Response to the Victorian Law Reform Commission consultation paper

Individual submission

Dr Michael Murray - Geriatrician

Q 1

Change is needed. The system is complex and as an educator of General Practitioner Registrars in legal and age related issues for many years it is extremely difficult to teach and for the inexperienced to appreciate. A single act (or at the most 2) with clear, and as often as possible, unambiguous choices and options is required backed by community and advocate education and support with a single enforcement / investigative unit appropriately funded is required. It is my personal view that current capacity at all levels but most notably the Office of the Public Advocate (OPA) is inadequate with substantial delays and little apparent accountability regarding timeliness of service is evident. That said OPA with experience and appropriate clinical, social and ethical expertise is the agency of choice to support VCAT changes. A dramatically better funded OPA coupled with an ability to undertake local/regional investigations supported by robust community partnerships with mandated KPIs can make a real difference to an expanding population of need.

There is no such thing as age related disability. The term is ageist, and supports negative stereo typing of the elderly. If cognitive impairment (e.g. dementia / delirium) is the issue giving rise to the disability then it, not Age (acknowledged as a risk factor for many chronic health conditions) should be listed as the cause.

Q 2

Yes though one could argue that the first mention of delirium is unneccessary as it is inherent in a modern concept of human rights

Q 3

Yes

Q 4

No, general prinicples are adequate

Q5

Single act / option C

Keep it simple

Q6

The difficulty with option B is that it doesn't acknowlege the role of the individual in decisions made on their behalf. That said preference is for medical decision maker

Q7

Option B

Q8

Option B

Q9

Enduring added to the choice in question 7 and 8

Q10

Target and partner key special interest groups e.g. Carer groups, Alzheimer's association, U3A, disability special interest groups their web sites and chat rooms, Nursing in undergraduate training or advance eg Nurse Practitioner, course inclusion, via Residential Aged Care, Hospital e.g. Geriatric medicine trainees, Paediatrics, Pharmacists, GP practice Nurses home nursing services e.g. RDNS

Target online training eg state funded or supported eg partnering with development of sites such as "Legal Issues" at http://www.anzsgm.org/vgmtp/

Train professionals esp. at an undergraduate or junior trainee level e.g. Medical students, junior doctors, GP Registrars, young lawyers undertaking articles

Q11

Yes as part of their advocacy role

Q12

Yes esp. if the act was easier to understand

Q13

Hospitals routinely collect data. De-identified data could be arranged via Government / with some inducement to cover cost

GP data collection (compliance likely to be poor)

Q14

Yes but subject to

a/ Clarification of role e.g. FOI

b/ An escape clause see Q15

Q15

Difficult and potentially catch 22 but needs trialling. It is potentially different when a person has a progressive impairment e.g. dementia when quite quickly co-decisions may be difficult thus needs a fallback position where the appointed co-decision maker becomes the enduring decision maker if /

when an individual's decision making capacity is assessed as having declined to a point where they can no longer reliably be an equal contributor to the necessary decision. The decision re Question 19 may make the transition to full Decision maker potentially problematic with not everyone prepared to take on the extra responsibility esp. if volunteer

Q17

Yes

Q18

Yes

Q19

Yes

Q20

Needs to apply to all

Q 23

Yes

On the basis of need

Q26/27

This is currently messy and confusing to families and professionals

Ideally reduced to one, at very least to 2 esp. guardianship Vs medical

Q28

If it is to be registered it needs to be accessible in times of emergency e.g. hospital emergency departments with appropriate safeguards. Otherwise an expensive undertaking with a much greater need for education / awareness and transition arrangements to crack a relatively small nut (inappropriate use / abuse)

Q 38

Largely No

The system generally works well and peoples wishes often communicated via letter, via NOK are respected and taken into account.

Advanced directives are poorly used even where available and often are so rigid or broad as to be of very limited assistance to family / clinicians

Those who have strong feelings have usually already communicated these to their NOK or have EPOA – Medical (even if the situation is out of scope eg unforeseeable at time of writing / communicating with EPOA

End of life decision making needs to be supported but is still in practice very rare

Q39

Yes

Q 40

Abode, level of care at home

I have been involved in cases where there exist significant assets available which are not utilised in the provision an individuals preferred level of care rather they have been preserved by their adult children in effect enhancing their subsequent inheritance

E.g.

- That financial assets such as the family home be drawn upon (e.g. reverse mortgage) to fund full time care at home where this is safe to do so
- That an individuals financial assets be utilised to provide a superior level of care e.g. extra services personal toiletries, clothes, additional outings / diversional therapy etc

Q 41

Yes. They should be binding with a need to demonstrate why they cannot be undertaken (e.g. insufficient assets, unsafe to remain in current abode eg unsafe stairs / environment unable to be modified

However instruction eg to maintain my independence / happiness / dignity may be so nebulas as to be undeliverable

Q42

Where there is a major departure from instructions the reason needs to be written. If however this is the case there will need to be record of the instructions and audit or review of the implementation

Q43

Yes, see Answer to Q 41

Q 44

Yes

Q45

Sanctions need to be proportional to the effect e.g. if for financial gain then restitution and risk of proceedings appropriate to the effect.

If apparent good faith error then subsequent supervision of role or loss of appointment

Q 50

Whilst symbolic Option B preferred

Q51

As written option A however it is unclear if option B is

a + b +(c or d)

or

a and/or b and/or (c or d)

I would support a hybrid of option A and B if the stem of option B and any of the subsequent components a to b are true

Q52

Option C i.e. No change

Huge additional resource allocation, often never required however if this need was highly probable / near certain some flexibility in need would be beneficial

Q 55

No. Option A

Q57

Current situation works well

Q58

No,

Q61

Option B. Simpler and appears equally effective

Q 62

No No No

Q 63

Yes. A persons habit of regular gifts e.g. birthdays, Christmas gifts to their hairdresser, many years of supporting their favourite charity or event should continue if this is financially appropriate

Q64

Yes

Q 65

Yes

Q68

yes

Q 69

Yes

Q70

Yes

Q 72

This should be encouraged and VCAT should have the provision to make this a requirement where there is a reasonable belief that a person's wishes are known

Q 73

Option A with the description as written (this in effect is change and strengthens the current scrutiny) AND make suspected elder abuse reporting by Health / care professionals mandatory

Chapter 15

There is inconsistency in the discussion and questions. Are we talking about RCF only or RCF and Hospitals. Is the consent only required at admission or dynamically according to a person's capacity? If the individual became confused for an hour / day or week would this trigger a deprivation of liberty safeguard as per option C. Would presentation to hospital be construed as consent for admission / treatment. If > 70% of some patient groups become delirious eg ICU, Palliative care or even 30% of those with a fractured neck of femur (many post operatively) or seriously ill medical patients, would these all trigger (ie tens of thousands of patients per year) a safeguard review

Q 74

Admission, yes but not as onerous as options E if patient is felt to be agreeable with the move as evident to an independent 3rd party e.g. ACAS/ACAT assessor

Remaining in a RCF, No (impractical see discussion re Chapter 15 above)

Q 75

See answer to Q 74

Additional safeguard - ACAS assessor

Q 76

Unclear re aim of regular review by VCAT especially if patient has progressive condition

Q77

No

Q78

All residential aged care facilities / public and private and state run

Q 79

Yes

Q80

This is an area subject to significant abuse with regular failure to consult. Whilst drugs / interventions should be allowed in the case of an emergency (risk to self or others or environment) in the case of regular or predictable use consent of the person responsible should be required. Thus the regular use of eg psychoactive drugs prescription or complementry should be authorised if used on a regular or predictable basis

Q 81

Only if the intervention could reasonably be considered invasive or involve drugs with psychoactive properties. Not physiotherapy / speech therapy /occupational therapy etc

Q 83

Yes, yes

Q84

No not if the procedure is minor or emergency

Q85

Yes, option B

Q86

Potential societal benefit Vs personal benefit, Risk of harm having assessed the likely personal burden over the period of the research / follow up

Q87

No other than to note where there is significant inconsistency and evidence of a cognitive deterioration / event etc this could add significantly to evidence of impairment and potential disability

Q88

Yes

Delays in the VCAT process and subsequent taking up of appointments ensure the acute and subacute health system at least, is very cognisant of the need to strike a balance accepting some risk on the part of the individual or providing clear evidence of unacceptable risk and where there is doubt trialling a less restrictive option.

If the system was efficient there may be more pressure to go to VCAT and free hospital beds sooner

Q 89

Yes

Q90

Option C give additional support to the rights of the individual whilst recognising the potential need override the individuals rights where there is clear evidence of inability to make an informed decision and unacceptable risk of harm

Thus substituted judgement is a major factor but appreciation of issue, and risk must be paramount

e.g. The long standing belief of wanting to stay in my own home cannot over ride an inability to appreciate the risk of an event occurring where the risk of major self harm is clearly demonstrable

Q91

Yes

Q92

Yes

Q 93

Yes

Q94

Yes.

Uniformity and clarity should be the mantra for the revision of the relevant acts

Q95

Use the same principles as in every other case

Risk vs real and perceived benefit relationship

Q96

The guiding principles should be the same. The process may have some (small as possible) variation

Q97

Yes, however as in FOI some assessment of best interest may be required

Q 98

Yes

Q99- 102

Option E supported by option C may be the only really practical option

There needs to be some ability to compensate for work undertaken by private advocates / attorneys / guardians etc

Q 104

OPA

Q 105

Yes

Q 106

Yes

Q107

Abuse, physical, mental and financial

Q109

In theory yes, how to monitor is less clear when anecdotal evidence suggests most do their best to strike that balance between autonomy / independence and the need to make decisions on behalf of an individual

Q110

Yes

Q 111

Option C

Those assessed as being substantive medical, social/lifestyle or financial

Q 112

Requests for review must be screened and can be rejected

Q 118

Unclear of scope

Q 119

yes

Q 120

Yes

Q 121

Yes or the system will not work

Q 135

Yes

Q 136

Yes. OPA is clearly currently very underfunded. All these changes must be predicated on a dramatic funding boost otherwise access will be a new roadblock to an individual's dignity and rights

Q 137

Option c

Q 138

They will anyway

Q 139

Option A, No change

Q 141

Yes

Q 142

There needs to be an ability to maintain, at VCATs discretion, confidentiality of information

Q 143

Option B

Q 144

Option B

Q 149

Yes, providing the orders could not compel conduct of a third party that the represented person themselves would not have been able to compel

Q 150

Not Option A or B

Make it discretionary

Q 151 / 2

Informal style hearings

Able to be heard where necessary for the individual given their disability

Regional VCAT hearings must be regularly available

Q 156

Yes

Q 157

Yes however a fusion model i.e. option B is preferred

Q 158/ 159

Yes to both

The prison population is ageing. Cognitive impairment as an issue in older prisoners is increasing. There can be a complex interplay of intellectual, mental health and degenerative cognitive decline which increases unpredictable over time during incarceration. The rights and dignity of prisoners cannot be diminished further for matters e.g. cognitive decline that are beyond their control and for which society (I believe) has not sought to be part of their punishment.

Individual submission on the part of

Dr Michael Murray, Geriatrician