

RECEIVED
- 6 JUN 2011
BY: _____

Submission No. 68



Australian Nursing Federation (Victorian Branch)

Submission to the Guardianship Consultation Paper

June 2011

Lisa Fitzpatrick
State Secretary
Box 12600 A' Beckett Street PO
Melbourne Victoria
Telephone: 03 9275 9333
Fax: 03 9275 9344
www.anfvic.asn.au

INTRODUCTION

The Australian Nursing Federation (Victorian Branch) (ANFVB) represents the industrial and professional interests of in excess of 60,000 registered nurses across all areas of healthcare in Victoria and, as such is a major stakeholder in nursing, midwifery and the broader healthcare environment.

The ANF was established in 1924 and is the national union for nurses and midwives, with Branches in each State and Territory of Australia.

The ANF is also the largest professional and industrial nursing and midwifery organisation in Australia, with a membership of over 200,000 nurses and midwives nationally, employed in a wide range of enterprises in urban, rural and remote locations in both the public and private sectors.

The ANF participates in the development of policy in nursing and midwifery, nursing and midwifery regulation, health, community services, veterans' affairs, education, training, occupational health and safety, industrial relations, immigration, foreign affairs and law reform.

EXECUTIVE SUMMARY

The ANF (VB) appreciates being afforded the opportunity to respond to the Guardianship Consultation Paper put out by the Victorian Law Reform Commission. In accordance with the Commissions request we are presenting our views in answer to specific questions.

General Comments

The ANF (VB) believes it is timely for this review to occur and note specific issues in relation to the following:-

- the need to have legislation that is clear, simple to understand and consistent for the community and service providers;
- the legislation must reflect current and future community needs and the change should encompass the ability for individuals to participate in decision making to the best of their ability even when this may be on an intermittent basis, for example, those suffering from Alzheimer's Disease – supported decision making;
- combining the relevant parts of the Medical Treatment Act and the Guardianship and Administration Acts will assist in this process;
- we believe it will be imperative that this review is completed in conjunction with the current review of the Mental Health Act to ensure there is consistency;
- there must be funding for resources and education provided to ensure all parties understand the application of these changes as well as funding appropriate mechanisms to allow for identification of the status of personal appointments and substituted decision makers;
- we believe the definition of medical treatment should be consistent and expanded to include other health professionals including Nurse Practitioners and we would prefer to see the definition of health decision maker to be applied;
- there should be clarification of the statutory right to make advanced instructional medical directives.

Specific Comments to the questions of the Commission

Do you have any general comments about the matters identified by the Commission as influencing the need for change?

Are there any important matters that should affect the content of the future guardianship laws?

It is imperative that the modernisation of future guardianship laws proceed as the effects of the ageing population and medical advances will have a significant influence on the future of the state of the Australian economy. The modernisation of the existing law should lead to a simplification of the obligations ensuring that the individual's ethical principle of autonomy is encouraged whilst still providing protection for the more vulnerable. We believe that currently the bulk of the Australian population do not fully comprehend the Guardianship and Administration Act, and it is not until they are in a situation of needing to become one, or being in a position to deal with someone appointed as a Guardian that they search out this information. Often at this point they are already under stress; for example, partner is diagnosed with dementia, and the difficulty they experience in trying to decipher what is available to assist them and their partner is enormous. Even then the requirements and complicated language do very little to provide clear direction about what is proposed under the amended law. Not only does the Act need to be updated but additional resources (including education) need to be allocated to ensure that everyone has a clearer understanding of the Act and its applicability to the health sector, the community and health professionals.

Do you agree with the Commission's draft statement of purpose for new guardianship laws?

The ANF (VB) is supportive of the statement of purpose and agrees that the new guardianship laws as outlined are clear and encompassing.

Do you agree with the Commission's draft general principles for new guardianship laws?

Yes, in particular the "substituted judgement" although how can an individual prove that the decision is the one that they think the person would have made. Checks and balances need to be in place to ensure there is no misuse under this principle. It was noted that there was no definition of "adult" and therefore it is difficult to see how this would work with the intent to lower the age to 16 years under the guardianship laws.

Are there principles you think should be added or removed from these general principles?

The ANF (VB) points out that given the changes to the demographics in Victoria there should be consideration given to a person's cultural and religious belief, and the role of family and other individual support networks. These factors are particularly important as the Australian population ages.

Do you agree with the Commission's proposal that Victoria's various substitute decision making laws be consolidated into one single Act?

The ANF (VB) agrees with Option C as the preferred position of having only one Act consolidating all the various substitute decision making laws. This option gives the Commission the opportunity to ensure the language in the Act is easily understood and provides clear direction as to the mechanisms and limitations. To continue with the three Acts (or two) will only ensure that the individuals who need to understand the law will still be faced with complex and difficult to interpret obligations and processes. However, we foreshadow our concern as to how this would be achieved? Will the amalgamation of those sections require the other Acts be amended to remove them, or do they serve other functions as well? It would be too confusing to have legislation sitting side by side without the ability to understand which parts of each Act apply in each setting.

Do you agree with the Commission's proposal that the term "medical decision maker" or "health decision maker" should replace "person responsible" in legislation? If so which do you prefer?

The ANF (VB) is of the view that there is much to be said for the use of consistency in language, particularly in relation to the regular movement of the large cohort of the population to other Australian states and territories. For example, people moving to warmer climates like Queensland for retirement. We note there are only three other states using the term "person responsible" and that this term does not reflect the true meaning in everyday Australian language. The ANF (VB) would prefer to see the term "health decision maker" as the term used as we believe it is a better reflection of the intended intent.

In relation to the term "medical decision maker" while the word "reasonable" can be interpreted as limiting, health encompasses much more than just a *medical* perspective.

Do you agree with the Commission's proposal that the term "guardian" be replaced with "adult guardian"?

The ANF (VB) agrees the term "guardian" does seem to be reasonably understood in the community and using the words "adult guardian", could by virtue of the descriptor suggest there could be a "child guardian".

We support the term "Guardian" as a reasonable term to encompass all life stages not just that of a child.

Where there was a need to make a change the ANF (VB) would consider "personal decision maker" as the one that best reflects what it means.

Do you agree with the Commission's proposal that the term "administrator" be replaced with "financial guardian"?

The ANF (VB) considers that either term is acceptable.

Should the terminology used for powers of attorney be better integrated with the terminology for guardianship and administration?

The ANF (VB) considers the use of consistent terminology should be used to reduce confusion in the wider community.

Ideas to target education about guardianship laws.

The ANF (VB) considers that there ought to be a targeted education/information program aimed at the community through a variety of health care agencies including GP clinics, aged care facilities, community health centres, acute health services, as well as local government, websites, feature articles in magazines, newspapers and the media at large. The ANF (VB) argues any education must also include the various support groups, networks and stakeholder groups and be available in a variety of languages other than English. Additionally, we suggest any education should be included in undergraduate educational programs and courses for the wide variety of worker that would come into contact with people who need to have guardianship arrangements instigated or carried out.

The ANF (VB) strongly advocates that the introduction of any education process will need to be sustainable into the future with appropriate funding and ongoing review and evaluation models in place.

The ANF (VB) recommends the Public Advocate play a greater role in producing materials for education as well as establishing a dedicated information unit providing for telephone advice and speaker presentations.

Do you agree with the Commissions proposal to introduce new supported decision-making arrangements?

The ANF (VB) see the proposed introduction of the new supported decision-making arrangements as a clear shift towards supported decision making that will be welcomed by our members. Furthermore we see the new decision-making arrangements as being consistent with the nursing and midwifery professionals desire to provide client centred models of care that do not restrict a persons autonomy and rights, including their right to access quality healthcare.

The concept of supported decision making is an important one particularly as it may address the issues surrounding "fluctuating" or "partial" capacity of the individual to make a decision. Any move to ensure people with decision making capacity, even if it is only partial or fluctuating, ought to be encouraged, in order to ensure the individual can participate in *their* decision making and maintain as far as possible their functional independence. This addition to the decision making arrangement would provide a range of instruments available to people. It is our view this is a far better option than leaving people without adequate supports; or applying too much support too early in the decision-making process and thus removing the independence and autonomy of the individual to make their own decisions.

Do you agree with any or all of the proposed roles of supporters and co- decision makers?

The ANF (VB) agrees that personally appointed supporters would be a valuable option particularly for those with "fluctuating" capacity and certainly draws heavily on the situation where individuals often make decisions with personal support which is not formalised. The role of supporters and co-decision makers becomes the foundation on which an individual may come to assist the person make important decisions about their need for guardianship and assist the person reconcile their situation without the ongoing fear of loss of control of their autonomy.

Further, we see personally appointed co-decision makers as being of benefit however, the requirement for both the person with impaired decision-making capacity and their co-decision maker to both agree before a decision is legally binding as requiring monitoring and some mechanism determined for intervention in situations where there is not be agreement. We acknowledge it is not the intent that State Trustees and the Public Advocate would not be appointed to this role however, there we argue that there may be merit in those offices being used to mediate/investigate concerns where they arise. The proposal really requires a mechanism to be available for people to cancel/change their arrangements should it be necessary.

What steps would need to be taken in order to ensure that these appointments operated fairly and efficiently?

In the past there have been a number of concerns raised by various bodies and policy makers in relation to the existing abuse of power by enduring powers of attorney (financial). The ANF (VB) believes the amended laws must provide a mechanism to be implemented in the Act to penalise a person with powers of attorney where there is a demonstrated abuse the trust of the guardian.

Do you agree that the Public Advocate should not be a "supporter" or a "co-decision maker"?

The ANF (VB) agrees with the Commissions' view that they should not be asked to undertake these roles. They should be drawn from family and friends networks. In order to fulfil these roles a supporter or co-decision maker needs to have a sound understanding of the individual's wishes and how best to interact with them to provide enable their wishes to be captured and enabled. The Public Advocate should be the guardian of last resort but provide resources and services to assist those undertaking these roles.

Do you think the public Advocate should play a role in training supporters and co decision makers, and monitoring supported decision making appointments?

The ANF (VB) believes there is most certainly the need for resources and education to be available that clearly articulate the required expectation of these roles and how these roles are expected to be managed. Given the confusion that currently exists there must be clear and simple communication mechanisms available that are easily accessible and available in a range of languages other than English. Communication should be available in writing and should include personnel to go out into the community to present the information on a face to face basis to groups. In addition it would be opportune to establish a call centre that could assist with answering concerns from the public.

Should the Public advocate establish and co ordinate a volunteer support program to assist people who do not have family or friends to assist them?

While there may be merit for this suggestion –volunteers would not have the intimate knowledge of the individuals that would assist in taking up these roles and would be required to undergo specialised training to be considered suitable for specialist volunteering roles. Additionally, a number of agencies report that they face increasing difficulty in finding people in vast numbers that are willing to volunteer their time. If there was a situation whereby there was an individual with no supports to call on then it would be preferable that the role be taken up by the Public Advocate. We believe this would provide improved safeguards for the individual.

Should "supporter" or "co-decision-maker" arrangements apply to financial matters, or be limited to personal decision making?

Given the requirement that persons with impaired decision making capacity and co-decision makers must both agree before a decision is legally binding; and that supporters fulfil a role that people with decision making capacity also use, we believe that it would be prudent to apply to financial matters as well as personal decision making. The ANF (VB) note however the concerns identified and believe that perhaps a balance can be made limiting the scope of the financial matters that can be managed in this way. It would also require the public advocate to extend their role to the training and monitoring of support arrangements inclusive of the points raised in 7.114

Should all enduring powers be activated at the same time? If so when?

There seems to be quite different views in relation to this point and inherent difficulties whichever way is taken. There is the safeguard that they should only be activated when a person loses their capacity however, we argue this would not address the issue of who makes the decision of about a person's capacity. The example of being able to utilise the attorney to attend the bank when capacity remains but mobility does not, will in the future be less important with the advent of technology changes like advancements to e-banking. Nonetheless, if the overriding objective is to simplify, clarify and provide mechanisms that are easily understood then it would be prudent to have the enactment of the various enduring powers to be simultaneous.

Should parents and carers of children with disabilities be able to file a document with VCAT that states their wishes about future guardianship or administration arrangements?

The ANF (VB) agrees that the wishes of family members should be part of VCAT's consideration into appointments. The best way to ensure these are accessible to VCAT would be in the registering of a formal document. The family members would have the best knowledge of the individual and what they need and who perhaps would best meet these needs. Therefore these must be a strong factor in any VCAT decision in appointing a substitute decision maker or supporter.

Should the number of enduring appointments be reduced from three to two by removing the option of appointing an agent under the Medical Treatment Act 1988(Vic) and by requiring people to use an enduring guardianship for medical treatment matters?

The concept of reducing enduring appointments from three to two by combining the Medical Treatment Act agent with that of the enduring guardian is appealing. It is simple, it removes the requirement to be across both Acts whilst at the same time ensures that no one is disadvantaged by confirming that the guardian could refuse medical treatment on their behalf if so appointed. Hopefully this would help ease the confusion in relation to the right to refuse treatment and those who can consent to treatment. So long as the combining of these two aspects also went hand in hand with an agreed single definition of medical treatment and with the inclusion of palliative care we would support this option.

Do you think the law concerning instructional medical directives should be set out in legislation?

Many of the problems associated with the current law and practice with instructional directives stem from lack of clarity, education and awareness. In particular the status of advanced directives in common law, the applicability of these as binding on a substitute decision maker, lack of community awareness about these directives, and how these are accessed or communicated to the appropriate parties are issues that could be addressed in the current situation.

However we acknowledge that a major limitation in the Medical Treatment Act is that the refusal of treatment can only be enacted in particular circumstances, for example, for a current condition.

We support option B: Broaden and clarify the statutory right to make instructional medical directives to provide people with increased certainty that their instructions will be followed.

Should there be an electronic registration system for advanced directives?

One of the problems in ensuring that the appropriate people/organisations are aware of these directives can be resolved through the direct link in to the Personally Controlled Electronic Health Record (PCEHR) This national scheme which will be introduced in July 2012 will allow individuals to choose whether or not to have a PCEHR, and to determine who will have access to the various levels of health information. They will also be able to nominate representatives to help manage their PCEHR. This system will allow advanced care directives to be loaded as a structural clinical document (Draft Concept of Operations: Relating to the introduction of a PCEHR system page 40). This paper also identifies that "Healthcare providers have advised NEHTA that they are unlikely to consider advance care directives available in a PCEHR without first communicating with the custodian"

Should registration extend to medical and lifestyle instructional directives?

The ANF (VB) consider it is a sensible approach to include medical instructional directives in the PCEHR as it is currently being developed for delivery next year and we do not believe there would be any benefit from registering them elsewhere. However there will not be a facility in this system for the registering of lifestyle directives, therefore a separate process would be necessary and perhaps use the same of online registration of enduring appointments.

Do you think that it should be possible to make statutory instructional directives about things other than medical treatment?

We believe that if a person has decision making capacity and expresses wishes in relation to lifestyle as an instructional directive then this should be accepted by the personally appointed decision maker. When situations occur and these directives cannot be followed the decision maker should be required to provide reasons for not abiding by them and this should be overseen by VCAT (this may need various levels for notification to be identified so that unenforceable issues do not clog up the system, for example, who looks after a pet).

Decision making powers of a guardian or administrator

The ANF (VB) believes that option A: providing for the detailing of potential powers in the legislation would provide clearer guidance to the represented person and the substitute decision maker. This would assist people to be able to make decisions on exactly what terms they wish substitute decision makers to act, and also have a central point for identifying them.

Automatic Appointments – the Person Responsible

We are concerned that this part of the G & A Act is poorly understood, even by medical practitioners and given it only applies to obtaining consent to medical procedures. If, as it is identified in this paper, the reasons for this situation is in the language used and the interaction with other laws then it is important that resources be provided to ensure that the community be availed of appropriate education. The person appointed hierarchy should not need to be amended to ensure that cultural differences are included if as the hierarchy identifies a variety of levels to be spoken to in relation to the decision which includes the patients spouse, primary carer or nearest relative following on from people appointed to various decision making guardianship orders. The ANF (VB) believe the cultural difference should be inherent in the decision of the spouse, primary carer, or nearest relative and given the others are also bound to act in the persons best interest considering what the patient would want, as well as the wishes of the nearest relative then these cultural differences should be covered.

Do you think the definition of medical treatment should be broadened?

We agree the definition of medical treatment should be broadened in line with the Public Advocates suggestions. In this case to include those whose activities would be subject to consent including nurse practitioners, naturopaths, physiotherapists, alternative/natural medicine practitioners and Chinese medicine suppliers. In fact this list should include all health practitioners covered by the National Law for registration purposes.

Furthermore, we that as previously stated if the relevant parts of the Acts are amalgamated and there is only one definition of medical treatment then there should be less confusion as to which applies in particular circumstances.

Do you agree with the Commission's proposal (Option C) that it should be possible, in some circumstances, for guardianship to be used as a mechanism for authorising psychiatric treatment and place of residence decisions for a person who is unable to make their own decisions due to mental illness?

We believe it is premature to either agree or disagree with the position as suggested by the Commission regarding proposed changes to the relationship between Guardianship and mental Health Laws within the current context of reviews of other legislation. ANF members in Victoria have been actively involved in the Victorian Review of the MHA. Nurses and midwives are mindful that the existing Mental Health legislation has principles embedded for substituted decision making, which may not continue into the new Mental Health legislation. It would appear that many of the arguments mentioned in Chapter 23 of the Consultation Paper are based on issues existing within the current legislation. These may not have the advantage of considering the extensive MHA consultations to date. We remain hopeful that the historic and current MHA will shift from substituted to supported decision making, with the capacity for the person to have both nominated persons and Advance Directives to provide guidance about their preferences in the event they have an altered decision making capacity directly related to mental illness. Such changes may actually be the preferential way for a person wishes to be upheld, as they will have been able to indicate whom they agree to have involved in the instance that they become unwell to a degree that they are considered to lack capacity for making their own decisions when directly related to mental illness. Further, some of our members do lean towards the expressed view of the Health Services Commissioner, that being that "mental health and guardianship laws should be complementary, but not overlap".

Closing Comments

The Australian Nursing Federation – Victorian Branch would be very grateful if we could be kept informed of the progress of this documents development.

Should you require further information in relation to the content of this submission, contact Ms Catherine Hutchings – Professional Officer, ANF Victorian Branch

