Office of the Public Advocate

Safeguarding the rights and interests of people with disability

Submission to the Independent Review of Compulsory Assessment and Treatment Criteria and Alignment of Decision-Making Laws

June 2023

The Public Advocate has approved this submission. It is a public submission.

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Acknowledgement of Country

This submission was written on the land of the Wurundjeri and Boon Wurrung people of the Kulin Nation. We acknowledge and pay our respects to Aboriginal and Torres Strait Islander peoples and Traditional Custodians throughout Victoria, including Elders past and present. We also acknowledge the strength and resilience of all First Nations people whose social and emotional wellbeing continues to be negatively affected by discrimination, racism, child removal and other devastating ongoing effects of colonisation.

Recommendations

Recommendation 1
The legislation should include decision-making principles that accord with the purpose of the Mental Health and Wellbeing Act, to promote the self-determination of people subject to compulsory treatment and limit the circumstances where a person's will and preferences can be overridden.

Recommendation 2
Safeguarding around substitute decision making should be strengthened by requiring authorised psychiatrists to keep records documenting the rationale for treatment decisions, including whether the decision was a substitute decision or the person provided consent.

Recommendation 3
Where necessary, state and territory governments should amend their mental health laws to ensure that only people who lack decision-making capacity in relation to the treatment of their mental illness can be subject to compulsory treatment and detention.

Recommendation 4
State and territory governments should introduce legislation to empower personally appointed substitute decision makers to make treatment decisions for individuals on compulsory mental health treatment orders if the individual does not pose a serious risk of harm to others. This power should extend to tribunal-appointed substitute decision makers whom the person would probably have wanted to make those treatment decisions.

Recommendation 5
State and territory governments should legislate to ensure that people are not subject to compulsory detention under mental health legislation for more than 14 days without tribunal approval.

Recommendation 6
All medical treatment decisions should be made by medical treatment decision makers, irrespective of whether the person concerned is subject to a compulsory treatment order. Where no appointed or appropriate substitute decision maker is available, OPA could be resourced to undertake this function.

1. About the Office of the Public Advocate

The Office of the Public Advocate (OPA) is a Victorian statutory office, independent of government and government services, that works to safeguard the rights and interests of people with disability.

The Public Advocate has seven functions under the *Guardianship and Administration Act 2019* (Vic), all of which relate to promoting the independence and human rights of people with disability and protecting people with disability from abuse, neglect, and exploitation. To this end, OPA provides a range of critical services for people with cognitive impairment or mental illness, including guardianship, advocacy, and investigation services. In 2021-22, OPA was appointed as substitute decision maker in 1976 guardianship matters.[1]

OPA also has a substitute decision-making role under the *Medical Treatment Planning and Decisions Act 2016* (Vic)[2] for people who do not have decision-making capacity or a medical treatment decision maker[3] and who need someone to consent to significant medical treatment on their behalf.

Another key function of the Public Advocate is to promote and facilitate public awareness and understanding about the Guardianship and Administration Act and any other legislation affecting persons with disability or persons who may not have decision-making capacity. To do so, OPA supports a full-service communications function with 120 publications in print or PDF, a website attracting approximately 150,000 visitors in the last year and strong media relations. It also operates an Advice Service which provided 10,133 instances of advice last financial year[4] and a community education program for professional and community audiences across Victoria. OPA's community education engages on a range of topics such as the role of OPA, guardianship and administration, and enduring powers of attorney and, most relevantly to this review, advance planning under the Medical Treatment Planning and Decisions Act.

OPA supports approximately 600 volunteers across three volunteer programs: the Community Visitors Program, the Independent Third Person (ITP) Program and the Corrections Independent Support Officer (CISO) Program. Most relevantly to this review, OPA Community Visitors are independent volunteers empowered by law to visit Victorian accommodation facilities for people with disability or mental illness – including to inpatient facilities such as psychiatric units in public hospitals. They monitor and report on the adequacy of services provided in the interests of residents and patients. In 2021-22, Community Visitors made 3411 statutory visits, including to sites of criminal and civil detention.[5]

2. Human rights approach

This submission applies a human rights approach that:

- holds that all people with disability have the right to enjoy equality of opportunity and to effectively participate in, and be fully included in, society
- recognises that most challenges experienced by people with disability are a result of disabling systems and environments, rather than being due to an inherent 'lack' in the individual
- considers impairment as an expected dimension of human diversity
- seeks for people with disability to be supported and resourced to have the capabilities to lead a dignifying and flourishing life.

[1] Office of the Public Advocate, *Annual Report* (2022) 9.
[2] *Medical Treatment Planning and Decisions Act* 2016 (Vic) s 63.
[3] Ibid s 55.
[4] Office of the Public Advocate, *Annual Report* (2022) 10.
[5] Office of the Public Advocate*, Community Visitors Annual Report 2020-2021* (2021) 10.

For this review, OPA also highlights the human rights-promoting value of ensuring independent oversight of closed environments and of substituted decision-making regimes. Australia's signing of the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) opens the door for independent monitoring of conditions in compulsory treatment settings. OPA hopes that such oversight would see the current over-representation of First Nations people subject to compulsory treatment orders addressed.[6]

3. OPA's engagement with this review

OPA is pleased to make a submission in response to the Independent Review's Consultation Paper. OPA strongly supports the panel's goal of centring human rights and supported decision-making practices in mental health laws to significantly reduce the rates of compulsory treatment in Victoria.

OPA's submission to the panel reflects its particular expertise in alternate substitute decision-making regimes in Victoria (set out in the Medical Treatment Planning and Decisions Act and the Guardianship and Administration Act). It contains OPA's reflections on the strengths and gaps of these legislative frameworks with the goal of assisting the panel to consider how these may translate to the mental health space.

OPA's submission is set out in three parts:

- Existing opportunities for diversion from compulsory treatment that do not require legislative reform
- Possibilities for legislative reform to reduce the use of compulsory treatment
- Improving alignment of substitute decision-making legislation.

4. Existing opportunities for diversion from compulsory treatment that do not require legislative reform

OPA supports the panel's commitment to reducing the use of compulsory mental health treatment in Victoria. OPA acknowledges that the terms of reference for this review necessarily limit the scope of the Panel's enquiries to questions of legislative reform. Nevertheless, this response to the Consultation Paper would not be complete without acknowledgement of the crucial roles played by policy, practice and resourcing in driving systemic change.

Indeed, OPA's recently publish report *Reflections on guardianship: The law and practice in Victoria* includes a section named 'Lack of less restrictive options due to lack of resourcing'[7] for supported decision-making alternatives which describes a choice made by the Victorian Civil and Administrative Tribunal (VCAT) to appoint a substitute decision maker where a decision supporter was all that was required, but none was available. In this case, the human rights objects of the Guardianship and Administration Act were not achieved. The *Mental Health and Wellbeing Act 2022* (Vic) faces similar risks.

In a similar vein, an additional and complementary path to reducing the use of compulsory mental health treatment is ensuring that existing mechanisms for supported and substitute

[6] *Royal Commission into Victoria's Mental Health System*, Final Report, Volume 4 (2021) p 377.
[7] This section references the apparent lack of resources devoted to making supported decision-making alternatives available and accessible to people without informal supporters. Report available on OPA's website: https://www.publicadvocate.vic.gov.au/opa-s-work/research/580-reflections-on-guardianship-the-law-and-practice-in-victoria

decision making (for people who need support with decisions) are used as often as possible. OPA's statutory role within the Medical Treatment Planning and Decisions Act as 'last resort' medical treatment decision maker,[8] alongside OPA's educative role in relation to advance planning, enables it to comment on the possibilities for early diversion from compulsory treatment the Medical Treatment Planning and Decisions Act presents.

In OPA's experience, the opportunities presented by the Medical Treatment Planning and Decisions Act for people with mental health issues have, to date, been underutilised. People with mental health issues, and the health systems that support them, need access to targeted education and information campaigns about these opportunities. Provisions in the Medical Treatment Planning and Decisions Act that are available to promote supported decision making in mental health contexts need to be more widely known, and, in situations where substitute decision making is required, these provisions would ensure that all decisions reflect the preferences and values of the person (where these are able to be known).

There are two key parts of the Medical Treatment Planning and Decisions Act which are relevant to promoting self-determination for people in need of mental health treatment: the 'medical treatment decision maker' hierarchy and the Act's advance planning provisions. The following aims to describe how these provisions might be used to reduce the incidence of compulsory mental health treatment in Victoria.

4.1. The 'medical treatment decision maker' hierarchy

Section 55 of the Medical Treatment Planning and Decisions Act provides a list to enable the identification of a person's medical treatment decision maker in circumstances where the person lacks capacity to make that decision for themselves. The legislation details a hierarchy for deciding who takes on this role.[9] Where no medical treatment decision maker can be identified by the section 55 hierarchy, section 63 enables any 'significant' medical treatment decisions to be made by the Public Advocate (or their delegate).

The potential benefit of these provisions for a person who cannot make their own decisions about their mental health treatment is the option for someone else (that is, the medical treatment decision maker) to make a decision on their behalf, without needing to appoint a guardian in such a circumstance. This legislative framework dictates that the decision maker must make the decision that they reasonably believe 'is the decision that the person would have made if the person had decision-making capacity', and where it is not possible to ascertain this, that they should make a decision that promotes the person's 'personal and social wellbeing, having regard to the need to respect the person's individuality'.[10]

OPA recognises that this framework would not be applicable to all situations involving a person in need of mental health treatment. The practical implications of section 61, which describes the criteria according to which a substitute decision maker must act, mean that medical treatment (which is inclusive of non-compulsory mental health treatment) could not be provided to anyone who was actively resisting that treatment.

In these cases, non-consensual treatment would be 'off the table' of mental health treatment options unless the threshold for compulsory mental health treatment was met. Currently, these criteria include the need for immediate treatment to prevent serious harm to self or others. The Medical Treatment Planning and Decisions Act could be used to provide treatment in such circumstances where it is believed the person would have

[8] *Medical Treatment Planning and Decisions Act 2016* (Vic) s 63.
[9] Ibid s 55.
[10] Ibid s 61.

accepted the treatment if they had capacity to make the decision themselves and they were not actively refusing it.

This decision-making framework is preferable to other 'best-interests' substitute decision-making regimes from a human rights perspective because it promotes supported and substituted decision making, following the will and preferences (or 'preferences and values' depending on the relevant act)[11] of the person where they are known and never acting to override known preferences. OPA notes that the medical practitioner is under no obligation to offer treatment that they do not believe would be beneficial to the person – hence the medical treatment decision maker can only make decisions about whether to accept or refuse offered treatments.

4.2. Advance planning options

The Medical Treatment Planning and Decisions Act also includes provisions for making medical treatment decisions pre-emptively, while a person has capacity for such decision making,[12] which are binding on medical practitioners in certain circumstances and provide guidance to substitute decision makers in others. These are called 'advance care directives'[13]:

> An advance care directive is a document that sets out a person's binding instructions or preferences and values in relation to the medical treatment of that person in the event that the person does not have decision-making capacity for that medical treatment.[14]

Advance care directives can take the form of an 'instructional directive'[15] or a 'values directive' (or include both aspects).

OPA's experience with community education regarding these new provisions is that it has been largely focused on 'end of life' medical treatment decisions. There is a greater need for community education on these advance planning options for people with experience of mental illness. Where a person has not been made subject to compulsory treatment, mental health treatment decisions for people without relevant decision-making capacity should be made in line with the framework set out by the Medical Treatment Planning and Decisions Act. This would enable people to make binding decisions about their refusal of ECT or certain medications, for example, in all circumstances that did not meet the criteria for compulsory treatment.

4.3. Community mental health services

Community mental health services have been hit hard by the transition to the National Disability Insurance Scheme (NDIS). Many community-based supports were discontinued or stripped back. The Mental Health and Wellbeing Act recognises the importance of localised, holistic, community-based responses to people's mental health related needs.

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[11] The Medical Treatment Planning and Decisions Act uses the language of 'preferences and values', while the Guardianship and Administration Act refers to the person's 'will and preferences'

[12] *Medical Treatment Planning and Decisions Act 2016* (Vic) s 13. To make an advance care directive under the Medical Treatment Planning and Decisions Act the person must have 'decision-making capacity in relation to each statement in the directive' and understand 'the nature and effect of each statement in the directive'.

[13] Ibid Part 2.

[14] Ibid s 12

[15] Ibid s 6(1): 'For the purposes of this Act, an "instructional directive"— (a) is an express statement in an advance care directive of a person's medical treatment decision; and (b) takes effect as if the person who gave it has consented to, or refused the commencement or continuation of, medical treatment, as the case may be.'

OPA recognises that early interventions and well-resourced community-based support structures have significant potential for preventing mental health crises, and thereby reducing the rate of compulsory treatment in Victoria.

4.4. Lack of a less restrictive option

OPA's experience undertaking the role of VCAT-appointed 'guardian of last-resort' provides certain insights that may be useful for this review.

Most relevantly, a person's access to support networks is a key factor in the appointment of a substitute decision maker (in this example, the need for a guardian). Where a person can make their own decisions with support but lacks people or services who might provide said support, a guardian may be appointed to fill this gap. In these cases, guardianship is the 'least restrictive' option of those available. Involvement of a supported decision-making service could prevent the appointment of a substitute decision maker and uphold the rights of the person to self-determination.

Similarly, policy reform and resourcing of early intervention mental health services which include supported decision-making services will keep treatment decision making in the hands of the people themselves, wherever possible.

5. Possibilities for legislative reform to reduce the use of compulsory treatment

OPA does not regularly operate in the compulsory mental health treatment space: guardians do not make compulsory treatment decisions and OPA's Community Visitors are concerned with the safety and wellbeing of people in acute mental health facilities but do not usually engage with the question of whether or not the person should be there in the first place. Hence, its ability to provide grounded comment on legislative amendments around compulsory treatment criteria is minimal.

OPA does have significant practice experience with the other substitute decision-making regimes currently operating in Victoria: guardianship, advance planning instruments and medical treatment decision making under the Medical Treatment Planning and Decisions Act.

With these points in mind, OPA's submission will focus on the following areas:

- the role played by legislated decision-making principles in guiding how supported and substitute decisions are made under a given act
- appropriate safeguards in substitute decision making
- key human-rights promoting principles that should drive reform to compulsory treatment legislation.

5.1. Decision-making principles for substitute decision makers

OPA's substitute decision-making powers and functions are governed by two acts, the Guardianship and Administration Act and the Medical Treatment Planning and Decisions Act. Delegates of the Public Advocate (including those making substitute decisions) are also required to act in accordance with the *Victorian Charter of Human Rights and Responsibilities Act 2006* (Vic). As mentioned above, the Public Advocate is Victoria's 'guardian of last resort' and, in effect, also the equivalent of Victoria's medical treatment

decision maker of last resort for people who need someone to consent to ‘significant’ medical treatment on their behalf.[16]

Guardians are empowered to make substitute decisions for people subject to a guardianship order in the ‘personal matter’ realms specified by that order. OPA’s Medical Decisions Team also makes substitute decisions in line with the Medical Treatment Planning and Decisions Act.

Both acts set out the principles for how substitute decisions must be made. This ensures that the person’s will and preference (‘preferences and values’ under the Medical Treatment Planning and Decisions Act) guide decision making and are enacted wherever possible. In situations where the person’s preferences cannot be determined the decision maker is required to make the decision which promotes the ‘personal and social wellbeing’ of the person.[17] Although a medical treatment decision maker can make a decision to consent to treatment that the person may be resistant to, this decision cannot be enforced where a person is actively resisting that treatment. A guardian’s decision (about personal matters not including medical treatment) can be enforced against the person’s will and preferences under certain circumstances. This threshold for making a guardianship decision that ‘overrides’ the person’s will and preference is set out in the section 9 of the Guardianship and Administration Act:

Section 9. Decision-making principles

1) A person making a decision for a represented person must have regard to the following principles—
   (a) the person should give all practicable and appropriate effect to the represented person's will and preferences, if known;
   (b) if the person is not able to determine the represented person's will and preferences, the person should give effect as far as practicable in the circumstances to what the person believes the represented person's will and preferences are likely to be, based on all the information available, including information obtained by consulting the represented person's relatives, close friends and carers;
   (c) if the person is not able to determine the represented person's likely will and preferences, the person should act in a manner which promotes the represented person's personal and social wellbeing;
   (d) if the represented person has a companion animal, the person should act in a manner that recognises the importance of the companion animal to the represented person and any benefits the represented person obtains from the companion animal;
   (e) the represented person's will and preferences should only be overridden if it is necessary to do so to prevent serious harm to the represented person.
2) In this section, "represented person"—
   (a) has the meaning given in section 3(1); and
   (b) includes a missing person for whom an administration (missing person) order has effect.

Both the Medical Treatment Planning and Decisions Act section 61 and the Guardianship and Administration Act section 9 provide guidance about what a substitute decision maker needs to consider and the scope of their legislated ability to make a decision that falls outside of the person’s will and preference (or ‘preferences and values’ as relevant).

OPA considers that these provisions (applied appropriately) promote the human rights of persons subject to substitute decision making under these acts. In the absence of such

[16] Ibid s 63.
[17] Ibid s 61 “Decision by medical treatment decision maker”.

provisions, it is unclear how substitute decision makers should make the necessary decisions and this leaves people more likely to be subject to paternalistic or 'best-interests' decisions that do not sufficiently promote their rights to self-determination.

OPA recommends that the panel consider the human rights benefit of making this type of legislative amendment to the new Mental Health and Wellbeing Act. Such legislative guidance could promote the self-determination opportunities available to people subject to compulsory treatment. The panel would need to consider what the appropriate threshold for overriding a person's will and preferences would best align with the intent of the Act.

Recommendation 1
The legislation should include decision-making principles that accord with the purpose of the Mental Health and Wellbeing Act, to promote the self-determination of people subject to compulsory treatment and limit the circumstances where a person's will and preferences can be overridden.

5.2. Documenting substitute decisions

OPA supports the position that all substitute decision-making regimes should be subject to safeguards which ensure the rights and safety of the people subject to these regimes. As a general principle, the decisions of substitute decision makers should be clearly justified, transparent and reviewable.

To enable safeguarding in relation to substitute decision making, decision makers should be required to document their decisions and how they complied with the relevant legislative framework. As discussed above, guardians and medical treatment decision makers both have [18] OPA guardians have been documenting their decisions for many years, and with the introduction of the new decision-making principles in the 2019 Act, the organisation has put much thought into how to most clearly document how guardians' decisions align with these principles. OPA staff making 'last resort' medical treatment decisions document the basis for their decisions with reference to the considerations required of them under the act.

OPA suggests that the panel consider, in concert with the inclusion of decision-making principles or similar, recommending that authorised psychiatrists acting as substitute decision makers be required to keep records that demonstrate their compliance with these new decision-making principles. This would enable independent advocates and/or lawyers to better advocate for people and ensure that substitute decisions are made using this new human-rights promoting, decision-making framework. OPA's experience with the Community Visitor Program, which visits residential mental health facilities among other supported residential settings, demonstrates the safeguarding benefits of having access to documentation that provides insights into service standards and practices.

Recommendation 2
Safeguarding around substitute decision making should be strengthened by requiring authorised psychiatrists to keep records documenting the rationale for treatment decisions, including whether the decision was a substitute decision or the person provided consent.

5.3. OPA's published positions on compulsory treatment

OPA's report Decision Time (2021) includes a chapter on Mental Health which includes a 'principles' discussion of some of the topics raised in this consultation paper. This section will highlight three recommendations from Decision Time that are most relevant to the questions posed in this paper.

[18] *Guardianship and Administration Act 2019* (Vic) s 9; *Medical Treatment Planning and Decisions Act 2016* (Vic) s 61.

Recommendation 3
Where necessary, state and territory governments should amend their mental health laws to ensure that only people who lack decision-making capacity in relation to the treatment of their mental illness can be subject to compulsory treatment and detention.

Recommendation 4
State and territory governments should introduce legislation to empower personally appointed substitute decision makers to make treatment decisions for individuals on compulsory mental health treatment orders if the individual does not pose a serious risk of harm to others. This power should extend to tribunal-appointed substitute decision makers whom the person would probably have wanted to make those treatment decisions.

Recommendation 5
State and territory governments should legislate to ensure that people are not subject to compulsory detention under mental health legislation for more than 14 days without tribunal approval.

Further, OPA stated that:

'Reform in this complex area must stem from [these] basic principles:

- Clinicians and others must be required to ensure that all reasonable steps are taken— including delaying treatment where it is safe to do so—to enable the person to make their own treatment decisions and support them in doing so.
- If a person has the ability to consent to treatment that ability should be respected, even in compulsory setting.
- The role of any substitute decision maker must be to make the decision the person concerned would probably make themselves were they able to do so.
- Substitute decision makers must not be put in the position of being asked to make decisions that have as their primary aim the protection of other members of society.
- The nature of many mental illnesses is such that objections to substitute consent are far more common than is the case with general medical treatment. For that reason, OPA supports the position of the VLRC: only individuals who have been personally appointed (or appointed by a tribunal on the basis that the individual would probably have appointed them had they been able to) should be able to make substitute mental health decisions in a compulsory context…
- It is necessary to acknowledge the need for and facilitate emergency treatment in order to save lives at times of acute crisis.'[19]

6. Improving alignment of substitute decision-making legislation

As a result of OPA's position in the State's substitute decision-making frameworks for medical treatment, OPA has noticed an anomaly in relation to non-mental health, medical treatment decision making for patients (under the mental health acts – current and pending). OPA has raised concerns about the mismatched substitute decision-making frameworks for this narrow cohort of people before. For example, in OPA's Submission to the Royal Commission into Victoria's Mental Health System (2019) it was noted that:

> "While both the … [Medical Treatment Planning and Decisions] and the Mental Health Acts determine a hierarchy of persons that can make medical treatment

[19] Office of the Public Advocate, *Decision Time: Activating the Rights of People with Cognitive Disability* (2021) p.80 <https://www.publicadvocate.vic.gov.au/opa-s-work/research/141-decision-time>.

> decisions on behalf of someone else who is unable to make the decision themselves, the hierarchies do not match… OPA considers that, by failing to replicate the hierarchy of the [Medical Treatment Planning and Decisions] Act, the Mental Health Act excludes persons (i.e. natural and informal support people) who could be appropriate to act as medical treatment decision makers. In this way, the Mental Health Act imposes unnecessary limitations on persons who lack decision making capacity."

OPA notes that the Mental Health and Wellbeing Act has altered the hierarchy (discussed above) from that set out in the Mental Health Act 2014 to now include unappointed medical treatment decision makers. OPA considers this to be an improvement. However, there still exists an unexplained misalignment in substitute decision-making frameworks applying to people who require a decision in relation to medical treatment (excluding compulsory mental health treatment decisions) based on whether or not they are a 'patient' (under the relevant mental health act).

The following table details the implications of these frameworks: that set out under the Medical Treatment Planning and Decisions Act and that set out under the Mental Health (or Mental Health and Wellbeing) Act. Note that this discussion does not seek to change the substitute decision-making framework that relates to compulsory mental health treatment, just clarify what happens when a non-mental health, medical treatment decision needs to be made for a 'patient'.

Table 1. Substitute decision making about medical treatment: Compulsory patients vs everyone else

	Patients	Everyone else
According to legislation, who should make Mental Health Treatment decisions for a person without decision-making capacity for the decision at hand?	The authorised psychiatrist under the Mental Health Act (or, post September 2024, under the Mental Health and Wellbeing Act).	The person's medical treatment decision maker (as determined by section 55 of the Medical Treatment Planning and Decisions Act). If no medical treatment decision maker is identified by this hierarchy, and no relevant advance care directive exists, 'significant' treatment decisions are made by the Public Advocate in accordance with section 63 of the Medical Treatment Planning and Decisions Act. Medical treatment decisions that are considered 'routine' do not require consent and treatment can be administered by the medical practitioner.
According to legislation, who should make medical treatment decisions for a person without decision-making capacity for the decision at hand?	Sections 74 to 76 of the MHA govern medical (non-mental health) treatment decision making. Section 75 states that medical treatment decisions for an adult should be made by: • The patient's **appointed** medical treatment decision maker • a person appointed by VCAT to make their medical treatment decisions • their guardian, where they hold medical treatment decision-making power, or • the authorised psychiatrist. In that order.	See above – where a person is not a patient, the Medical Treatment Planning and Decisions Act does not differentiate between medical and mental health treatment decisions.

	The upcoming 2022 act replicates this hierarchy of medical treatment decision makers in section 92, with a slight improvement. • 'the patient's medical treatment decision maker' (defined in accordance with section 55 of the Medical Treatment Planning and Decisions Act) could make medical treatment decisions **without** having to have been explicitly appointed by the person.	
What human rights promoting guidance is provided to substitute decision makers making **medical treatment** decisions?	The Mental Health Act (and the Mental Health and Wellbeing Act) ONLY provide decision-making guidance to the **authorised psychiatrist** (section 76 in the Mental Health Act and the slightly different section 93 in the Mental Health and Wellbeing Act). No guidance, or basis for substitute decisions, is provided to medical treatment decision makers who are not the authorised psychiatrist.	Section 61 of the Medical Treatment Planning and Decisions Act says that the medical treatment decision maker 'must make the medical treatment decision that the medical treatment decision maker reasonably believes is the decision that the person would have made if the person had decision-making capacity'. It also provides guidance as to how this outcome should be achieved and, importantly, how to make a decision when the decision maker cannot discover the person's values and preferences.
What safeguards are available to the person?	There is no process or grounds to challenge the medical treatment decisions made for patients by the substitute decision maker.	A decision by the person's medical treatment decision maker to refuse significant treatment can be challenged via a process that involves the medical practitioner, the Public Advocate and VCAT. (Part 4, Divisions 2 & 3.)

OPA finds that the current two-track system for people requiring a medical treatment decision that currently exists, and will continue to exist under the 2022 Act, is unnecessary and unhelpful. As identified in the table above:

- no decision-making principles are provided to medical treatment decision makers (except Authorised Psychiatrists) who are making medical treatment decisions for compulsory 'patients'
- no safeguarding framework applies to these sorts of substitute decisions when they are made for patients under the mental health regime.

In OPA's practice experience, Authorised Psychiatrists would often prefer not to be making non-mental health, medical treatment decisions. In some cases, this has resulted in a mental health service seeking the appointment of a guardian to make medical treatment decisions for a compulsory patient.

Recommendation 6

All medical treatment decisions should be made by medical treatment decision makers, irrespective of whether the person concerned is subject to a compulsory treatment order. Where no appointed or appropriate substitute decision maker is available, OPA could be resourced to undertake this function.

If these laws were amended to leave all medical treatment decision making (excluding compulsory mental health treatment decisions) to the Medical Treatment Planning and Decisions Act, then the full framework of substitute decision making for a person who needs a medical treatment decision would be enabled. This would include the Public Advocate's power to make a 'significant' medical treatment decision for a person under the Medical Treatment Planning and Decisions Act (section 63) without the need for a guardian to be appointed. This extremely time-limited and decision-specific substitute decision-making regime is a less restrictive option than guardianship, which people are regularly subject to for months (if not years) at a time.

An additional benefit of improving the alignment of medical treatment related substitute decision-making laws is that it would simplify community education efforts, and, more importantly, provide decision-making principles that are more clearly aligned with modern human rights laws.[20]

[20] *Medical Treatment Planning and Decisions Act 2016* (Vic) s 61.

Appendix A: Decision by medical treatment decision maker

Medical Treatment Planning and Decisions Act, section 61.

(1) A medical treatment decision maker who is making a medical treatment decision on behalf of a person who does not have decision-making capacity in respect of that medical treatment must make the medical treatment decision that the medical treatment decision maker reasonably believes is the decision that the person would have made if the person had decision-making capacity.

(2) To make a decision in accordance with subsection (1), the medical treatment decision maker must do the following—

(a) first consider any valid and relevant values directive;

(b) next consider any other relevant preferences that the person has expressed and the circumstances in which those preferences were expressed;

(c) if the medical treatment decision maker is unable to identify any relevant preferences under paragraph (a) or (b), give consideration to the person's values, whether—

(i) expressed other than by way of a values directive; or

(ii) inferred from the person's life;

(d) also consider the following—

(i) the likely effects and consequences of the medical treatment, including the likely effectiveness of the medical treatment, and whether these are consistent with the person's preferences or values;

(ii) whether there are any alternatives, including refusing medical treatment, that would be more consistent with the person's preferences or values;

(e) act in good faith and with due diligence.

(3) If the medical treatment decision maker is unable to apply the process required by subsection (2) because it is not possible to ascertain or apply the person's preferences or values, the medical treatment decision maker must—

(a) make a decision under subsection (1) that promotes the personal and social wellbeing of the person, having regard to the need to respect the person's individuality; and

(b) consider the following—

(i) the likely effects and consequences of the medical treatment, including the likely effectiveness of the medical treatment, and whether these promote the person's personal and social wellbeing, having regard to the need to respect the person's individuality;

(ii) whether there are any alternatives, including refusing medical treatment, that would better promote the person's personal and social wellbeing, having regard to the need to respect the person's individuality;

(c) act in good faith and with due diligence.

(4) In the case of either subsection (2) or (3), the medical treatment decision maker must also consult with any person who the medical treatment decision maker reasonably believes the person would want to be consulted in the circumstances.

(5) A contravention of subsection (1), (2), (3) or (4) does not, of itself, result in any civil or criminal liability on the part of the medical treatment decision maker.