1.	Expanded role of the Public Advocate. Seems to be a gap at present. Greater capacity for objective follow-through measures. Consideration needs to be given to the fact that the population is ageing, and this may place greater demands on the role of VCAT to determine Decision Making Capacity and need for a Substitute Decision Maker (SDM). As such, laws and VCAT processes need to be simplified.
2	Yes. Entirely with all parts. The statement of purpose is good and clear – in reality may be difficult to follow through and protect dignity with scarce resources in our current service system.
3	Yes. More information required about "substituted judgement" – will need guidelines and processes that are consistent to ascertain what a clients wishes may have been retrospectively.
4	The principles are focused on autonomy and participation. However, consideration needs to be given to the fact that some decisions go against the person's wishes, but is necessary for safety and minimisation of harm – there needs to be a balance between these two demands.
5	Yes
6	No. Medical decision maker and Health decision maker are too closely aligned. Potential ambiguity resulting from terminology. This may need to be broken down into more specific domains. Preference is for use of 'medical decision maker' as it is clear about the types of decisions that this SDM can make. The term 'health' is more ambiguous.
7	Retain the term 'guardian' or use 'personal guardian' (not adult guardian). Retain 'administrator' or use 'financial manager' for consistency and clarity The term 'guardian' should not be used for both types of powers as it is confusing.
8	As above
9	Yes
10	Medical professionals (consultants, Reg, Interns) would benefit greatly from more education regarding medical guardianship and in particular section 42K. Regular forums in the hospital setting would greatly assist with this. The public needs to be better informed about Guardianship and Administration, particularly about the powers (conflict can arise in hospital for example when family members believe they can make all decisions with a financial EPOA), and about the role of VCAT when capacity is questioned. Community education: via community groups (i.e., Probus, Rotary), all patients provided with information on admission/discharge from hospital Specialist lawyers trained in these areas Greater public advocate involvement in education is recommended
11	Yes – community legal centres/lawyers may also be of assistance, also G.Ps
12	Yes
13	Effectiveness of decisions made about appointments. Retrospective review of decisions. Recurrence of problem that lead to VCAT application. Feedback from professionals about time frames and views regarding effectiveness of appointments. A register of personally appointed guardians and administrators is recommended and monitored by OPA / VCAT KPIs on timelines would assist in monitoring delays
14	Ambiguous – who determines when this is required, when a person has 'some capacity' and in what circumstances etc?
15	Agree with Personally appointed "supporters" and co decision makers.

16	Some assessment or judgment needed to indicate that the person has some capacity to understand the significance of co-decision makers or supporters and that co-decision makers or supporters are appropriate for the role.
17	No 17-19 A supporter needs to be appropriately trained particularly given the nature of some of the decisions to be made (the use of volunteers therefore is problematic).
18	As above
19	As above
20	Limited to personal decision making
21	Yes. Undertake a background check, police check, assess basic competence to undertake role
22	Use of referee to vouch for supported person's credibility ?family meeting if appropriate A register may help protect people against abuse. Monitoring may be too heavy-handed and time consuming for most people where EPOAs are appointed in good faith Private guardians and attorneys should to have to lodge periodic reports however, guidelines about reporting alleged misuse/abuse should be clearer
23	Enduring Powers should be activated when person who made the appointment becomes incapable. All powers should not be enacted at the same time; only when person is no longer able to make specific types of decisions. As a safeguard, the SDM could provide justification to VCAT about why they are now enacting the power (i.e., evidence of risk)
24	Yes
25	Yes
26	Yes Reduce the three powers to only two. One type of appointment with range of powers is problematic as it can be ambiguous and can result in greater conflicts within families
27	Yes Reduce the three powers to only two. One type of appointment with range of powers is problematic as it can be ambiguous and can result in greater conflicts within families
28	Yes Registration should be compulsory for accountability if problems arise. The register should be managed by VCAT and if access to the register is required, a request should be made to VCAT (i.e., if a hospital needs to confirm an EPOA for instance)
29	OPA Registration should be compulsory for accountability if problems arise. The register should be managed by VCAT and if access to the register is required, a request should be made to VCAT (i.e., if a hospital needs to confirm an EPOA for instance)
30	Should be compulsory. At present the process is very unclear and does not appear to be a great deal of accountability. Registration should be compulsory for accountability if problems arise. The register should be managed by VCAT and if access to the register is required, a request should be made to VCAT (i.e., if a hospital needs to confirm an EPOA for instance)

31	Unregistered appointments would not be valid Registration should be compulsory for accountability if problems arise. The register should be managed by VCAT and if access to the register is required, a request should be made to VCAT (i.e., if a hospital needs to confirm an EPOA for instance)
32	At time of appointment Registration should be compulsory for accountability if problems arise. The register should be managed by VCAT and if access to the register is required, a request should be made to VCAT (i.e., if a hospital needs to confirm an EPOA for instance)
33	OPA, VCAT Registration should be compulsory for accountability if problems arise. The register should be managed by VCAT and if access to the register is required, a request should be made to VCAT (i.e., if a hospital needs to confirm an EPOA for instance)
34	Yes
35	Yes
36	Legal representatives may be involved
37	Yes
38	Yes
39	Yes Other than medical treatment, it is problematic to make statutory instructional directive (i.e., about not going to a nursing home, when it is clearly required)
40	Accommodation; residential care; formal support services Other than medical treatment, it is problematic to make statutory instructional directive (i.e., about not going to a nursing home, when it is clearly required)
41	Not binding but appointed decision maker should consider Wishes should not be binding – again, some wishes need to be overturned by SDM if the person is at risk (e.g., return home unsafely versus supported accommodation). However, if a person has consistently stated a wish, greater weight and attempts should be made to uphold this wish. Changes to wishes do not need to be in writing, but the person should have the opportunity to express the reason for changes to wishes. The SDM can be allowed to override wishes, but should be governed by external authority, however VCAT may be over-used in this instance; consider alternative authority.
42	Yes Wishes should not be binding – again, some wishes need to be overturned by SDM if the person is at risk (e.g., return home unsafely versus supported accommodation). However, if a person has consistently stated a wish, greater weight and attempts should be made to uphold this wish. Changes to wishes do not need to be in writing, but the person should have the opportunity to express the reason for changes to wishes. The SDM can be allowed to override wishes, but should be governed by external authority, however VCAT may be over-used in this instance; consider alternative authority.
43	Yes, should be possible to override. VCAT should perform this role - when clearly the person's interests will be compromised.

44	Yes
45	Yes, formal review of reasons for overriding of instructional direction.
46	Yes
47	Yes
48	Voluntary
49	All advanced directives should be registered. Issues around privacy need to be considered and managed, however registration allows for consistency and cross checking.
50	Yes Retain current criteria, but define disability as a 'cognitive' and irreversible disability
51	Yes. – Professional opinion; support. Option B is the preferred option. Guidance about decision making to be provided by specialised medical team (i.e. Geriatrician) and Neuropsychology
52	Yes
53	No? Retain Option A otherwise there are two distinct age groups that require double expertise in terms of decision-making capacity assessments (ie. Child vs adult specialty) To remain in line with other government entities and available services, age to remain 18 years
54	Yes
55	Yes. Option B could work. Powers should remain distinct. Allow dual appointments but not restricted to dual appointments
56	Yes. Points 1,2,3,4
57	Yes Choosing between family members cannot be prescribed by law due to complexity and uniqueness of each family
58	Yes Yes – list of powers. Current powers to remain
59	Lifestyle, accommodation, future care, formal/informal support services
60	All financial day to day; property
61	
62	No. A medical/allied health professional should make decisions about holding a drivers licence. Wills and organ donation should not involve decisions by guardians/administrators.
63	No, however provisions should be further clarified
64	No to all
65	No to all
66	A specialist agency should be established to act as a litigation guardian when one is required.
67	No

68	This may depend on how you interpret the term "force"
69	Yes
70	Yes
71	
72	Yes
73	Yes. Involvement of a third party, eg. Public Advocate
74	No need for specific laws if person lacks capacity, but all in agreement (or no objection) to placement in residential care. Laws will be too heavy handed especially if no conflict
75	Yes
76	Yes
77	No
78	Residential aged care (high and low), SRS, CRU
79	Yes
80	
81	Yes – this may assist with accessing rehabilitation. These procedures may rely heavily on the person participating. Also, naturopathy and Chinese medicines may not be "within a person's belief system" and therefore may not be in the person's best interest.
82	No 82 -84 Medical decisions should be separate from guardianship. Minor or major procedures should be clarified. Ultimately, medical staff practitioners should be able to carry out major procedures if there is no SDM available if it is in the person's interest (i.e if the treatment will enhance health or keep a person alive etc). Person responsible list should be changed to spouse/partner, then to other family members before the primary carer (where this person is not a family member)
83	No
84	Yes
85	Yes
86	
87	Yes
88	Yes
89	Yes
90	Just one guiding principle
91	Yes
92	Yes
93	Yes
94	Yes
95	
96	No
97	Yes
98	Yes
99	Yes A register may help protect people against abuse. Monitoring may be too heavy-handed and time consuming for most people where EPOAs are appointed in good faith Private guardians and attorneys should to have to lodge periodic reports however, guidelines about reporting alleged misuse/abuse should be clearer
100	Yes
101	OPA or a specialist agency (legal agency?)

102	Yes
103	Yes
104	OPA
105	Yes
106	Yes 106-110 Penalties should exist for misuse/abuse of powers. However, proof has to be very clear of misuse particularly when the opinions about the appropriateness of a decision/action can be varied and where family conflict/dynamics is an issue
107	Theft; misappropriation
108	Yes
109	Yes
110	Yes
111	Yes May be useful to permit merit reviews for private appointments as well as circumstances can often change over time.
112	The represented person and people with a special interest in the affairs of the represented person (including professionals involved in represented persons care)
113	Sale of property and assets, lifestyle decisions and accommodation (as poor financial management can impact on access to appropriate accommodation and services that a person may need). A decision that has a great impact/adverse affect on those people with a special interest in the affairs of the represented person.
114	A dedicated review 'hotline' for interested parties to gain advice about whether a situation warrants review. Perhaps through OPA. Clear guidelines – perhaps indicating a minimum amount of applications for reviews allowed each year (unless extreme circumstances).
115	No
116	Guardianship List of VCAT, before a senior tribunal member. A specialist guardianship review list (with specialist training in the area and senior members).
117	Yes
118	Yes
119	Yes
120	Yes
121	Yes
122	Yes
123	Yes
124	Yes
125	Yes
126	Yes
127	Yes – or to organize training under their oversight
128	Yes, should have capacity to monitor all
129	Given sufficient warning of any monitoring activities, eg. Visits, documentation of key decisions and their availability for review / audit if cause for such action is deemed necessary. Yearly meetings with the guardian and represented person would be good and may ensure accountability. A yearly report may not be sufficient in all cases (as this could be misleading).
130	Yes
131	Yes

132	To enquire and when deemed necessary to investigate
133	Yes
134	Yes
135	Yes, should have capacity to monitor all
136	Yes
137	Agree to option A and B only
138	To enquire and when deemed necessary to investigate. Yes.
139	Yes
140	Initial orders should be reviewed within 12 months and continuing orders every 3 years unless otherwise indicated by the represented person or interested parties.
141	Yes
142	Yes 1420-143 Any psychological reports (including neuropsychological) should NOT be released to any other party at VCAT hearings and should only be made available to the member who is hearing the case. This is because psychological reports contain sensitive and highly confidential information covered by the Privacy Act, and can also include information obtained from third parties who have not consented for that information to be made public. Relevant parties need to be aware that an opinion has been provided about capacity by a psychologist only. The background information that leads to a psychologist's diagnosis and opinion is highly confidential. Psychologists should NOT have to inform VCAT that the report is confidential, as all psychological reports are confidential and permission is required to release reports. Even if people themselves request their own reports, psychologists have a duty to meet with the person and explain the contents of the report to them, particularly if the report was not written for the person (ie. written for other medical and allied health staff, for GPs, etc). If reports are released to all attendees at the hearing (the person and family members, solicitors etc), these people do not have the expertise to interpret the content of the report accurately and there is concern that this may cause greater psychological distress to the individual and their families, as well as potential to increase the likelihood of conflict between family members. Similarly, release of reports also increases the potential for the reports to be misused (i.e., family members then trying to claim person lacks testamentary capacity for prior arrangements). Release of highly confidential psychological reports without permission, can potentially place the psychologist at risk of outcomes are considered unfavourable by the client or family, or if confidential and sensitive information is released in the public domain (i.e., sexual/physical abuse etc).
143	Yes
144	Closed with only parties involved having right of access
145	No
146	Yes
147	Yes
148	No
149	In a manner akin to the current arrangements. Informality: preference against professional legal staff attendance, opportunity for direct address by parties immediately involved.
150	Access to volunteers, appropriately skilled to accompany represented person. Option B – single member panels for initial hearings have shown great inconsistencies in decision making.
151	Access to VCAT Koori Liaison Officer. Location of VCAT hearings in more Neutral surrounds. Less formality with a therapeutic inclusive approach. Set up of the VCAT room is not great for group dynamics in general.

152	Increased hearings on location eg. At hospital sites, CRUs, SRS, Aged Care facilities. ? Availability of video conferencing – particularly for those people with interstate/overseas next of kin.
153	VCAT Koori liaison officer
154	Yes More written material written in different languages (on website) and CALD support workers at VCAT
155	Offices to be located in country areas with dedicated session times. Travel and associated expenses are an issue for regional Victorians. ICT may assist with this.