# 10. Review of State and Territory Legislation

## Contents



## Summary

10.1 This chapter discusses the implications of the ALRC's recommendation for review of state and territory laws and legal frameworks that have an impact on the exercise of legal capacity. The Terms of Reference for the Inquiry focused on Commonwealth laws and legal frameworks, but also asked the Inquiry to consider how maximising individual autonomy and independence could be 'modelled'.

10.2 Modelling a new approach to individual decision-making at the Commonwealth level provides an opportunity to guide law reform at the state and territory level. Reform at the state and territory level is critical to the implementation of the *United Nations Convention on the Rights of Persons with Disabilities* (CRPD)[1] because many important areas of decision-making are governed by state and territory law—including in relation to guardianship and administration, consent to medical treatment, mental health and disability services.

10.3 The key elements of the ALRC's approach include the National Decision-Making Principles and the Commonwealth supporter and representative scheme ('Commonwealth decision-making model'), which reflects them.

10.4 The ALRC recommends that state and territory governments facilitate review of legislation that deals with decision-making by people who need decision-making support to ensure laws are consistent with the National Decision-Making Principles and

1 *UN Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 999 UNTS 3 (entered into force 3 May 2008).

the Commonwealth decision-making model. This chapter explains some of the implications of this recommendation and how the ALRC's recommendations might be applied in specific areas of state and territory law.

## Review of state and territory legislation

**Recommendation 10–1** State and territory governments should review laws and legal frameworks concerning individual decision-making to ensure they are consistent with the National Decision-Making Principles and the Commonwealth decision-making model. In conducting such a review, regard should also be given to:

(a) interaction with any supporter and representative schemes under Commonwealth legislation;

(b) consistency between jurisdictions, including in terminology;

(c) maximising cross-jurisdictional recognition of arrangements; and

(d) mechanisms for consistent and national data collection.

Any review should include, but not be limited to, laws and legal frameworks with respect to guardianship and administration; consent to medical treatment; mental health; and disability services.

10.5 The practical outcomes of the ALRC's Inquiry will depend, in significant part, on whether it serves as a catalyst for review of state and territory laws. This is mainly because guardianship and administration laws are state and territory based, and remain the primary mechanism in which others are vested with power to make decisions on behalf of a substantial number of people who need decision-making support.[2]

10.6 Further, many Commonwealth agencies and Commonwealth funded services, such as aged care service providers, rely on state and territory appointed substitute decision-makers in managing their relationships with individuals. In some areas—such as disability services under the National Disability Insurance Scheme (NDIS)—while states and territories will continue to play the major role in providing or overseeing the provision of services, 'federal authorities … will likely exercise more direct federal

2 In 2007, there were over 4,000 people under public guardianship in Australia: NSW Office of the Public Guardian, Submission No 7 to the NSW Legislative Council Standing Committee on Social Issues, *Substitute Decision-Making for People Lacking Capacity*, 2010. At the end of August 2009, the NSW Trustee and Guardian was directly managing the affairs of 9,182 individuals and overseeing the work of a further 2,795 Private Managers: NSW Trustee and Guardian, Submission No 13 to the NSW Legislative Council Standing Committee on Social Issues, *Substitute Decision-Making for People Lacking Capacity*, 2010. The Victorian body, State Trustees protects the legal and financial interests of over 9,500 people: State Trustees, *Did You Know?* <www.statetrustees.com.au>.

regulation of, and prescription of, the way states and territories administer disability funding'.[3]

10.7 As discussed in Chapter 3, the National Decision-Making Principles and associated Guidelines are intended to be consistent with art 12 of the CRPD. By reviewing guardianship and other laws in the light of these principles, states and territories will advance compliance with the CRPD.

10.8 This is important as, under international law, parties to treaties undertake to ensure that the terms of the treaty are performed in all parts of federal states. This is a requirement of the *Vienna Convention on the Law of Treaties*, to which Australia is a party,[4] and an obligation required expressly by art 4(5) of the CRPD.[5] Although it is the Australian Government that entered into the CRPD, the provisions of the Convention are binding not only upon the Australian Government, but also upon each state and territory government.[6]

10.9 The intention of Recommendation 10–1 is that states and territories would examine relevant legislation to see how the approaches represented by the National Decision-Making Principles and associated guidelines might be incorporated—most fundamentally by facilitating a shift to supported decision-making.

10.10 The process envisaged by the ALRC would involve review of legislation that deals with decision-making by people who require decision-making support to ensure, among other things, that:

- legislative tests of decision-making capacity do not provide that people are assumed to lack capacity on the basis of having a disability, and that ability is assessed by reference to the decision to be made and the available supports;
- supported decision-making is facilitated by appropriate legislative recognition of supporters;
- laws providing for the appointment of representative decision-makers do so only as a last resort and not as a substitute for appropriate support;
- laws providing for the appointment of representative decision-makers provide for appointments that are limited in scope, proportionate, and apply for the minimum time; and

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3 John Chesterman, 'The Future of Adult Guardianship in Federal Australia' (2013) 66 *Australian Social Work* 26, 33.

4 *Vienna Convention on the Law of Treaties*, 1155 UNTS 331, 8 ILM 679 (entered into force 27 January 1980) art 27.

5 'The provisions of the present Convention shall extend to all parts of federal states without any limitations or exceptions': *UN Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 999 UNTS 3 (entered into force 3 May 2008) art 4(5).

6 See Philip French, Julie Dardel and Sonya Price-Kelly, 'Rights Denied: Towards a National Policy Agenda about Abuse, Neglect and Exploitation of Persons with Cognitive Impairment' (People with Disability Australia, 2009) 14–15.

- laws providing for supported and representative decision-making ensure that a person's 'will, preferences and rights' are respected—including by imposing appropriate duties on supporters and representative decision-makers.

10.11 To some extent, states and territories have already commenced this process—in particular, with regard to guardianship, the legislative area of most obvious relevance. For example:

- the Victorian Law Reform Commission (VLRC), in its review of the *Guardianship and Administration Act 1986* (Vic), was asked to have regard to 'the principle of respect for the inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons, and the other General Principles and provisions' of the CRPD;[7] and
- the Queensland Law Reform Commission has recommended that the General Principles in the *Guardianship and Administration Act 2000* (Qld) be amended to 'reflect more closely the relevant articles' of the CRPD.[8]

10.12 The Victorian Government has been actively reviewing laws dealing with decision-making by people who need decision-making support. The *Powers of Attorney Act 2014* (Vic) aims to simplify and consolidate certain aspects of Victoria's power of attorney laws, to create the role of a 'supportive attorney' and to improve the protections for vulnerable people.[9] A supportive attorney is a new legal mechanism, which recognises that some people with impaired decision-making ability do not need a guardian or administrator. The ability to appoint a supportive attorney will acknowledge family and other relationships of support, while ensuring that the person retains their right to make decisions.[10]

10.13 Stakeholders endorsed the idea that the role of this Report should include influencing reform of state and territory laws.[11] Some suggested, however, that review based on the ALRC's recommendations would not go far enough towards desired results.[12] Pave the Way described the ideal outcome as a 'a cohesive national approach' to the implementation of art 12 of the CRPD, and a national regime of supported decision-making that no longer permits 'substitute' or 'best interest' decision-making.[13]

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7 Victorian Law Reform Commission, *Guardianship*, Final Report No 24 (2012) xi.

8 Queensland Law Reform Commission, *A Review of Queensland's Guardianship Laws*, Report No 67 (2010) i, rec 4–1.

9 Explanatory Memorandum, Powers of Attorney Bill 2014 (Vic).

10 Ibid. The Act implements a number of the VLRC's recommendations: Victorian Law Reform Commission, *Guardianship*, Final Report No 24 (2012).

11 National Association of Community Legal Centres, *Submission 127*; Illawarra Forum, *Submission 124*; National Mental Health Consumer & Carer Forum, *Submission 100*; AGAC, *Submission 91*; Pave the Way, *Submission 90*.

12 F Beaupert, P Gooding and L Steele, *Submission 123*; Pave the Way, *Submission 90*.

13 Pave the Way, *Submission 90*.

10.14 Dr Fleur Beaupert, Dr Piers Gooding and Linda Steele advocated for the repeal of all 'discriminatory mental health legislation, guardianship legislation, and any other substituted decision-making regimes' and stated:

> When restrictions are placed on the right to exercise legal capacity and the right to refuse medical treatment on an equal basis with others, the basis for supported decision-making as a remedy for disability-based discrimination is compromised. Hence, even if provisions for 'supported decision-making' and other measures to support the exercise of legal capacity were installed into current mental health and guardianship laws, the violation of core obligations of the CRPD would remain.[14]

10.15 In relation to the process of reform, the Australian Guardianship and Administration Council (AGAC) observed that the 'move to harmonisation of legislation will take some time to achieve and the complexity of this process cannot be underestimated'.[15]

10.16 The Law Council of Australia suggested that a co-operative approach with states and territories 'in the form of mirror legislation or for the State and Territories to adopt model Commonwealth legislation, is the most practical way to achieve consistency across jurisdictions'.[16] Justice Connect and Seniors Rights Victoria suggested that there should be a nationally consistent approach to implementing decision-making principles and that states and territories retain responsibility for the implementation of supported decision-making under the oversight of a federal monitoring body.[17]

10.17 A comprehensive national review process might be coordinated through the Council of Australian Governments (COAG) or its ministerial councils, such as the Disability Reform Council, Law Crime and Community Safety Council or Health Council, in consultation with peak bodies such as AGAC.

## Application of the National Decision-Making Principles

10.18 The following material discusses, in general terms, how the National Decision-Making Principles and associated Guidelines may be used to guide review and amendment of state and territory laws, in the particular areas of:

- guardianship and administration;
- consent to medical treatment;
- mental health; and
- disability services.

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14 F Beaupert, P Gooding and L Steele, *Submission 123*.
15 AGAC, *Submission 91*.
16 Law Council of Australia, *Submission 83*.
17 Justice Connect and Seniors Rights Victoria, *Submission 120*.

## Guardianship and administration

10.19 As discussed in Chapter 2, one of the key debates of central importance to the Inquiry concerned the extent to which art 12 of the CRPD permits 'substitute' or 'fully supported' decision-making.

10.20 A major element of this debate concerns the extent to which the CRPD permits decision-making in the form of guardianship and administration, as currently provided for under state and territory laws. However, regardless of the lack of consensus, there is 'a general acknowledgement', underpinned by the paradigm shift heralded by the CRPD, that 'the focus must move from what a person with disability cannot do to the supports that should be provided to enable them to make decisions and exercise their legal capacity'.[18]

10.21 Some room for fully supported decision-making should remain. This conclusion is, in part, dictated by the reality that some people will always need decisions made for them. The AGAC submitted that there needs to be 'careful development of supported decision making practices', but supported decision-making cannot 'completely replace substitute decision making and there will be an ongoing need for substitute decision making in limited circumstances'.[19] The Caxton Legal Centre noted:

> given the projected exponential increase in the ageing population and the consequent increase in the incidence of terminal cognitive diseases such as dementia and Alzheimer's, coupled with the factor of social isolation and sparse or non-existent support networks for many older people, the retention of a process of formal substituted decision making may be essential.[20]

10.22 Guardianship and administration laws need to be reviewed to ensure, among other things, that guardianship and administration are:

- invoked only as a last resort and after considering the availability of support to assist people in decision-making;
- as confined in scope and duration as is reasonably possible;[21]
- subject to accessible mechanisms for review; and
- consistent with decision-making that respects the will, preferences and rights of the individual.

10.23 For example, the provisions of state and territory guardianship legislation differ in the extent to which decision-making that respects the will, preferences and rights of

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18 Office of the Public Advocate Systems Advocacy (Qld), 'Autonomy and Decision-Making Support in Australia: A Targeted Overview of Guardianship Legislation' (February 2014).

19 AGAC, *Submission 51*. See Ch 2.

20 Caxton Legal Centre, *Submission 67*. See also NSW Council for Intellectual Disability, *Submission 131*; Justice Connect and Seniors Rights Victoria, *Submission 120*.

21 The Office of the Public Advocate (SA) highlighted that 'there are different rates of full (plenary) appointments as opposed to limited appointments (limited to one area of decision making) between jurisdictions, and different rates for the appointments of private guardians': Office of the Public Advocate (SA), *Submission 17*.

the individual is expressly promoted. In New South Wales, Western Australia and the Northern Territory, there is an overriding duty of guardians and administrators to act in the 'best interest' of the person.[22] In Victoria and Tasmania, the 'best interest' of the person is an equal consideration along with the wishes of the person and the least restrictive alternative.[23] In the Australian Capital Territory and Queensland, guardians are obliged to act in a way that least interferes with a person's right to make a decision,[24] or to give effect to a person's wishes, so far as they can be determined.[25] South Australia provides for 'substitute judgment', where the paramount consideration is the guardian's opinion of what the wishes of the person would have been if they were not mentally incapacitated.[26]

10.24 Recent reviews give important leads on how guardianship and administration laws may change. For example, the VLRC review recommended the development of a supported decision-making and a co-decision-making structure.[27]

10.25 Briefly, this would provide recognition to supporters—trusted persons providing support and assistance to an adult who needs help in making a decision—and external oversight by the Victorian Civil and Administrative Tribunal (VCAT). The co-decision-maker would act jointly with the adult, and decisions would have to be made with the consent and authority of the represented person, and would be treated as if they were the acts of the represented person with capacity.

10.26 Appointments would be made by the VCAT and the range of decisions for which the person needs support could, in principle, range across the areas previously covered by guardians and administrators. Safeguards against exploitation are detailed and include registration of co-decision-making orders, regular review on a range of grounds and the options to renew, amend or revoke the order.

10.27 Stakeholders in this Inquiry called for continuing review of Australian guardianship laws,[28] as has the United Nations Committee on the Rights of Persons with Disabilities (UNCRPD).[29] AGAC stated that the principles of supported decision-making articulated in the Discussion Paper could be 'incorporated into any review of state-based guardianship and administration regimes'.[30]

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22 *Guardianship Act 1987* (NSW) s 4; *NSW Trustee and Guardian Act 2009* (NSW) s 39; *Guardianship and Administration Act 1990* (WA) s 4; *Adult Guardianship Act 1988* (NT) s 4.

23 *Guardianship and Administration Act 2000* (Qld) s 4; *Guardianship and Administration Act 1995* (Tas) s 6.

24 Ibid ss 5–7, sch 1.

25 *Guardianship and Management of Property Act 1991* (ACT) ss 4, 5A. See Ch 2.

26 *Guardianship and Administration Act 1993* (SA) s 5.

27 Victorian Law Reform Commission, *Guardianship*, Final Report No 24 (2012) chs 8–9.

28 See, eg, National Association of Community Legal Centres, *Submission 127*; F Beaupert, P Gooding and L Steele, *Submission 123*; Justice Connect and Seniors Rights Victoria, *Submission 120*; AGAC, *Submission 91*; National Seniors Australia, *Submission 57*.

29 United Nations Committee on the Rights of Persons with Disabilities, *General Comment No 1 on Article 12 of the Convention—Equal Recognition before the Law*, 2014.

30 AGAC, *Submission 91*.

10.28 In addition to highlighting the desirability of reviewing state and territory laws to ensure consistency with the National Decision-Making Principles and the Commonwealth decision-making model, the ALRC's recommendation outlines a number of particular considerations that should inform such reviews. These are briefly discussed below, with particular reference to guardianship laws.

## Interaction with Commonwealth supporter and representative schemes

10.29 As discussed in Chapter 4, the ALRC recommends that a Commonwealth decision-making model, including 'supporters' and 'representatives', should be introduced into relevant Commonwealth legislation, including that relating to the NDIS, social security, aged care, eHealth and privacy.[31]

10.30 If implemented, the interaction of these Commonwealth schemes with state and territory guardianship and administration laws may need to be taken into account in review of the latter.

10.31 Chapter 4 highlights some of the issues involved but they will vary depending on what approach is taken in Commonwealth laws.

10.32 For example, the ALRC envisages that before a representative is appointed for someone, the Commonwealth agency would have to be satisfied that the person actually needs a representative, and that an appointment is not being used as a substitute for appropriate decision-making support.

10.33 While there should be a presumption that an existing state or territory appointee should be appointed where a representative is needed under a Commonwealth law, sometimes there may be both a Commonwealth representative and a state or territory appointed decision-maker. If they have power to make decisions in the same area, interaction problems may occur (or be avoided by consultation and cooperation) but ultimately where a decision is being made for the purposes of the Commonwealth legislation, the Commonwealth representative is responsible.

10.34 If an existing state or territory appointee is also appointed under Commonwealth law, other issues may arise, particularly if the appointee's duties under state or territory legislation conflict significantly with those under Commonwealth law. Legislative change may be required to allow state or territory appointees to be appointed under orders that better align with duties and responsibilities under Commonwealth legislation—for example, so that they can make both lifestyle and financial decisions as representatives under the NDIS.

## Consistency

10.35 It is clearly desirable for there to be consistency between Commonwealth, state and territory legislation dealing with individual decision-making, including in relation to terminology. At present, no such consistency exists:

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31 See Chs 5 and 6.

> Terminology varies considerably between state/territory jurisdictions, including terms such as guardian, manager, administrator, which are inconsistently defined. Powers held under these appointments may also vary—noting that they are often specified by orders of a tribunal, within the scope of powers outlined in legislation; and cross-recognition is, at best, arbitrary.[32]

10.36 Such inconsistency causes problems, in particular because the criteria and scope of state and territory appointments vary; and appointments may not be recognised in other jurisdictions.

10.37 Stakeholders supported a nationally consistent approach.[33] National Disability Services, for example, said that unless there are 'nationally consistent definitions, processes and safeguards around legal capacity assessment and decision support', people with disability and their families can experience inconsistent and additional administrative hurdles across different jurisdictions or areas of their lives.[34]

10.38 The Queenslanders with Disability Network (QDN) highlighted the opportunity the NDIS may provide to promote a more consistent approach to the appointment and powers of decision-makers, in order to prevent 'confusion in the appointment of nominees with regard to disability supports for the NDIS'.[35] That is, where the appointment of NDIS nominees may not correlate with existing guardianship arrangements at a state level, the 'NDIS should be used as a catalyst for systemic change in this area'.[36]

## Cross-jurisdictional recognition

10.39 A related issue is the need to maximise cross-jurisdictional recognition of appointments and other decision-making arrangements. Stakeholders emphasised this need—especially as people commonly travel between jurisdictions or live in towns which straddle jurisdictional boundaries.[37] QDN, for example, stated that:

> One of the great advantages of the NDIS will be that it will allow people with disability more freedom to move interstate, without having to be concerned with different support systems across jurisdictions. It would be a terrible shame for such significant reforms to be undermined by other inter-jurisdictional hurdles such as legal capacity definitions.[38]

10.40 Bruce Arnold and Dr Wendy Bonython submitted that the 'rise of yet another class of substitute decision-makers or power-holders' appointed under Commonwealth legislation may lead to problems if it 'creates uncertainty about the validity of pre-emptive appointments made by people in anticipation of future loss of capacity,

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32 B Arnold and W Bonython, *Submission 38*.
33 See, eg, National Seniors Australia, *Submission 57*; National Disability Services, *Submission 49*; Office of the Public Advocate (SA), *Submission 17*.
34 National Disability Services, *Submission 49*. With respect to the impact on movement interstate, see also: AFDS, *Submission 47*; Office of the Public Advocate (SA), *Submission 17*.
35 QDN, *Submission 59*.
36 Ibid.
37 See, eg, Office of the Public Advocate (SA), *Submission 17*.
38 QDN, *Submission 59*.

particularly if they lose capacity outside the jurisdiction the appointment was made in, or if they hold assets in multiple jurisdictions'.[39]

10.41 There are some provisions permitting cross-jurisdictional recognition. However, these arrangements are not comprehensive and should be improved. For instance, while the Victorian legislation makes provision for the recognition of interstate guardianship and administration orders,[40] Queensland has no corresponding law.

### Data collection

10.42 Stakeholders raised concerns about difficulties associated with obtaining consistent data in relation to the appointment of substitute decision-makers. They emphasised the need for improved data collection to facilitate comparisons across jurisdictions and inform policy development.[41] Arnold and Bonython observed that,

> although data is often collected by service providers, regulatory bodies and third parties that data is often held within institutional silos and is not readily accessible. That inaccessibility militates against informed policy-making.[42]

10.43 State and territory review of guardianship and administration legislation may provide an opportunity to promote mechanisms for consistent and national data collection about supported and fully supported decision-making.

## Consent to medical treatment

10.44 At common law, all competent adults can consent to and refuse medical treatment. If consent is not established, there may be legal consequences for health professionals. Under the law of trespass, patients have a right not be subjected to an invasive procedure without consent or other lawful justification, such as an emergency or necessity. The CRPD expresses this in terms of a 'right to respect for his or her physical and mental integrity on an equal basis with others'.[43]

10.45 As part of their duty of care, health professionals must obtain 'informed consent' by providing such information as is necessary for the patient to give consent to treatment, including information on all material risks of the proposed treatment. Failure to do so may lead to civil liability for an adverse outcome, even if the treatment itself was not negligent.[44]

10.46 The common law recognises that there are circumstances where an individual may not be capable of giving informed consent, for example, due to requiring decision-making support with respect to medical treatment. However, except in the case of children—where the High Court has recognised the courts' *parens patriae* jurisdiction

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39 B Arnold and W Bonython, *Submission 38*.
40 *Guardianship and Administration Act 1986* (Vic) pt 6A.
41 See, eg, B Arnold and W Bonython, *Submission 38*; Office of the Public Advocate (SA), *Submission 17*.
42 B Arnold and W Bonython, *Submission 38*.
43 *UN Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 999 UNTS 3 (entered into force 3 May 2008) art 17.
44 *Rogers v Whitaker* (1992) 175 CLR 479.

in authorising treatment[45]—it does not provide significant guidance on supported decision-making in health care settings.

10.47 State and territory guardianship and mental health laws provide detailed rules for substitute decision-making concerning the medical treatment of adults who are deemed incapable of giving consent.[46]

10.48 Guardianship legislation outlines criteria for appointing substitute decision-makers, the hierarchy of possible decision-makers and the scope of their powers, which depend on the age of the patient and the type of treatment proposed.

10.49 In all jurisdictions, except the Northern Territory, guardianship legislation provides for a decision-maker who is chosen (for example, an enduring guardian), assigned by the legislation (for example, a spouse, close friend or relative) or appointed (for example, by a court) to make health decisions for an adult who is not capable of giving consent.[47]

10.50 Currently, in exercising their powers, substitute decision-makers are required to adopt one of two tests (or a combination of both in some jurisdictions) in reaching their decision for the person with impaired decision-making capacity. One is the best interests test, which requires a balancing of the benefit to the patient against the risks of the proposed treatment, and the other is the substituted judgment test, which involves making a decision which is consistent with what the person would have decided if they had the capacity to do so. Evidence of such wishes may be provided by advance care directives, religious beliefs and previous history of treatment.[48]

### *Supported decision-making in health care*

10.51 Stakeholders expressed opposition to existing substitute decision-making mechanisms in health care and favoured supported decision-making.[49] NSW Council of Social Service (NCOSS) stated that 'quality of life decisions should be made by the affected person'. [50] The Illawarra Forum submitted that 'every effort should be made to support people to make informed decisions and choices', including in relation to healthcare.[51]

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45 *Secretary, Department of Health and Community Services v JWB and SMB (Marion's case)* (1992) 175 CLR 218.

46 Eg, *Guardianship and Management of Property Act 1991* (ACT) ss 32B, 32D; *Mental Health Act 2009* (SA) ss 56, 57.

47 At the time of writing, in the Northern Territory, there was no provision for consent to medical treatment without an appointment being made. South Australia has legislation specific to consent to medical treatment, which provides for medical powers of attorney: *Consent to Medical Treatment and Palliative Care Act 1995* (SA).

48 See, eg, *Hunter and New England Area Health Service v A* [2009] NSWSC 761. The Supreme Court of NSW confirmed a person's advance care directive to refuse medical treatment is valid if it is made by a capable adult, is clear and unambiguous and applies to the situation at hand.

49 See, eg, NCOSS, *Submission 26*; The Illawarra Forum, *Submission 19*; Office of the Public Advocate (SA), *Submission 17*.

50 NCOSS, *Submission 26*.

51 The Illawarra Forum, *Submission 19*.

10.52 Stakeholders suggested that a supported decision-making framework would be more likely to result in health care decisions that accord with an individual's personal beliefs and values.[52] The Carers Alliance asserted the primacy of the family who know of a person's beliefs and values in supporting people with disability to exercise capacity.[53] On the other hand, Family Planning NSW considered that encouraging supporters who are not family members but health care workers may help overcome a lack of understanding about what constitutes informed consent in reproductive and sexual health and any discomfort between family members to discuss such matters.

> A supported decision making framework needs to encompass the requirement for clinicians, other health and support workers to take on the role of assisting a person to make decisions. This means that they need to develop the skills necessary to talk about reproductive and sexual health in ways that encourage the person to make their own decisions.[54]

10.53 Under the Commonwealth decision-making model, the person requiring support chooses who their supporter should be when making medical decisions, such as a family member, friend, carer, health care worker or a group of these people. If a representative is appointed for the person under the model, the representative may make decisions about medical treatment for the person in accordance with that person's will, preferences and rights.

10.54 A number of stakeholders expressed concerns about the current laws on sterilisation procedures. Women with Disabilities Australia submitted the 'best interest' approach to the sterilisation of women and girls has been used in a discriminatory way and that a lack of education and accessible services can prevent women from making choices regarding their fertility and conception.[55] Organisation Intersex International Australia argued that, in the absence of a national policy framework, 'intersex-related medical interventions must be subject to legal scrutiny within a human rights framework'.[56]

10.55 Children with Disability Australia submitted that the criminalisation of forced sterilisation may be justified, as existing requirements for court authorisation have failed to protect the rights of people with disability, under the CRPD, to be free from violence and to retain their physical integrity.[57] Several other stakeholders supported legislative prohibition of sterilisation without informed consent.[58]

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52 See, eg, Office of the Public Advocate (Qld), *Submission 05*.

53 Carers Alliance, *Submission 84*. It was suggested that there is currently insufficient recognition of the role and contribution of carers and family members who possess 'intimate knowledge and understanding of the cognitively impaired person': N Widdowson, *Submission 31*.

54 Family Planning NSW, *Submission 04*.

55 WWDA, *Submission 58*.

56 Organisation Intersex International Australia Limited, *Submission 97*.

57 Children with Disability Australia, *Submission 68*.

58 Law Council of Australia, *Submission 83*; Women's Legal Services NSW, *Submission 76*; ADACAS, *Submission 29*.

### *Review of the law*

10.56 The law on decision-making in health care is complex. Inconsistency in language, and different tests of decision-making ability and processes across the jurisdictions may cause difficulties for health service providers and consumers.

10.57 A number of recent reports have suggested reforms. The VLRC's guardianship report recommended consolidating existing laws into new legislation distinguishing 'health decision makers' from 'guardians', as well as differentiating between 'significant' and 'routine' medical procedures.[59] In the context of developing a national code of conduct for unregistered health care workers, the Australian Health Ministers' Advisory Council (AHMAC) has queried whether a national 'minimum enforceable standard' for informed consent should be introduced.[60]

10.58 In 2011, AHMAC developed a national policy framework for advance care directives to address challenges posed by divergent laws affecting consent to medical treatment.[61] The ALRC received submissions noting the desirability of nationally consistent and enforceable laws on advance care directives.[62]

10.59 The Mental Health Council of Australia and the National Mental Health Consumer and Carer Forum expressed support for a legal framework for assessing health care decision-making ability in line with developments in the United Kingdom under the *Mental Capacity Act 2005* (UK).[63] This would place a focus on the ability of people to understand information relevant to a health care decision; retain that information; use or weigh that information as part of a decision-making process; or communicate the decision.[64]

10.60 The ALRC recommends that state and territory governments review legislation relating to informed consent to medical treatment, including in relation to advanced care directives,[65] with a view to reform that is consistent with the National Decision-Making Principles and the Commonwealth decision-making model.

10.61 Reform encouraging a supported decision-making model might involve recognition that a person may be able to give informed consent to medical treatment with the assistance of a supporter. The implications of such a change, including in relation to the legal liability of health practitioners, would need to be carefully assessed.

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59 Victorian Law Reform Commission, *Guardianship*, Final Report No 24 (2012) recs 12, 199–219, ch 13.

60 'Consultation Paper: A National Code of Conduct for Health Care Workers' (Australian Health Ministers' Advisory Council, March 2014) 16. Most state and territory health departments issue guidelines on consent to health care.

61 Australian Health Ministers' Advisory Council, *National Framework for Advance Health Care Directives*, September 2011.

62 Law Council of Australia, *Submission 83*; ADACAS, *Submission 29*; Mental Health Coordinating Council, *Submission 07*.

63 NMHCCF and MHCA, *Submission 81*.

64 See *Mental Capacity Act 2005* (UK) s 3.

65 See Best Practice Standards in Australian Health Ministers' Advisory Council, *National Framework for Advance Health Care Directives*, September 2011.

10.62 Any new approach to consent to medical treatment would need to be reflected in guidance such as the Australian Charter of Rights in Healthcare, the National Safety and Quality Health Service Standards, the National Framework on Advance Care Directives, publications on communication with patients[66] and the national codes of conduct for health practitioners.[67]

## Mental health

10.63 All states and territories have mental health laws that regulate consent to medical treatment, including the involuntary detention and treatment of people with severe mental illness. Generally, mental health laws have provided for treatment based on a person's need for treatment and the risk of harm posed to themselves and others.[68]

10.64 New mental health legislation in Tasmania and Victoria has changed the focus of criteria for the involuntary detention and treatment from the risk of harm to a person's capacity to consent to treatment.[69] There are active mental health reviews and legislative initiatives in other jurisdictions.[70]

10.65 The Mental Health Coordinating Council (MHCC) submitted that the *Mental Health Act 2007* (NSW) is 'problematic', because there is little detail about the basis of decisions made by doctors on the treatment of detained psychiatric patients, particularly those who retain decision-making capacity in relation to certain treatment decisions and who have a view about the preferred treatment or wish to forgo certain treatments.[71]

10.66 The MHCC stated that the law should outline the rights of patients to refuse and receive treatment and deal with how patients' preferences can be taken into account in medical decisions—including by way of advance care directives—to ensure that doctors override patients' preferences only in limited circumstances, where a patient lacks capacity to make that decision, and the proposed treatment is 'manifestly in the person's best interests'.[72]

10.67 New legislation in Tasmania and Victoria protects the rights of mental health patients through statements of rights. In Tasmania, the rights of involuntary patients are outlined in statute and whenever a person is admitted to, or discharged from, an

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66 'General Guidelines for Medical Practitioners on Providing Information to Patients' (National Health and Medical Research Council, 2004); 'Communicating with Patients: Advice for Medical Practitioners' (National Health and Medical Research Council, 2004).

67 The codes of conduct for the 14 national boards of health practitioners are available at Australian Health Practitioner Regulation Agency, *National Boards* <www.ahpra.gov.au>.

68 See, eg, *Mental Health and Related Services Act* (NT) s 14; *Mental Health Act 2007* (NSW) s 14.

69 The *Mental Health Act 2013* (Tas) factors in a person's decision-making capacity, and not just the mental illness or a risk of harm in the assessment criteria: s 8; the *Mental Health Act 2014* (Vic) defines 'capacity to give informed consent' and provides a statutory presumption of capacity: (Vic) ss 68, 70.

70 See, eg, ACT Second Exposure Draft Bill to amend the *Mental Health (Treatment and Care) Act 1994* (ACT); Mental Health Bill 2013 (WA); SA Department of Health review of the *Mental Health Act 2009* (SA); Queensland review of the *Mental Health Act 2000* (Qld); NSW review of the *Mental Health Act 2007* (NSW).

71 Mental Health Coordinating Council, *Submission 07*.

72 Ibid.

approved facility, its controlling authority must give the person a statement of their rights.[73] In Victoria, a statement of rights must be explained to people being assessed or receiving treatment in relation to their mental illness.[74]

10.68 A person's rights under the *Mental Health Act 2014* (Vic) include the right to communicate, make advance statements and have a nominated person to support them and help represent their interests.[75] The role of a nominated person is to receive information about the patient; be one of the persons who must be consulted in accordance with the Act about the patient's treatment; and assist the patient to exercise any right under the Act.[76] A person can only nominate another person in writing and the nomination must be witnessed.[77] A nomination can be revoked in the same manner by the person who made the nomination or if a nominated person declines to act in the role.[78]

10.69 A similar model for supported decision-making in mental health services is contained in the Mental Health Bill 2013 (WA) (the WA Bill).[79] Under the proposed legislation, mental health services are obliged to comply with a charter of mental health care principles. The charter recognises the involvement of other people such as family members and carers.[80] In addition, the WA Bill would give effect to the carers' charter provided for in the *Carers Recognition Act 2004* (WA).[81]

10.70 The WA Bill provides for a 'nominated person', someone chosen by the person with mental illness to assist them in ensuring their rights under the Act are observed and their interests and wishes are taken into account by medical practitioners and mental health workers.[82] A nominated person is entitled to 'uncensored' communication with the person with mental illness, and to receive information related to that person's treatment and care.[83]

10.71 Under the WA Bill, a nominated person may exercise the rights of the person with mental illness under the legislation, but is not authorised to apply for the admission to or discharge by a mental health service.[84] Unless the provision of information is not in the best interests of the patient, a nominated person has a right to be involved in matters relating to the treatment and care of the patient, including the

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73 *Mental Health Act 2013* (Tas) ss 62, 129, sch 1.
74 From 1 July 2014: *Mental Health Act 2014* (Vic) ss 12, 13.
75 Ibid pt 3.
76 Ibid s 23.
77 Ibid s 24.
78 Ibid ss 25–27.
79 The Mental Health Bill 2013 (WA) was adopted by the WA Legislative Assembly in April 2014 and at the time of writing was expected to progress to the Legislative Council for review. If enacted, it will replace the *Mental Health Act 1996* (WA).
80 Mental Health Bill 2013 (WA) sch 1.
81 Ibid cl 319(2)(g), 332(3)(e).
82 Ibid cl 263.
83 Ibid cl 264(2). This includes information about the grounds on which an involuntary treatment order was made, the treatment provided to the patient and the patient's response to that treatment, and the seclusion of, or use of bodily restraint on, the patient: Ibid cl 266(1)(a).
84 Mental Health Bill 2013 (WA) cl 264(5)–(6).

consideration of the options that are reasonably available for the patient and the provision of support to the patient.[85]

10.72 The ALRC recommends that state and territory governments review mental health legislation, with a view to reform that is consistent with the National Decision-Making Principles and the Commonwealth decision-making model. This might involve, for example, moving towards supported decision-making models similar to those contained in the Victorian legislation and in the WA Bill.

10.73 COAG's Standing Council on Health has long overseen developments in mental health laws, and may be able to advance such an initiative. The AHMAC, a component committee of the Standing Council, commissioned a national project on model mental health legislation, which was completed in 1994.[86] This project propelled review of mental health laws in every state and territory in Australia in the late 1990s.[87]

## Disability services

10.74 States and territories legislate for the provision of supports and services to persons with disability.[88] The role of disability services legislation in regulating restrictive practices is discussed in Chapter 8, where the ALRC recommends the development of a national approach to restrictive practices in disability services.

10.75 As a national quality and safeguards system for the NDIS is being developed by COAG,[89] the ALRC considers it desirable for state and territory governments to review their disability services legislation, with a view to reform that is consistent with the National Decision-Making Principles and the Commonwealth decision-making model. This might involve, for example, moving towards compliance with the CRPD, as well as preparing for the implementation of the NDIS.

10.76 The *Disability Inclusion Act 2014* (NSW) is an example of legislation which moves towards more complete recognition of the right of persons with disability to make decisions that affect their lives and to have those decisions respected.[90] The Act includes an objective to 'enable people with disability to exercise choice and control in the pursuit of their goals'[91] and a general principle that 'people with disability have the same rights as other members of the community to make decisions that affect their lives (including decisions involving risk) to the full extent of their capacity to do so and to be supported in making those decisions if they want or require support'.[92]

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85 Ibid cl 266(1)(b).

86 The University of Newcastle, 'Model Mental Health Legislation' (Australian Health Ministers' Advisory Council, 1994).

87 Chris Sidoti, 'Mental Health for All: What's the Vision?' (Speech delivered at the National Conference on Mental Health Services, Policy and Law Reform in the Twenty First Century, Newcastle, 13–14 February 1997).

88 *Disability Act 2006* (Vic); *Disability Inclusion Act 2014* (NSW); *Disability Services Act 2006* (Qld); *Disability Services Act 1993* (SA); *Disability Services Act 1993* (WA); *Disability Services Act 1993* (NT); *Disability Services Act 1991* (ACT).

89 COAG Disability Reform Council, *Meeting Communiqué*, 21 March 2014.

90 *Disability Inclusion Act 2014* (NSW).

91 Ibid s 3(c).

92 Ibid s 4(5).