Dear Professor Rice

ACT Health Submission to Inquiry into ACT law pertaining to guardianship of adults

Thank you for your letter advising that the ACT Law Reform Advisory Council was seeking submissions on its Inquiry into ACT statute law on guardianship of adults.

Please find ACT Health’s submission attached.

As per the Inquiry’s Terms of Reference, ACT Health’s submission focuses on the implications for that law of the:

- United Nations Convention on the Rights of Persons with Disabilities and other international human rights instruments, particularly in respect of assessment of the decision-making capacity, and support of the decision-making, of adults whose decision-making capacity is impaired by mental or physical illnesses or disabilities.
- Human Rights Act 2004 (ACT), the Powers of Attorney Act 2006 (ACT), and the Mental Health (Treatment and Care) Act 1994 (ACT).

More specifically, the submission is comprised of:

- A completed consent form authorising publication of the submission;
- Appendix A which answers the Inquiry booklet’s twelve questions; and

I look forward to the publication of the Inquiry report.
If ACT Health may be of any further assistance to the Inquiry, please contact Mr Richard Bromhead, Manager, Mental Health Policy on 6207 1066 or email richard.bromhead@act.gov.au.

Yours sincerely

Nicole Feely
Director-General
ACT Health

September 2015.
WRITTEN CONSENT

People and organisations making submissions

Inquiry into the Guardianship and Management of Property Act 1991 (ACT)

I have read and understood the Participant Information about the Inquiry that is at the back of this booklet.
I have had any questions and concerns about the inquiry addressed to my satisfaction.
I understand that there are a number of ways I can participate in the Inquiry, including making a submission, having an interview or participating in a group discussion.
Completing the questions in this booklet and forwarding my answers to the Council is one way of making a written submission.

I wish to participate through making a written submission.  

Please mail the submission to:  
Guardianship Submissions  
ACT Law Reform Advisory Council  
c/o ANU College of Law  
ANU CANBERRA ACT 0200

Or please email submissions to:  
nrac@anu.edu.au

When the ACT Law Reform Advisory Council reports the findings from the various possible forms of participation, I understand that much of it may not be personally attributed. However, where it is, I agree to be identified in the following way:

Full name YES ☐ NO ☑ ACT HEALTH

Pseudonym YES ☐ NO ☑

Complete confidentiality YES ☐ NO ☑

Signature:  
Date: 10/9/15
Appendix A:
ACT Health Responses to ACT Law Reform Advisory Council Inquiry’s
Reform of guardianship arrangements for adult people with disabilities booklet

Booklet questions 1. and 2.
Overview of Mental Health Law Review recommendations on guardianship

1. The Inquiry booklet questions 1. and 2. ask about the responder’s experience in relation to the Guardianship and Management of Property Act 1991 (ACT) (‘the Guardianship Act’) and the Powers of Attorney Act 2006 (‘the Powers of Attorney Act’). Further, the Australian National University (‘ANU’) advisors to the Inquiry have expressed they wish to learn as much as possible about the observations on these Acts of the ACT’s recently concluded seven-year Mental Health Law Review (‘the Review’).

2. The Review was a highly, publicly consultative one, administered by ACT Health and the Justice and Community Safety Directorate and advised by a ‘Review Advisory Committee’ (‘the Committee’). The Committee was comprised of many people intimately acquainted with guardianship issues. They included people with mental illness/es and/or disorder/s, carers of such people, a former acting ACT Deputy Public Advocate, the ACT Public Advocate, the General President of the ACT Civil and Administrative Tribunal (‘ACAT’), the ACT Health Services Commissioner, the ACT Disability and Community Services Commissioner, and others.1

3. The Committee recommended that the ACT’s mental health legislation enable a guardian to consent to treatment, care and support delivered under that legislation, for the person for whom they are the guardian (‘the person’), but only if that person is willing to accept the treatment, care and support, and is lacking in the decision-making capacity to give or withhold consent to it, at the time the decision needs to be made. This reform will be effected, by amendments to the Mental Health (Treatment and Care) Act 1994 (‘the current legislation’), provided by the Mental Health (Treatment and Care) Amendment Act 2014 (‘the Amendment Act’), upon its commencement on 12 November 2015, and the Mental Health Bill 2015 (‘the Bill’), should it be enacted. Appendix B explains these amendments.

4. Further, the Committee recommended that there be a review of the Guardianship Act. Several stakeholders in the Review who were not members of the Committee also advocated for that review. There were five bases upon which the Committee and other stakeholders made this call. These are discussed below, in no particular order.

Basis one: Perception of unnecessary, and unnecessarily wide, guardianship orders

5. Stakeholders said they had observed that, in the ACT, there is a high number of:
   • guardians for persons who do not need substitute decision-makers, but, rather, people who can support those persons’ in their own decision-making; and
   • plenary guardianship orders for persons who are not so lacking in decision-making capacity that they need all their powers to make decisions displaced by a guardian’s.

Basis two: Lack of statutory review and oversight of uses of powers

6. The second basis was that the Guardianship Act seems to afford much lower transparency, and independent oversight and review, of uses of substitute decision-making powers by guardians than the current and forthcoming mental health
legislation provides for uses of substitute decision-making powers by the Chief Psychiatrist and their delegates. For instance, both a guardian and the Chief Psychiatrist may decide where a person resides, in some circumstances. However, there are at least six main ways in which the guardian’s power is less restricted, checked and balanced than the Chief Psychiatrist’s.

7. First, there is no public register of which persons are guardians. In contrast, the Chief Psychiatrist is statutorily required to be appointed by the Minister responsible for the appointment provision in the current and forthcoming legislation.2 The respective names of the Minister2 and Chief Psychiatrist4 are notified on the ACT Legislation Register.

8. Second, a guardian has a carte blanche power to decide ‘where a person lives, and with whom’, if they are granted that power in a guardianship order made under the Guardianship Act.5 Meanwhile, the Chief Psychiatrist is only permitted to decide that a person needs to live in an approved mental health facility, and only while the person is receiving treatment, under a psychiatric treatment order. The Chief Psychiatrist’s power to restrict where people live will be limited, in the same way, in respect of persons subject to forensic psychiatric treatment orders, once the Amendment Act brings such orders into being, upon its commencement.6

9. Third, the guardian is not required to record their decisions about where the person will live, while the Chief Psychiatrist can only decide by written determination that a person will live in an approved facility. Fourth, while the guardian has to make their decision under the terms of their appointment in the guardianship order, the Guardianship Act neither commends nor mandates that ACAT limit the duration of that order. Further, the Act only compels ACAT to review a guardianship order three-yearly.7 Conversely, under the mental health legislation, the Chief Psychiatrist’s determination can only be made under orders9 that have far more limited terms.

10. Fifth, the Guardianship Act obliges a guardian to consult with each of the person’s carers,10 when making a decision about the person, but not if the consultation would, in the guardian’s opinion, adversely affect the person’s interests11. Conversely, the Chief Psychiatrist, under the forthcoming legislation, is only permitted to make a determination, after taking ‘all reasonable steps’ to consult with not only the person, but also a range of persons. Further, under that legislation, the Chief Psychiatrist must perform two tasks, after making a determination: one is to record what the person’s views were, and if they did not consult with the person, why they did not;12 and, two is to give a copy of the determination to numerous persons.13

11. The persons the legislation stipulates must be consulted about, and given a copy of, the determination, include, among many others, the person’s guardian and health attorney, under the Guardianship Act.14 There will be much scrutiny of the Chief Psychiatrist’s determination-making, by dent of these consultations and notifications.

12. Sixth, under the current15 and forthcoming16 legislation, if the Chief Psychiatrist is satisfied that a person is no longer someone for whom ACAT could make a psychiatric treatment order, the Chief Psychiatrist must report that to ACAT and the Public Advocate. The Chief Psychiatrist will have the same duty in respect of a person under a forensic psychiatric treatment order.17 The Guardianship Act does not require a similar response should a person no longer meet the Act’s criteria18 for a guardianship order.

13. The ANU advisers have discussed with the Mental Health Law Review Unit, the latter’s awareness that respected Australian authorities have argued19 for so-called ‘fusion
legislation' to be enacted by Australia's states and territories and that the Northern Ireland Assembly currently has before it a bill for fusion legislation, the first in the world. An argument often put for such legislation is that it can comprehensively provide for safeguarding the human rights of all persons who have impaired decision-making capacity, irrespective of the cause of that impairment and of the kinds of decisions that the person cannot make or needs support to make. That is, fusion legislation would displace disparate statutes – such as guardianship and mental health ones – which provide unjustifiably different levels of transparency and review of how the decision-making of people with impaired capacity is supported or substituted.

For instance, the Mental Capacity Bill of Northern Ireland - a common law jurisdiction like the ACT - defines capacity, in a time- and decision-specific way for all people who are thought to have, or have impaired decision-making capacity, regardless of the source of that impairment. The Bill also affords protections relating to how people’s decision-making capacity is assessed, how decisions are made with them, if their capacity is impaired, but they can make some or all decisions with support; and, how decisions they altogether lack the capacity to make are made for them. The decisions the Bill covers include, but are not limited to, ones regarding mental and physical treatment, diversion of people with impaired capacity from the criminal justice system, and management of their property and finances.

In contrast, the ACT’s forthcoming mental health legislation provides for supported decision-making with, substituted decision-making for, and decision-making capacity assessment of, only persons with mental illness/es and/or disorder/s, and only in respect of their decisions about the treatment, care and support they receive under the mental health legislation. As detailed earlier, the Guardianship Act provides for substitute decision-making - no supported decision-making - for persons with guardians and/or managers, who are assumed to be globally incapacitous. Further, that Act provides for one set of safeguards of persons’ rights and the current and the forthcoming mental health legislation provides for another.

Basis three: Act turns on false binary conception of decision-making capacity

A third basis on which stakeholders called for review of the Guardianship Act was that the Act is predicated on the assumption that a person who is appointed a guardian (‘the person’) has so called global decision-making incapacity, which is to say no capacity, at any time, to make decisions about anything. There is a large body of peer-reviewed evidence that shows an individual with (a) condition(s) impairing their capacity may, at different times, demonstrate states of capacity, apart from global incapacity. Basically speaking, these states can be defined as three.

One is where the person is capable of making some kinds of decisions, but not others, with or without support to make decisions. A second is where the person has periods of so-called ‘global decision-making capacity’, in which they are capable of making any decision, with or without support. The third is where the person has global decision-making incapacity, but returns to having one, or the other, or both, of the other two states of capacity. Some individuals experience one of these states and/or fluctuate between two or more of them, temporarily or permanently.

However, the Act, as it currently stands, ignores this flux in the time- and decision-specificity of the capacities of many individuals. That is because all the Act’s provisions, bar those in Part 3, pivot on the Act’s section 5 definition of when a person has ‘impaired decision-making capacity’ and Part 3 pivots on the definition supplied by section 9 of the Powers of Attorney Act 2006. Both definitions are premised on capacity being an all or nothing phenomenon and are unqualified by any statutory
provisions on supported decision-making or capacity assessment.

19. The Act permits its decision-makers for persons - guardians, managers, health attorneys, and ACAT - to substitute their decision for the person's, without conditioning that on a capacity assessment of the person yielding that they do not possess the capacity to make that decision. Further, it makes no requirement to arrange for the person to be supported in their process of making a decision that they have the capacity to make with support. Many stakeholders in the Review stated that these elements of the Act contravene the Convention on the Rights of Persons with Disabilities, a treaty to which Australia is a state party ("the Convention").

20. If these elements contravene the Convention, the contraventions would be of Convention Articles 12(2) and (3), even after those Articles are 'read down' to accord with that part of Australia's 'Declaration' on the Convention that addresses decision-making. Articles 12(2) and (3) respectively state that 'persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life' and 'States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity'. The decision-making part of Australia's Declaration is:

"Australia declares its understanding that the Convention allows for fully supported or substituted decision-making arrangements, which provide for decisions to be made on behalf of a person, only where such arrangements are necessary, as a last resort and subject to safeguards..."

Basis four: Lack of statutory process for supplying consent to medical trial

21. The fourth basis people gave for reviewing the Guardianship Act was the absence of a statutory process enabling a guardian or ACAT to supply the person's consent to their participation in a medical trial, where the person lacks the capacity to consent to that participation. The ACT Justice and Community Safety Directorate has consulted ACT Health about some reform work it is doing on this topic. In response, ACT Health has provided its comments to the Directorate. Further, many of the ethical and legal dilemmas related to this fourth basis, are discussed in respect of the fifth, below.

Basis five: When a person refuses or resists physical treatment

22. The fifth basis was the absence of a statutory process for obtaining ACAT or court dis/approval of a guardian using, or authorising appropriate others to use, force to ensure the person receives necessary assessment and/or treatment, by health professionals, for 'physical' conditions, where the person lacks the capacity to give or withhold consent, and they are resisting or refusing the assessment and/or treatment, or a necessary antecedent to it, such as travelling to the assessment site, like a mammogram unit, or treatment site, like an operating theatre. Under section 7(2) of the Guardianship Act, ACAT may, by order, appoint a guardian and, under section 7(3)(e) of the same Act, ACAT may, in making that order, grant the guardian the power to consent to the person receiving all therapeutic treatments, bar some prescribed medical procedures. There are two problems with this power that have serious implications for the health and well-being of people under guardianship orders.

23. One flows from the Act's silence on supported decision-making. The Act's section 4 decision-making principles govern the exercise of any function under the Act 'in relation to a person with impaired decision-making ability'. However, none of these, nor any other part of the Act, require the guardian to make exercises of their power to consent to treatments contingent on capacity assessment of the person indicating that they lack the capacity, even when supported, to give or withhold that consent.
24. Conversely, where the person has the capacity to make that decision with support, the Act fails to compel the guardian to ensure they, or someone else, appropriately support the person to make that decision. Rather, the Act assumes the guardian’s decision must be substituted for the person’s. This is problematic not only ethically, but also in terms of the logic of the applicable law. That law is common law which clearly holds a person must not be provided with medical treatment, unless they have given informed consent to it; it is necessary to obtain such consent, even when the treatment would save the person’s life; and that it is only a person who is lacking in decision-making capacity who cannot give or withhold consent to treatment.

25. There is a second problem with the guardian’s section 7(3)(e) power to consent to treatment. It is that it seems unlikely to extend to the guardian being permitted to use reasonable, proportionate force to ensure the person receives treatment for so-called ‘physical’ conditions, even when a doctor would reasonably say the person needs that treatment to avert impending death or severely compromised health. Whenever treatment is provided to a person on the basis of substituted consent, at least two of the person’s human rights, provided by common law and the Human Rights Act 1994 (ACT) (‘Human Rights Act’), are engaged: the person’s right to privacy and right to be free from cruel, inhuman and degrading treatment. The latter right incorporates the right not to be subjected to medical treatment without the person’s free consent.

26. The European Court of Human Rights has ruled that fundamental to the right to privacy is the right to physical integrity and that the latter connotes a right to refuse consent to medical treatment. The Court has also ruled that coercive treatment that is therapeutically necessary will not infringe the prohibition on inhuman and degrading treatment, where that necessity can be ‘convincingly shown to exist and the treatment is given in the context of proper procedural guarantees’ (emphasis added).

27. As noted previously, there are no such procedural guarantees, in the ACT, by way of legislation enabling ACAT, or a court, to consider an application from a person’s guardian or health professionals for an order that authorises forcing the person to receive physical treatment, where it will seriously, adversely impact on the person’s health to not receive it.

28. In some emergencies, there will be no question that the common law doctrine of medical necessity supplies the authority to treat a person without their consent, where they lack the capacity to give it, even if the person refuses or resists the treatment. Those emergencies, however, are limited to ones in which it is unarguable that the person’s life or limb is in immediate and grave jeopardy and that the person lacks the capacity to consent to the treatment the emergency warrants.

29. Expert analysis of the law in Australia on giving physical treatment to someone who lacks the capacity to consent to it, shows how fraught with problems it is to rely on that doctrine. Further, in 2013, the United Nations Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment unequivocally disputed uses of the medical necessity doctrine to authorise the non-consensual treatment of any people, on the grounds the doctrine is inconsistent with the Convention and the protection against inhuman and degrading treatment.

30. This leave little option, but for a guardian to apply to a superior court, in its parens patriae jurisdiction, for an order consenting to the person’s forcible treatment. ACAT does not have the statutory power in the ACT to make such an order. Moreover, it is well illustrated by the on-point reported judgement of the ACT Supreme Court.
applications to the Supreme Court in its *parens patriae* jurisdiction are an unsatisfactory solution due to the time delays and other difficulties that they involve.53

31. Accordingly, the inquiry, or work progressing its recommendations, may wish to consider the merits and demerits of legislatively:

a. codifying that:
   i) wherever there is time to do so, without seriously risking the person’s life or health, there be assessment of their capacity to make a decision about whether they receive physical assessment and/or treatment;
   ii) if the person possesses that capacity, they are supported to make the decision, and if they decide against the assessment and/or treatment, they do not receive it and if they decide for it, they receive it;
   iii) if the person lacks that capacity, and there is a possibility they will (re)gain it, and it is safe to wait until then, the person should be asked, when they have (re)gained the capacity, whether they give or withhold their consent;
   iv) all these steps are performed, as far as is commensurate with the person’s safety, before there is consideration of whether they need to be forcibly treated for a physical condition within legislated procedures, such as those contemplated in b. to n., below.

b. codifying that health professionals can, with the minimum force necessary, immediately assess and/or treat a person for a physical condition, even if the person is refusing or resisting that, where a doctor decides on reasonable grounds:
   1) the person’s life and health is at imminent and grave risk, as a consequence of the physical condition or its sequelae; and
   2) the person lacks the capacity to refuse that assessment and/or treatment; and
   3) if there is a reasonable possibility the person will (re)gain that capacity, it is unsafe to wait to see, before assessing and/or treating them.

c. stating that where a guardian reasonably believes b. 1), 2) and 3), they can use proportionate force to the minimum extent necessary to bring the person to health professionals for physical assessment and/or treatment, or authorise appropriate others, such as police officers, to do so, and as soon as practicable after that use of force, the guardian must then report on it the Public Advocate.

d. forbidding a guardian from availing themselves of the power specified in c., unless they reasonably believe b. 1), 2) and 3).

e. forbidding health professionals from availing themselves of the power specified in b., unless they reasonably believe that a doctor has decided b. 1), 2) and 3).

f. enabling a guardian, or appropriate others authorised by the guardian, to use the minimum, proportionate force necessary to remove a person to health professionals for ‘non-invasive physical assessment and/or treatment’ - or terms to that effect - defined in the legislation, even where the person’s life and health is not at imminent and grave risk as a consequence of the physical condition or its sequelae, so long as:
   i) the guardian reasonably believes b. 2); and
   ii) a doctor has certified in writing that they believe the person’s health is likely to seriously deteriorate if the person does not receive that treatment or that assessment and treatment; and
   iii) the doctor gives a copy of that certificate to the guardian and Public Advocate, before the removal, within a period stated in the legislation.

g. forbidding a guardian and others from availing themselves of the power specified in f., unless f. i), ii) and iii) obtain.

h. defining ‘minor’ physical treatments, such as administration of non-prescription medication to them, and permitting them to be given with reasonable and proportionate force, by the person’s guardian and health professionals, even where the person is refusing or resisting such treatment(s), if the person lacks the capacity to make a decision about receiving such treatment(s), and the treatment(s) are
likely to be of therapeutic benefit to them.

i. stating how and when the guardian and professionals must notify the Public Advocate that they forced minor physical treatments upon a refusing or resisting person.

j. stipulating that the guardian cannot substitute their decision, but rather must:
   1) obtain two written opinions from doctors that they reasonably believe that the person needs physical assessment and/or treatment to avoid serious deterioration in their health; and
   2) include those two opinions in applications for orders to ACAT, if the guardian wishes to forcibly remove a person whose life and health is not at imminent and grave risk to:
      i) a place for ‘significant or invasive’ physical assessment or treatment, and/or to forcibly make the person receive such assessment or treatment; or
      ii) a place for physical assessment or treatment that may not be ‘significant or invasive’, objectively speaking, but, is, nonetheless, assessment or treatment that the person anticipates with non-momentary distress; or
      iii) forcibly make the person receive physical assessment or treatment that may not be ‘significant or invasive’, objectively speaking, but that the person anticipates with non-momentary distress.

k. endeavouring to prevent incompetent or abusive capacity assessment and supported decision-making, perhaps via a statutory scheme for compulsory accredited training, continuing education, and registration, of capacity assessors and verifiers of supported decision-making, backed by disciplinary procedures.

l. enabling applications to be made to the ACAT or other decision-making body for a declaration on whether the person has the capacity to give or withhold consent to assessment or treatment or to a necessary incident of that, where there is disagreement among assessors about the person’s capacity, or the assessment is a concerning for the Public Advocate or the person’s guardian.

m. providing that ACAT can order that a person will be assessed for their capacity by an assessor, and if necessary, removed to a place for that assessment, and that the assessor will report the results to ACAT, and, if ACAT so requests, appear before it.

n. compelling the guardian and ACAT to document how they regarded, in any of the above decision-making, known, capacitous expressions of the person’s will and preferences in respect of physical treatments, including, but not limited to directions under the Medical Treatment (Health Directions) Act 2006 (ACT), the forthcoming mental health legislation, and the Powers of Attorney Act.

32. Similar solutions are afforded by the Northern Ireland Mental Capacity Bill 2015 and the legislation of some Australian states and territories.

Booklet questions 3 to 11

33. In preparing for implementation of the proposed Mental Health Act, the Mental Health Law Review Unit comprehensively searched for reports on common law jurisdictions’ pre- and post-implementation evaluations of their actual and proposed legislative duties to conduct capacity assessments and supported decision-making. The most instructive of these reports describe and analyse people’s experiences of the matters covered by the Inquiry booklet’s questions 3 to 11, inclusive. One of these is the Victorian Law Reform Commission one, cited earlier, particularly its chapter on supported decision-making. The rest are on the United Kingdom’s:
   • HOL, House of Commons (‘HC’) Joint Committee report Draft Mental Incapacity Bill (2003).
   • HC Health Committee Post-legislative scrutiny of the Mental Health Act 2007
Booklet question 12

34. ACT Health agrees with the Australian Law Reform Commission’s suggestion that the areas regulated by states and territories which will be most affected by changes in supported decision-making are: guardianship and administration, medical treatment, and disability support. ACT Health also considers that the states and territories will understand more about the implications of supported decision-making, as they review their legislation on the said three areas, and learn from people with disabilities and their carers about the outcomes of the National Disability Insurance Scheme.

2 Section 112(1) of the Mental Health (Treatment and Care) Act 1994 (‘the current Act’) requires the Minister to appoint a person as Chief Psychiatrist. This provision is not amended or removed by the Amendment Act it is preserved by the Mental Health Bill 2015 (‘the Bill’).
5 Under section 7(2) of the Guardianship and Management of Property Act 1991 (‘the Guardianship Act’), the ACT Civil and Administrative Tribunal (‘ACAT’) may, by order, appoint a guardian and, under section 7(3)(a) of the same Act, ACAT may, in making that order, grant the guardian the power to ‘decide where, and with whom, the person is to live’.
6 Under section 11’s clause 362 of the Amendment Act, the Chief Psychiatrist must determine, in writing, within 5 working days after the day a psychiatric treatment order is made: one, ‘whether the person requires admission to an approved mental health facility to receive treatment, care or support under the order...’ and, two, if the Chief Psychiatrist requires the person’s admission ‘the approved mental health facility that the person is to be admitted too’. Under section 43’s clause 48ZC of the same Act, the Chief Psychiatrist will also be required to make a written determination on matters one and two, within five days of a forensic psychiatric treatment order being made.
7 See para. 9 and 10 of the ACT Supreme Court case Omari v Omari, Omari and Guardianship and Management of Property Tribunal [2009] ACTSC 28 for guardianship orders made, and continued, until three-yearly review of them was required by section 19(2) of the Guardianship Act, even though there was a protection order made under the Domestic Violence and Protection Orders Act 2001 (ACT), on application from one of the guardians, against a family member of the person under guardianship for guardianship of the latter as well as other obvious signs of conflict between the guardians and other family members: <http://www.austlit.edu.au/cpbin/sinodisp/au/cases/act/ACTSC/2009/28.html?stem=0&synonyms=0 &query=guardianship>, accessed 10 Aug. 2015.
8 Amendment Act, section 111’s clause 362(2) and section 43’s clause 48ZC(2) state: ‘Within 5 working days after the day the order is made, the chief psychiatrist must determine...’.
9 A psychiatric treatment order can only be made for six months or a shorter period (Section 36J(1)(a) of the current Act, preserved by the Amendment Act and the Bill); and a forensic psychiatric treatment order will have a duration of up to three months or, not longer than one year, if the person has been subject to consecutive forensic psychiatric treatment orders for one year or more (Amendment Act, section 43, clause 48ZQ(1)(a)). Further, after the expiration of either kind of order, a person can only be made subject to the same or another kind of order, under the legislation, on application to ACAT
(Amendment Act, section 11’s clause 360) and ACAT can only make the order if the person meets the multiple mandatory criteria for it (Amendment Act, section 11’s clause 36V). That will also be the case for persons whose forensic psychiatric treatment orders have expired (Amendment Act, Chapter 7, Part 7.1, Division 7.1.2). The Bill preserves in their entirety all Amendment Act provisions mentioned in this endnote.

10 Guardianship Act, section 4(3).
11 Guardianship Act, section 4(4).
12 Amendment Act, section 11’s clause 362(6).
13 Amendment Act, section 11’s clause 362(7).
14 Amendment Act, section 11’s clause 362(8).
15 Section 34 of the current Act.
16 Section 11’s clause 362B of the Amendment Act. This provision is not amended and is preserved, by the Bill.
17 Section 43’s clause 482E of the Amendment Act. This provision is not amended, and is preserved, by the Bill.
18 The Guardianship Act’s criteria for a guardianship order are in its section 7(1).
20 Northern Ireland is said to be the first and only jurisdiction in the world to be adopting fusion legislation: p. 113 of Daw, R. ‘Chapter 6: The case for a fusion law: challenges and issues’, in McSherry, B. and Freckleton, I. (2013) Coercive Care: Rights, Law and Policy, Routledge, London; and third and fourth last paragraphs of the speech of Mr Ross, Chairperson of the Ad Hoc Joint Committee on the Mental Capacity Bill in the Second Stage of the Mental Capacity Bill, on 8 June 2015, in the Northern Ireland Assembly

21 See the phrase ‘at the material time’, in section 3 of the Mental Capacity Bill (Northern Ireland)

22 Section 4 of the Mental Capacity Bill (Northern Ireland).
23 Sections 6, 13 and 14 of the Mental Capacity Bill (Northern Ireland).
24 Section 5 of the Mental Capacity Bill (Northern Ireland).
25 Sections 2, 7 and 8 of the Mental Capacity Bill (Northern Ireland).
26 Chapters 3 and 4 of the Mental Capacity Bill (Northern Ireland).
27 Part 10 of the Mental Capacity Bill (Northern Ireland).
28 See, for instance, sections 95(1) (b), 98, and 99(1)(b) and (2) of the Mental Capacity Bill (Northern Ireland).
30 A 2009 study showed that when people with mental illness were interviewed about their impaired capacity, they said that it is a partial, not total, phenomenon, and that services need to assess a person’s capacity for how much the person is capable, at that particular time, of contributing to decision-making about their life, rather than assume the person is incapable because they have mental illness or have lacked capacity in the past: Amnesty International Ireland (2009) Decision-making capacity in mental health: exploratory research into the views of people with personal experience, December.
31 That definition in section 5 of the Guardianship Act is that ‘a person has impaired decision-making ability if the person’s decision-making ability is impaired because of a physical, mental, psychological or intellectual condition or state, whether or not the condition or state is a diagnosable illness’.
32 Section 9 of the Powers of Attorney Act 2006 reads that, for the purposes of that Act ‘a person has decision-making capacity if the person can make decisions in relation to the person’s affairs and

Appendix A: ACT Health Responses to Guardianship Inquiry Booklet 9 of 11
understands the nature and effect of the decisions' and 'a person has impaired decision-making
capacity if the person cannot make decisions in relation to the person's affairs or does not understand
the nature or effect of the decisions the person makes in relation to the person's affairs'.

Indeed, while section 4(3) of the Guardianship Act dictates that before making a decision, the
decision-maker must consult with each of the person's carers, it imposes no duty on them to consult
the person, much less ensure that the person is supported to make decisions that they have the
capacity to make.

Australia ratified the Convention on the Rights of Persons with Disabilities on 17 July 2008 and
accessed to the Optional Protocol to the Convention on 21 Aug. 2009. The Optional Protocol came into
accessed 10 Aug. 2015. The Optional Protocol allows people to complain to the United Nations that a
State Party to the Convention is not complying with it and for the United Nations to rule on that
complaint.

This Convention is applicable in the ACT. Article 29 of the Vienna Convention on the Law of Treaties,
to which Australia acceded on 13 June 1974, proclaims that treaty obligations extend to all territorial
units of any state party to a treaty, 'unless a different intention appears from the treaty state or is
otherwise established'. No such intention has appeared, or been otherwise established.

Australia's Declaration on the Convention was made on 17 July 2008:

See that the Mental Capacity Act Bill 2015 (Northern Ireland) addresses consent to research at Part
8 (Research) <http://www.niassembly.gov.uk/globalassets/documents/legislation/bills/executive-
2015.

Defined in the Dictionary of the Guardianship Act, provided by section 2 of that Act.

See, for example, Schloendorff v Society of New York Hospital (1914) 211 NY 125 at 126.


Washington v Harper 494 US 210 (1990); Re T (Adult: Refusal of Treatment) [1992] 4 All ER 469; Re S

Some cases in Australia have expressly recognised a common law right of action for a breach of an
individual's right to privacy: Grosse v Purvis [2003] QDC 151 and Jane Doe v Australian Broadcasting
Corporation [2007] VCC 281. Further, section 12(a) of the Human Rights Act 1994 (ACT) supplies a
statutory right to privacy.

Section 10 of the Human Rights Act 1994 (ACT).

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This is acknowledged by section 32N of the Guardianship Act, which reads: 'This part does not affect any common law right of a health professional to provide urgent medical treatment without consent'.

In re F (Mental Patient: Sterilisation) [1990] 2 AC 1; Ariendale National Health Service Trust, ex parte L [1999] AC 458.


United Nations General Assembly, Human Rights Council, Report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment, Juan E. Méndez, 1 February 2013, A/HRC/22/53, para. 34, p.8

See section 48A(1) of the Australian Capital Territory (Self-Government) Act 1988 (ACT) states that the ACT ‘Supreme Court is to have all original and appellate jurisdiction that is necessary for the administration of justice in the Territory. For cases that show the court can, in its parens patriae jurisdiction, substitute the court’s consent for that of the patient’s, see Pollin v Department of Social Welfare [1983] NZLR 266 and Re X [1991] 2 NZLR 365.

Australian Capital Territory v JT [2009] ACTSC 105, para. 22

For similar provisions, see sections 16 (Second opinion needed for certain treatment), 17 (Second opinion needed for continuation of medication Mental Capacity) and 18 (Second opinion: relevant certificates) of the Mental Capacity Act 2015 (Northern Ireland).

Please note well Justice Vickery stated, in the Supreme Court of Victoria decision Nicholson & Ors v Knaggs & Ors [2009] VSC 64 (27 February 2009), that:

The “safeguards” contemplated by Article 12(4) are required to ensure that “measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free from conflict of interest and undue influence, are proportional…” Although this text is not perfectly expressed, after considering the ordinary meaning of these terms in their context and in the light of the object and purpose of the Convention, and the travaux préparatoires, the meaning becomes clear. The article recognises that some people with disability need support to make decisions in the exercise of their legal rights. If a State Party implements a mechanism of supported decision making to assist such persons, the State is obliged to ensure that appropriate and effective safeguards are in place which respect the rights, will and preferences of the person with disabilities, so that those rights, will and preferences are, amongst other things, free of conflict of interest and undue influence….(emphasis added) (<http://www.austlii.edu.au/au/cases/vic/VSC/2009/64.html>, accessed 10 Aug. 2015).

For problems that have occurred, and suggestions for systematically preventing them, in the administration of capacity assessment and supported decision-making, see pages 37 to 40 and pages 41 to 43, respectively, in the House Of Lords Select Committee on the Mental Capacity Act 2005, Report of Session 2013–14, Mental Capacity Act 2005: post-legislative scrutiny, published 13 March 2014, HL Paper 139

For clear illumination of the interaction between the Powers of Attorney Act 2006 and the Guardianship and Management of Property Act 1991, see the following decisions of the General President of ACAT: JOAN WHYTE (Guardianship and Management of Property) [2010] ACAT 23 (21 April 2010)

See, particularly, Mental Capacity Bill 2015 (Northern Ireland), sections 19 (Treatment with serious consequences: objection from nominated person), 20 (Meaning of “treatment with serious consequences”), 21 (Section 19: the prevention of serious harm condition), 22 (Resistance etc by P to provision of certain treatment), and sections 28 and 29 under ‘Requirements to attend for treatment with serious consequences’


Appendix A: ACT Health Responses to Guardianship Inquiry Booklet 11 of 11


Appendix B:
Mental Health (Treatment and Care) Amendment Act 2014 and Mental Health Bill 2015 on Guardians and Health Attorneys under the Guardianship and Management of Property Act 1991 and Attorneys under the Powers of Attorney Act 2006

Overview of the Amendment Act and Bill

1. The commencement clause of the Mental Health (Treatment and Care) Amendment Act 2014 (ACT) ('the Amendment Act') provides that all the Amendment Act's clauses will commence on 12 November 2015. The commencement clause of the Mental Health Bill 2015 (ACT) ('the Bill') provides for its enactment to commence 'immediately after the commencement' of the Amendment Act.

2. The Bill was presented to the ACT Legislative Assembly on 4 June 2015 and is expected to be debated in September 2015. It provides for relocation into its proposed Mental Health Act 2015 (ACT) all of the clauses of the Mental Health (Treatment and Care) Act 1994 (ACT) ('the Act') that are preserved, amended or not amended, by the Amendment Act and Bill and all the altogether new clauses supplied by the Amendment Act and Bill.

Amendments of Guardianship Act and mental health statute regarding guardians

Consent of ACAT to a person’s treatment for mental illness

3. Section 120 of the Amendment Act omits 'treatment for mental illness' from section 142(2)(a) of the Mental Health (Treatment and Care) Amendment Act 1994 (ACT) ('current mental health statute'). Accordingly, upon commencement of the Amendment Act, section 142(2)(a) will no longer prohibit the ACT Civil and Administrative Tribunal ('ACAT') from making an order in relation to any consent to treatment for mental illness', while exercising its jurisdiction under the Guardianship Act.1

4. Amendment [1.50] of Schedule 1 of the Amendment Act (ACAT may consent to prescribed medical procedures) enables ACAT to, on application, make an order supplying consent to a prescribed medical procedure (other than treatment for electroconvulsive therapy or psychiatric surgery) for a person for whom ACAT has made an order under section 69(2) of the Guardianship Act in relation to that person. Under section 69(2) of the current Guardianship Act, ACAT may, by order, declare that a person for whom a guardian has been appointed is not competent to give a consent required for a prescribed medical procedure.

Consent of guardian to a person’s treatment for mental illness

5. Section 120 of the Amendment Act omits 'treatment for mental illness' from section 142(1)(a) of the Act. This will have the effect, upon commencement of the Amendment Act, that section 142(1)(a) will no longer prohibit a guardian appointed for a person, under the Guardianship Act, from consenting to the person’s treatment for mental illness.2

6. Upon commencement of the Amendment Act, section 7(3) of the Guardianship Act will no longer proscribe a person's guardian giving for the person, 'a consent required for medical treatment involving treatment, care or support under the Mental Health (Treatment and Care) Act 1994' other than those procedures that fall under the definition of prescribed medical procedure in the Guardianship Act's Dictionary. Upon the Amendment Act's commencement, that definition will read:
(a) an abortion; or
(b) reproductive sterilisation; or
(c) a hysterectomy; or
[d] a medical procedure concerned with contraception; or
[e] removal of non-regenerative tissue for transplantation to the body of another living person; or
[f] electroconvulsive therapy or psychiatric surgery; or
[g] any other medical or surgical procedure prescribed for this definition.3

Restrictions on consent by guardian to mental health treatment, care or support

7. Schedule 7, Part 7.1, Amendment [1.53] of the Amendment Act will, upon that Act’s commencement, insert an altogether new section 70A into the Guardianship Act. Consequently, section 70A(1) of the Guardianship Act will state:

A guardian who has power to give for a person a consent required for medical treatment involving treatment, care or support under the Mental Health (Treatment and Care) Act 1994 may consent to that treatment only if the person—
(a) does not have decision-making capacity under that Act; and
(b) does not have an advance consent direction under that Act authorising the treatment; and
(c) expresses willingness to receive the treatment.

8. The definition of ‘decision-making capacity’ upon which the new section 70A(1)(a) will turn is that supplied by the Amendment Act’s section 11, clause 7.

9. The new section 70A(2) of the Guardianship Act will declare that the consent referred to in the new section 70A(1) ‘must be in writing’.

10. The new sections 70A(3) to (6) will be all about the ‘stated period’ of that consent:
    a. section 70A(3) will dictate that it ‘must be for a stated period, of not longer than 6 months, but can be renewed (and further renewed) for another stated period of not longer than 6 months’.
    b. section 70A(4) will mandate that ‘in considering the stated period necessary for a consent to treatment, a health professional who is giving the treatment must take into account’ certain matters, which are —
       (a) whether, and when, the person is likely to regain decision-making capacity under the Mental Health (Treatment and Care) Act 1994; and
       (b) the likely duration of the treatment, care or support required; and
       (c) the content of any advance consent direction in force for the person.
    c. section 70A(5) will require the health professional who is giving the treatment to ‘tell the ACAT and the public advocate in writing about a consent, including the stated period’.
    d. section 70A(6) will compel the same professional to ‘tell the ACAT in writing, if a consent is not renewed at the end of its stated period’.
    e. section 70A(7)(a) and (b) will be the ACAT review provisions in respect of the section 70A powers, with section 70A(7)(a) dictating that ACAT ‘must, on application, review a consent’ and section 70A(7)(b) permitting ACAT ‘at any time on its own initiative’ to ‘review a consent’.
    f. section 70A(8) rules that ‘A consent ends before the end of its stated period if the ACAT directs that the consent be withdrawn or the person is no longer someone to whom one or more of the following three criteria specified by 70A(1)(a) to (c), inclusive, apply, being, respectively, that the person:
       - does not have decision-making capacity under the Act;
       - does not have an advance consent direction under the Act authorising the treatment; and
       - expresses willingness to receive the treatment.'
11. The Amendment Act will insert this Note at the end of section 70A: ‘The chief psychiatrist or another relevant person may apply for a mental health order in relation to the person (see Mental Health (Treatment and Care) Act 1994, s 360).’

Review of guardians and managers

12. Amendment [1.41] of Schedule 1 of the Amendment Act, will cause section 19(2) of the Guardianship Act to read: ‘The ACAT must review an order appointing a guardian or manager at least every 3 years’. Presently, this section reads that ‘The ACAT must consider...’ (emphasis added).

13. Amendment [1.42] of the same Schedule will insert an altogether new section 19(2A) into the Guardianship Act, which will read: The ACAT must review an order appointing a guardian for a person if—

(a) the guardian tells the ACAT under section 70A (6) that a consent to treatment is not to be renewed; or

(b) an advance consent direction made by the person is given to the ACAT under the Mental Health (Treatment and Care) Act 1994, section 27 (5).

Health attorney may give consent for mental health treatment, care or support

14. Amendment [1.46] of Schedule 1 amends section 32D (Health attorney may give consent) of the Guardianship Act to make the application of that section contingent on when a health professional believes on reasonable grounds that a person does not have an advance consent direction under the Act authorising the treatment.

15. This is an addition to the two contingencies that must already obtain for section 32D to apply. Those two contingencies are: when a health professional believes on reasonable grounds that: 1) a person is a protected person and 2) while a protected person, they need, or are likely to need, medical treatment.

16. Amendment [1.47] of Schedule 1 amends section 32D(4) (Health attorney may give consent) of the Guardianship Act to insert ‘However, for medical treatment involving consent for treatment, care or support under the Act, the health professional may rely on the consent to provide the treatment care or support only for the period allowed under section 32JA’, by which it means the consent supplied by the health attorney asked for by the health professional, under section 32D(2).

Notice and duration of consent to mental health treatment, care or support

17. Amendment [1.49] of Schedule 1 of the Amendment Act inserts a new section 32JA into the Guardianship Act. Subsection (1) states that the new section will apply if consent has been given under Part 2A of the Guardianship Act for medical treatment for a protected person that involves treatment, care or support under the Act.

18. Subsection (2) of the new section 32JA will compel a health professional who is giving the treatment, care or support to, ‘within 7 days after the consent is given tell the public advocate, in writing, that treatment, care or support is being given to the protected person in accordance with the consent’ and ‘give the public advocate a copy of the plan for the proposed treatment, care or support’.

19. Subsection (3) will allow the health professional to rely on the consent for 21 days after it is given (the initial consent period).
20. Subsection (4) will dictate that if treatment, care or support in accordance with the consent is likely to be required for longer than the initial consent period, then the health professional will be required to, before the end of that period, 'apply to ACAT for approval to continue providing treatment, care or support in accordance with the consent' and 'unless the health professional believes on reasonable grounds that someone else has applied to ACAT for an order appointing a guardian for the person—apply to the ACAT under part 2' of the Guardianship Act 'for an order appointing a guardian for the person'.

21. Subsection (5) will permit ACAT to give approval for the health professional to continue to provide treatment, care or support in accordance with the consent for a stated period of not longer than 8 weeks after the end of the initial consent period. Subsection (6) will compel ACAT to tell the public advocate of any approval given under subsection (5).

Effect of advance agreement and advance consent direction on guardian with authority to give consent for treatment, care or support

22. Section 11's new clause 30(1) states that clause 30 of the Act will apply if a person has an advance agreement or advance consent direction in force and they have a guardian under the Guardianship Act who has the authority to give consent for medical treatment involving treatment, care or support under the Act.

23. Subsection (2) of clause 30 will mandate that any power of the guardian to consent to the person's treatment, care or support be exercised taking into account the advance agreement or consent direction. Subsection (3) makes clear that the guardian's consent will not, however, be required for any treatment, care or support for which the advance consent direction provides consent.

24. In complying with clause 30, guardians will need to be aware of how Amendment Act, section 11, clause 32, provides that an advance consent direction has no effect to the extent it is inconsistent with a health direction, under the Medical Treatment (Health Directions) Act 2006, if, after a person makes an advance consent direction, they make a health direction that deals with a matter mentioned in the advance consent direction.

Section 32A (Definitions—pt 2A) of Guardianship Act

25. The current Guardianship Act's section 32A definition of health professional is 'health professional means a doctor or dentist'. Amendment [1.43] of Schedule 1 of the Amendment Act extends that definition, so that it will read:

   health professional means—
   (a) in relation to medical treatment involving treatment, care or support under the Mental Health (Treatment and Care) Act 1994—a mental health professional under that Act; and
   (b) in any other case—a doctor or dentist.

26. Amendment [1.44] of Schedule 1 adds to the section 32A definition of medical treatment to include 'medical treatment involving treatment, care or support under the Mental Health (Treatment and Care) Act 1994'.

27. Amendment [1.45] alters paragraph (c) of the section 32A definition of protected person to replace an adult 'for whom the ACAT has not appointed a guardian with authority to give consent for medical treatment under this Act' with 'an adult:

   for whom the ACAT has not appointed a guardian under this Act with authority to—
   (i) give consent to medical treatment not involving consent for treatment, care or support under the Mental Health (Treatment and Care) Act 1994; or
Amendments relating to powers of attorney

28. Amendment [1.65] of Schedule 1 of the Amendment Act removes the Powers of Attorney Act 2006 ('the Powers of Attorney Act') section 35(1)(b) prohibition on a principal authorising their attorney to exercise power in relation to 'treatment for mental illness'. In turn:
   a. Amendment [1.63] inserts this new example of a health care matter that an attorney may deal with, under section 12 (Meaning of health care matter): ‘consenting to treatment for a mental illness (other than electroconvulsive therapy or psychiatric surgery) necessary for the principal’s wellbeing’.
   b. Amendment [1.64] inserts this example of when a power of attorney may be exercisable, under section 16(1) (When and how power under the power of attorney is exercisable): ‘if I do not have capacity to make a decision that needs to be made about my treatment, care or support for a mental illness’.

29. Amendment [1.67] inserts into the Powers of Attorney Act a new section 46A (Restrictions on consent by attorney to mental health treatment, care or support). It mirrors the new section 70A of the Guardianship Act explained above at paragraphs 7, to 11., inclusive, except in so far as it allows, a person’s attorney, under an enduring power of attorney, rather than a person’s guardian, to consent to a person’s treatment for mental illness (other than electroconvulsive therapy or psychiatric surgery).

Effect of advance agreement and advance consent direction on attorney with power to deal with health care matters

30. Amendment Act section 11, clause 31(1), states that new clause 31 of the Act will apply if a person has an advance agreement or advance consent direction in force and the person has an enduring power of attorney under the Powers of Attorney Act that deals with health care matters under that Act.

31. Subsection (2) of clause 31 will permit an attorney to use a person’s advance agreement or advance consent direction to work out the person’s wishes or needs under the Powers of Attorney Act, schedule 1, section 1.6 (Participation in decision making). Subsection (3) will compel a person’s attorney to take into account a person’s advance agreement or advance consent direction in exercising any power of the attorney to consent to the person’s treatment, care or support. Subsection (4) makes clear that the attorney’s consent will not required for any treatment, care or support for a person for which the person has already consented in their advance consent direction.

32. In complying with clause 31, attorneys will need to be aware of how Amendment Act, section 11, clause 32 provides an advance consent direction has no effect to the extent it is inconsistent with a health direction, under the Medical Treatment (Health Directions) Act 2006, if the health direction is made after the advance consent direction and the latter deals with a matter mentioned in the former.

Bill requirements to consult or notify guardians, attorneys, and health attorneys
33. Bill section 55D provides for requiring ACAT to, before making an electroconvulsive therapy order in relation to a person who is not subject to a mental health order, consult, as far as practicable—

(b) if the person has a guardian under the Guardianship and Management of Property Act 1991—the guardian; and

(c) if the person has an attorney under the Powers of Attorney Act 2006—the attorney; and

(e) if a health attorney is involved in the treatment, care or support of the person—the health attorney.

34. Bill section 55JA provides for compelling ACAT, in making an emergency electroconvulsive therapy order, to take into account:

(c) the views of the following, so far as those views are made known to the ACAT:

(iii) if the person has a guardian under the Guardianship and Management of Property Act 1991—the guardian;

(iv) if the person has an attorney under the Powers of Attorney Act 2006—the attorney;

(vi) if a health attorney is involved in the treatment, care or support of the person—the health attorney.

35. Bill sections 62(2)(iii), (iv) and (vi), respectively mandate that a person’s guardian, if they have one, attorney, if they have one, and health attorney if one is involved in the person’s ‘treatment, care and support’, will be notified, in writing, that the committee has received an application to perform psychiatric surgery on the person. The section 62(2) duty-holder for notification of all three people is the chairperson of the committee that considers psychiatric surgery applications, under the proposed Mental Health Act 2015.

36. Similar requirements in respect of guardians, attorneys and health attorneys are declared by Bill:

- clause 139CH(4)(b)(iii), (iv) (Transfer to interstate mental health facility—emergency detention); and
- Schedule 2 Part 2.1 Division 2.1.1, Amendment [2.25] which provides for inserting sections 72(6)(f), (g) and (i) (Review of detention under court order) into the Bill’s enactment.

New Amendment Act requirements to consult with, or notify, guardians, attorneys and health attorneys

37. There are similar requirements to consult and notify guardians, attorneys, and/or health attorneys, under Amendment Act section:

- 11’s clause 36R(1) (Consultation by ACAT—mental health order); clause 36Z(5)(a) and (7) (Role of chief psychiatrist—psychiatric treatment order); clause 36ZH(3) and (5) (Role of care coordinator—community care order); and clause 36L(2)(b) (Copy of assessment).

- 16’s clause 42(2) (Notification of certain people about detention);

- 43’s clause 48W (Consultation by ACAT—forensic mental health order); clause 48ZC(6) and (8) (Role of chief psychiatrist—forensic psychiatric treatment order); and clause 48ZJ(4) and (6) (Role of care coordinator—forensic community care order).

- 60’s clause 79A(1) (Notice of hearing).

- 99’s clause 122H(4) (Information sharing protocol).
Other Amendment Act provisions regarding guardians, attorneys, and health attorneys

Definition of 'carer' and 'affected person'

38. Section 11, clause 12, will supply a definition of 'carer', and Amendment Act section 43, clause 48ZZB, will supply a definition of 'affected person' to the Act and proposed Mental Health Act. Both definitions involve guardians.

Requirement to give information on the person's rights

39. Section 11 clauses 15(4)(b), (c) and (c), will respectively require that a person's guardians, attorneys, and health attorneys, be given certain information specified in clause 15 on the person's rights 'as soon as practicable after it is decided to give treatment, care or support' to the person at the facility. Clause 15 will impose this duty on the 'responsible person for a mental health facility or community care facility'.

Advance agreements

40. Section 11's clause 26(2) allows an 'advance agreement for a person to set out':

   (e) if the person has a guardian under the Guardianship and Management of Property Act 1997—contact details for the guardian;
   (f) if the person has an attorney under the Powers of Attorney Act 2006—contact details for the attorney;

Advance consent directions

41. Section 11’s clause 27(5) dictates that the 'representative of the person's treating must ensure that':

   (b) a copy of the advance consent direction is given to—
   (iii) if the person has a guardian under the Guardianship and Management of Property Act 1991—the guardian and the ACAT; and
   (iv) if the person has an attorney under the Powers of Attorney Act 2006—the attorney;

42. Section 11's clause 28(5), 'If a mental health professional believes on reasonable grounds that giving treatment, care or support to a person with impaired decision-making capacity in accordance with an advance consent direction is unsafe or inappropriate', they 'may give the person other treatment, care or support only if':

   (a) both of the following apply:
   (i) the person is willing to receive the treatment, care or support; and
   (ii) the person has a guardian or health attorney under the Guardianship and Management of Property Act 1991, or attorney under the Powers of Attorney Act 2006, and the guardian, health attorney or attorney gives consent to the treatment, care or support in accordance with the guardian, health attorney or attorney's appointment; or
   (b) the ACAT, on application by the mental health professional, orders that the treatment, care or support may be given (emphasis added).

Review, amendment or revocation of mental health order

43. Section 11's clause 36ZQ:

   (2) The ACAT must review a mental health order in force in relation to a person if the person, or the person's representative, applies for the review on the basis that the order, or part of the order, is no longer required.

   (7) In this section: representative, of a person, means any of the following:

Appendix B: Amendments Related to Guardianship Act and Powers of Attorneys Act 7 of 7
(a) if the person has a guardian under the Guardianship and Management of Property Act 1991—the guardian;
(b) if the person has an attorney under the Powers of Attorney Act 2006—the attorney;

44. Section 43's clause 48ZZ, mirrors 362Q, except in so far as it pertains to review of forensic mental health orders.

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1 Section 142(1)(a) currently reads: 'Despite anything in the Guardianship and Management of Property Act 1992, section 70 (ACAT may consent to prescribed medical procedures), the ACT must not, while exercising its jurisdiction under the Act, make an order in relation to any consent to treatment for mental illness...’ and then states some other prohibitions that will not be affected by the Amendment Act or enactment of the Bill.
2 Section 142(1)(b) currently reads: 'Despite anything in the Guardianship and Management of Property Act 1992 or an order appointing a guardian, a guardian appointed for a person under that Act is not entitled to give consent to treatment for mental illness...’ and then states some other prohibitions that will not be affected by the Amendment Act or enactment of the Mental Health Bill 2015 which is currently before the Legislative Assembly (the Bill).
3 The definition will read this way as an outcome of these amendments: Schedule 1, Part 1.6, Amendment [1.65] replaces (other than a prescribed medical procedure) with (other than a prescribed medical procedure or medical treatment mentioned in paragraph (aa)), in section 7(3)(e) of the Guardianship Act. Further, Schedule 1, Part 1.6, Amendment [1.65] inserts a new section 7(3)(ee), which reads: 'To give, for the person, a consent required for medical treatment involving treatment, care or support under the Mental Health (Treatment and Care) Act 2014 (other than a prescribed medical procedure), Schedule 1Part 1.7, Amendment [1.64] of the Amendment Act will remove 'treatment for mental illness' from (b) in the Guardianship Act’s Dictionary definition of prescribed medical procedure.
4 Amendment [1.65] of Schedule 1 omits 'treatment for mental illness' from the section 1.65 definition of special health care matters.'