Dr K Pearson

May 16, 2011

Prof Neil Rees
Chairperson
Victorian Law Reform Commission
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Dear Prof Rees

Submission to Review of Victoria's Guardianship and Administration laws

As a practising Geriatrician, current President of the Victorian Division of the Australia and New Zealand Society for Geriatric Medicine, and a person who has contributed to previous submissions (both personally and on behalf of our Society), I wish to submit the following comments related to your current Consultation Paper. Our Society has had the opportunity to contribute to the process with a face-to-face consultation meeting between yourselves and some of our interested members.

This submission is based on my opinion and does not purport to represent the range of opinions held by members of our society, some of whom will make their own submissions. This submission is based upon a lay reading of the current legislation and consultation paper – I do not have a legal background. Given that many of the questions are complex and detailed (and many could be the potential subject of several PhD theses), I have erred in favour of giving more detailed answers in areas of experience. When uncertain as to the full implications of proposal, this has been indicated. I have used abbreviation "PoA" for Power of Attorney.

1.Overall I find the Consultation paper to be thorough and well considered with detailed analyses of the options. Victoria currently already has an excellent system in place and it is important that the strengths are not lost. However, the current legislation is outdated and unhelpful in many areas.

There are some areas where further detail and clarification would be appreciated:

- How the proposed new legislation aligns with and, particularly, will be recognised in other states. I strongly support clear processes around national recognition of appointments and orders. People and families are mobile around Australia, and indeed overseas. Their interests, particularly financial, may cross borders and authority becomes difficult across different jurisdictions.

- Although further detail and definition is provided regarding capacity, it is not clear who and how this will be determined. Health professionals (particular medical and neuropsychology) may be in a position to provide an opinion regarding capacity, but it is my understanding that the ultimate test of competence is a legal test. The proposed wording provides definitions and tests which set the foundation for a common language across legal and medical fields. However, no direction is provided

regarding their respective roles, including the role of the courts. Given that (medical and/or legal) assessment procedures will inevitably be required in some cases, any clarification regarding the model for this would be appreciated. An example of the complexities is where a person lacking capacity is thereby unable to give informed consent to enter into (and be financially responsible for paying for) a capacity assessment.

- Consider reviewing in more depth and detailing possible informal models ("less restrictive") if these are still appropriate in some circumstances.

- Consider recommending expert advice or second opinion as one aspect of these informal approaches. Fully competent adults frequently use this strategy to assist in decision making (eg. Seeking financial advice or requesting a second medical opinion), and empowering those who are more vulnerable could assist. The result could be: a more thoroughly assessed situation; better documentation of the process; reinforcement of recommendations; reducing conflict or differing opinions etc.

2. Consider replacing "protect their inherent dignity" with "have their wishes upheld" or "have their best interests represented". "Dignity" already used in first sentence. Part of the purpose of the laws is to provide a mechanism for representation.

3 Yes. Principle of presumption of capacity fundamental.
4. Should include "right to choose representation (appoint an agent)" in this list. Whether statements about context (culture, linguistic background, family, other supports) should be listed separately is not clear. Seems to be covered by "right to communicate in any way"; "entitled to support"; "have wishes and preferences that ... inform decisions".

5. Should be aligned and streamlined. Unable to comment regarding best format for legislation.

6. Should be changed. Consider "Medical guardian" to align with proposed terms for Guardians and Administrators.

7. Prefer "Personal guardian" for Guardian. Don't like "Adult Guardian", as it seems to imply only that the person appointed as Guardian is an adult.

8. Consider: "Financial guardian" for Administrator. Then all three would be aligned: "Medical Guardian"; "Personal Guardian"; "Financial Guardian"

9. Yes. To align: "Medical PoA"; "Personal PoA"; "Financial PoA". "Enduring" not a particularly helpful term to lay people – perhaps could be used as a secondary label.

10. No, but it needs to be done! See also 11.

11. I think Fact Sheets and website are very good resources which are authoritative, accessible and align understanding. Obviously would need updating with new laws. Cautious about Public Advocate expanding role in multiple directions, as overloaded. Professional bodies (for medical; legal; other health professions etc) would have to take a role for these groups.

Community groups more difficult, and ideally would be co-ordinated somehow, perhaps "train the trainer" type models to improve consistency of information presented. Groups like University of the Third Age; Council for Adult Education; Probus; Rotary; Community Health Centres etc. could run information sessions. These groups would have slightly different

approaches and models to organising sessions, but all could use the resources from the Public Advocate.

12. Yes. See Q11.

13. If appointments registered, it would be straightforward to collect data about numbers of appointments and penetration through community. Demographic information may be more difficult. Any registry would need to have guidelines around safeguarding privacy of information but should allow de-identified access to certain types of information to inform public policy; allow some quality-assurance measures and facilitating research.

14-16. Although I support the concept of supported decision making, I think that have multiple levels of authority will result in more confusion, not less. The "cut-off" between the various levels will always be open to debate – there is in fact a continuum.

I wonder how models of supported decision making in place in other jurisdictions could inform Victoria's model.

I suggest that the current concept of "informal arrangements" could be further defined and expanded.

Another model would be for personal appointments to become active immediately (rather than once true incapacity is reached) and could thereby confer the ability for the appointed person to act immediately or at some future time as a supporter and/or co-decision maker and/or attorney. This would reflect the reality that:

- the appointed person is trusted by the donor
- there is a spectrum of complexity of decisions to be made (across a continuum)
- there is a spectrum of possible levels of involvement (from independent through to support; through to co-decision making; to substitute decision making).
- Capacity may fluctuate
- Most capable adults are influenced in day-to-day decision making by people around them, particularly people they trust – options are discussed, weighed, supported etc – making it artificial to believe that we always act truly independently.

This option would allow a single appointment and a single document to represent a spectrum of authority. It could be seen as analogous to making someone a signatory to your bank account: that person instantly has authority to complete a transaction, and may result in that person completing a variable number of transactions. For example, they may complete only 1% of the transactions on that account or, in some circumstances may complete most of the transactions on that account. This occurs currently, with essentially no formal system of oversight.

17. Yes
18. Yes, in regard to resources. Not necessarily with regard to provision of training (hugely expanded role for Public Advocate will become unwieldy). Difficult to expect monitoring, but role for VCAT where any occasions of concern re persons undertaking this role, eg misuse.
19. Unclear to me whether this is desirable.

20. Yes. However, see qualifying comments under questions 14-16.
21, 22. See answer to Q 18. See also Federal parliamentary committee report "Older people and the law" conducted by the House of Representatives Standing Committe eon Legal and Constitutional Affairs, published September 2007.

23. Uncertain. However, see comments from Q14-16 re gradation of activation.

24. Yes.
25. Yes.

26, 27. No. Although some merit in reducing, there are safeguards in having separate appointments in some situations. It is not intuitive that a person appointed as Medical Power of Attorney should also receive guardianship rights. May discourage appointments of Med PoA if donors thought that resulting authority would be too broad. Presently we are encouraging everyone to appoint a Medical PoA, in case required. Appointing a Power of Guardianship role is currently uncommon (vanishingly rare), and requires a significantly greater "leap of faith".

28-33. Registration appears to be a sensible and appropriate next step as our system matures. The problem of not being able to determine whether a person has previously made personal appointments creates a difficult situation.

However, the complexities of funding and administering such as system should not be under-estimated. Online registration is logical, but the pitfalls of the multiple software systems involved in health records (for example) demonstrate that it is far from straightforward.

34-37. Very complex, especially given my suggested model of graduated activation, which may entail activation at the time of appointment. Interested to know whether there are any jurisdictions in which notification of activation has been trialled or introduced.

38. Uncertain. There is some merit in the current situation of having "advanced directives" as a "statement of wishes or choices", providing guidance and reflecting wishes but not being legally binding. Protection added by having appointed a Medical PoA to act as an advocate.

39-40. Difficult to see how this could work. Appointment of a Power of Guardianship plus some sort of "statement of wishes" may be most workable.

41-45. Preference for "statement of wishes", not legally binding.

46-49. Do not support this. This type of document of most use if a copy is recorded by usual treating doctor/healthprofessional/hospitals, as well as by Medical PoA. This type of document is generally less formal (format and wording) and more likely to evolve over time, requiring updating. These features do not fit well with registration.

50. Prefer Option B. Do not support "physical disability" being included in this list of criteria.

51. Merit in including both Option A and Option B.

Further complexity in definition of capacity is exemplified by a situation when a person seems able to <u>state</u> reasoned answers but unable to <u>act</u> upon them. For example a person at home who has become bedridden, incontinent and unable to toilet. This person may state that they would go to hospital or residential care if they were unable to care for themselves; yet when presented with that exact situation, refuse to leave their home.

52. Support Option B. There are some people in a situation where they have ongoing incapacity but uncertain future needs. Anticipatory appointments avoid crisis and emergency applications.

Even when applying the "Person Responsible" hierarchy, not all medical situations/decisions are able to be covered, as it may not be possible to find the person highest in the list in a timely fashion. Equally the person highest in the hierarchy may not be an appropriate person to be involved (they may have disability of their own; they may not have a significant relationship with the person etc.).

53-54. No opinion.
55. Yes – maintains safeguards in some situations.

56. Support all suggestions.

57. The current "system" (even if not legislated) seems to work well (at least from point of view of health professionals). Unless an independent person is appointed in these situations, can come to an impasse and/or be open to criticism. When an independent person is appointed, the onus is for them to work with all parties, attempting to develop understanding of complex situations while at all times being an advocate for the represented person.

58-61. Certainly legislation needs to be much clearer in listing or describing decision making powers. The current wording is vague and circular. Terminology "plenary" and "limited" not intuitive and difficult for lay person. Mechanism uncertain: attempts to list will certainly be non-exhaustive, so perhaps description more appropriate. Examples help to clarify, but perhaps difficult to include in legislation. Examples could be included in educational resources.

62. Drivers licence: Yes- it can be very difficult to manage the situation of incapable person continuing to drive unsafely, being unable to consent to driving assessment. They will often not have the insight to cease driving or forgo their licence. Continuing to drive has legal, lifestyle and possibly health implications which they are not competent to understand. It is not just the matter of having a current license that is the issue: the guardian may have to take steps to ensure a vehicle is not driven eg. Remove the keys or disable the car.

Will: No.
Organ donation: uncertain.

63. Yes
64. No opinion.
65. Yes.

66-67. Uncertain.
68-69. Yes. Unfortunately occasionally necessary eg. Ambulance transport.

70. Yes.
72. Yes.

73. No, can't see that this would be workable.

74-78. Unable to comment about situation for younger people, but with regards to residential aged care, there appear to be adequate processes for the vast majority, as well as safeguards. Current processes involve assessment by ACAS, and frequently involve input from health professionals (including medical, social work, nursing, case managers etc) as well as oversight from family members/carers/friends and from the admitting facility. Current safeguard is primarily appeal to VCAT if there is conflict that can't be resolved. Option C appears unworkable and to provide poor "sensitivity" (using a statistical term) ie. Huge

throughput/workload of cases to potentially detect a very small number of cases where the outcome is altered by the assessment process.

79. Yes
80. Yes
81. Yes
82. Any distinction would have to be practical to define. Terminology such as "invasive" might be helpful to distinguish. NSW terminology of "high level" of risk not supported. This implies that a procedure needs to be very risky to be considered major. A major treatment would be one with any "significant risk" in relation to death, brain damage, paralysis, scarring etc.
83. Probably yes to both.
84. Yes. Consider recommending a second opinion in this situation.

85. Yes. Current legislation is heavily weighted in favour of researches at odds with person's human rights. Should be much more aligned to medical treatment, if not even more conservative threshold for giving permission for research.
86. Substituted decision making including factors such as "what are the risks and benefits" and "would the person have chosen this for themselves".

87. Agree with principle but uncertain whether should be legislated.
88. No, but suggested revisions especially Option A for Q51 provide this.
89. Probably.
90. Yes.
91. Yes.
92. Yes.
93. Difficult to legislate for this!
94-96. Uncertain.
97. Yes, but may be difficult in practice.
98. Yes.

99. Uncertain.
100. Probably.
101-104. Uncertain.
105. Yes.
106. Yes.
107-110. Uncertain.

111-117. Uncertain

118-121. Uncertain as to detail. However, the power (and therefore responsibility) to "investigate any complaint or allegation" seems to be onerous and unwieldy. I would suggest that this responsibility may become akin to that of Dept of Human Services with regard to child protection – huge demand with associated difficulty covering the expected functions and response times.

122. Uncertain.
123-126. Yes.
127-129. Uncertain.
130. Yes.
131-132. Uncertain but again, appears unwieldy.
133, Should be VCAT?
134. Yes.
135. Uncertain re: scope, but proposal could help demystify and ensure hearings better prepared and informed.

136-137. Uncertain.

138. Don't see how this would be workable – see comments on Qs 14-16. Would have thought support or co-decision making appointments should be personal appointments not orders. If a substitute decision maker is appointed, they should be obliged to consult with the represented person (encourage participation), as well as use substituted judgement processes.

139-141. Uncertain.
142-144. Yes.
145-148. Uncertain.

149. Yes. This is also an issue for personal appointees – sometimes third parties have difficulty recognising the authority of an Enduring PoA.

150. Appears unwieldy in most cases (cost), however, would be useful mechanism for difficult cases (including perhaps re-hearings) and as a training and quality assurance tool (learning from each other).

151. Strongly support informal approach to hearings – needs to be accessible.
152-153. No.
154-155. Uncertain.

156-157. Uncertain.
158. Yes.
159. Uncertain.

Thank you for the Commission's work to date and for the opportunity to be involved in the process.

Yours sincerely

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