – detention and coercive treatment - to a single person, the guardian. In many instances the use of these powers would be privatised because the guardian may be a friend or relative of the person who is the subject of the guardianship order.

It is arguable that because of the fundamental importance of the issues of liberty and bodily integrity, there is a great need for independent and transparent decision-making processes when these rights are lost. These processes are a central feature of mental health laws. Guardianship laws contain far fewer mechanisms for supervising the use of coercive powers. With few exceptions, there is no external review of individual decisions made by guardians concerning deprivation of liberty and coercive treatment.

Thirdly, it may be argued that guardianship laws lack the necessary process provisions to respond effectively to the circumstances in which some people with a mental illness come to the attention of police and ambulance services. As we have seen, mental health laws contain detailed provisions concerning the emergency intervention that may take place when a person poses a risk of harm because they are in the acute stage of a mental illness. Guardianship laws do not contain any of the emergency intervention processes found in mental health laws.

Fourthly, the trigger for the operation of guardianship laws – lack of capacity – may not be an effective means of providing assistance in some cases involving people with a mental illness. If a person’s capacity to make decisions for themselves is a contestable issue, as is the case for people with some mental illnesses, the processes which exist under guardianship laws to resolve disputes about capacity may be too slow and awkward to permit timely clinical intervention in many cases.

Fifthly, 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.\textsuperscript{113} In some instances this task may be very difficult if guardianship were used to authorise involuntary detention and treatment for people with a mental illness. It is inevitable that there would be instances in which the guardian was encouraged by clinical staff to make

\textsuperscript{111} For example, section 3(d) of the \textit{Mental Health Act 2007} (NSW) provides that one of the objects of the legislation is to give people an opportunity to have access to appropriate care.


\textsuperscript{113} \textit{Guardianship and Administration Act 1986} (Vic) s 28.
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 rather than follow the wishes of the represented person. This is a recipe for conflict. The ongoing relationship between a friend or relative who accepts appointment as a guardian and the represented person may be irrevocably damaged in these circumstances.

E. The concurrent operation of mental health and guardianship laws

Recent English experience suggests that the path to fusion of mental health and guardianship laws is probably a long one. The introduction of generic substitute decision-making legislation based on lack of capacity rather than risk of harm was pressed strongly during the community debates which ultimately led to the passage of the English Mental Health Act 2007.114 The fusion argument was not successful, resulting in mental health and incapacity (or guardianship) laws operating side by side in England, as they do in Australia.115

The recent events in England suggest that the fusion proposal will succeed only if consensus can be reached among a coalition of consumers, clinicians, carers and human rights lawyers who are able to persuade the broader community that the suggestion is fair and workable. That consensus may not be easily achieved given the struggles that invariably accompany attempts to rewrite mental health laws.

While the arguments in favour of fusion are strong, so too are many of the counter arguments. At present, there is only some limited interaction between Australian mental health and guardianship laws - a guardian may cause a person to be admitted to a psychiatric hospital as a voluntary or informal patient.116

A way forward may be to permit the concurrent operation of mental health and guardianship laws, so that either statutory regime may be used to authorise involuntary treatment and detention (in hospital or in the community) for a person with a mental illness who is unable to consent to their own treatment. Under this system, mental health laws would continue to operate in those circumstances where the issue of capacity is not easily resolved and there is a clear risk of harm resulting from a person’s untreated mental illness.

If both bodies of law are able to operate concurrently, however, a guardian (including an enduring guardian appointed by the person concerned) could authorise detention and involuntary treatment in some circumstances now covered by the civil commitment provisions of mental health laws. The choice of legal regime in a particular case would be

115 Ibid.
116 See Mental Health Act 2007 (NSW) s 7; Guardianship Act 1987 (NSW) s 3C. In Victoria the power of a guardian to admit a person to a psychiatric hospital as a voluntary patient is not specifically dealt with in legislation but arises by implication from the broad powers granted under guardianship legislation.
a matter for all people with a direct interest in the decision, including carers, clinicians and, whenever possible, consumers.

During a trial period of the proposed system it is highly likely that mental health laws would continue to be the regime of choice in those circumstances where emergency intervention is needed to promptly deal with the risk of harm to the person concerned, or to other members of the community. Guardianship laws may be preferred, however, in instances where a person with a strong support network has acknowledged the cyclical nature of their illness and has appointed a trusted relative or friend to be their enduring guardian. The guardian would have the capacity to intervene in a more personal and less dramatic way than is generally available under mental health laws when the need for compulsory treatment arises. Guardianship laws may also be preferred when there is little or no dispute about lack of capacity and the person concerned is not actively resisting clinical intervention.

Concurrent operation of mental health and guardianship laws during a trial period merits discussion as one means of advancing the fusion proposal.