25 September 2011

Victorian Law Reform Commission,
GPO Box 4637,
Melbourne VIC 3001

Submission to the Victorian Law Reform Commission in response to the Guardianship Consultation Paper:

Dear Sir/Madam,

I would like to provide a response to question 1 of the Commission's Guardianship consultation paper.

Question 1: Do you have any general comments about matters identified by the Commission as influencing the need for change? Are there any other important matters that should affect the content of future guardianship laws?

My concerns relate to the lack of adequate regulation and procedural safeguards in place in Victoria for persons with impaired capacity who are subjected to deprivations of liberty, isolation and the long-term use of restraints for '*medical treatment*'. Guardianship legislation may provide limited protection in some circumstances, but for most, these arrangements do not adequately safeguard the charter rights or ensure the safety of patients who are subjected to detention and highly restrictive measures for extensive periods of time in general hospital wards.

As a cyclist, my husband was involved in a road accident that resulted in multiple facial and spinal fractures, medical complications (including pneumonia and swallowing difficulties), nerve injuries (blindness in one eye and arm paralysis), and an acquired brain injury (ABI). Following nineteen days of acute management of his injuries at a major hospital, he was transferred to a private Melbourne hospital for continuing treatment.

My husband was immediately admitted and confined to the secure unit of the ABI ward on his arrival at this hospital. The secure unit is designated for all patients in post-traumatic amnesia (PTA), the early pre-rehabilitation phase of recovery from traumatic brain injury. He was not free to leave the secure unit and was unable to access the patient lounge and other ward facilities. He was alone in this area for long periods of time as nurses were stationed on the other side of the locked doors. The confinement and subsequent isolation of patients in PTA at this hospital meets all key elements of 'seclusion' as defined by the National Mental Health Seclusion and Restraint Project (2009).

According to the medical practitioner responsible for my husband's confinement, the best evidence-based treatment for all patients in PTA is in a low stimulation unit and that this cannot be provided in an environment that is not secure. The secure unit is said to be the least restrictive means of any restraint thought necessary for all individuals. Despite a wide spectrum of potential co-existing injuries, medical complications, cognitive impairments and behavioural symptoms amongst individuals in PTA, all patients who demonstrate a degree of memory impairment and/or disorientation (based on the Westmead PTA scale), are detained.

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Like many patients in PTA, my husband was extremely fatigued, quiet and withdrawn throughout his recovery. In order to achieve a low stimulation environment it was not necessary to lock him in. A single hospital room with environmental controls in place to maintain adequate stimulation would have been less restrictive and more conducive to his recovery. In my view, the attendant safety risks and detrimental affects of his confinement and subsequent isolation in the 'low stimulation unit' outweighed any potential therapeutic benefits.

Release from the secure section was permitted only when patients provided correct responses to all questions on the Westmead Scale for three consecutive weekdays. In this way, a patient's inability to recall the name of the therapist or to know the time of day for instance, resulted in continuing confinement and isolation. While many patients at this hospital are subjected to this treatment for many months (more than eight months in some cases), my husband was detained and isolated in the secure unit for twenty-one continuous days before his release to the broader ABI ward.

Under guardianship's automatic appointment arrangements, I was the 'person responsible' for medical decision making on my husband's behalf as he temporarily lacked the capacity to make his own treatment decisions during this period. Taking into consideration a range of matters including his injuries, significant medical complications and his quiet withdrawn demeanor, I did not consent to his isolation in the secure unit of the ABI ward. My objections to his treatment are well documented in the hospital record.

At no time did the medical practitioner discuss or initiate procedures under guardianship legislation that provide for situations where the 'person responsible' does not provide 'consent' or there is contention over proposed medical treatment. As would be the case for many family members who are 'persons responsible' under guardianship arrangements, I was unaware that VCAT provisions were available to make a ruling.

On a broader scale, practices involving deprivations of liberty and other restraints for the treatment of individuals in PTA appear to vary considerably amongst hospital wards across Victoria (and Australia). This variability raises obvious questions about which hospitals are providing evidence-based treatments for individual patients and which are not. In terms of the scope of this submission however, the degree, variability or reasons for their use are largely irrelevant and serve only to highlight the immediate need for adequate regulation. The lack of prescribed safeguards surrounding the authorization and long-term use of these extreme restrictive practices in general hospital wards is in strong contrast to the extensive network of safeguards for involuntary patients under Victoria's mental health legislation.

In summary, an important matter that should effect new guardianship legislation concerns the need to better regulate the means by which people who lack capacity are subjected to deprivations of liberty, seclusion and the long-term use of restraints for 'medical treatment' in hospital wards. New legislation should provide extensive procedural safeguards that take into account the following:

- Deprivations of liberty, seclusion and restrictive practices clearly limit a person's charter rights. New guardianship legislation should ensure that a limitation to any right is only permissible following independent and impartial decision-making processes that take into account the nature of the right and whether the limitation is reasonable and proportionate in the individual circumstances. Individuals with impaired capacity who are detained for

medical treatment should also have access to an independent and impartial court or tribunal appeal/review mechanism (similar in practice to Victoria's Mental Health Board).

- The automatic appointment provisions in the G & A Act may provide a more streamlined process of obtaining consent for medical treatment than former arrangements but are not appropriate when dealing with important matters such as a person's liberty. Given that 'consent' for my husband's treatment was not provided, guardianship processes failed to work effectively in his circumstances. In many other circumstances and for a range of reasons, authorisation for medical treatment is largely gained by default (eg. 'persons responsible' who have no knowledge of their own 'consent' powers under the G & A Act or those who consent to recommended treatments without question or without proper understanding of treatments, risks or charter rights etc). Substitute decision-making processes that are flawed in any way are particularly grave for individuals who are seriously injured and are subjected to deprivations of liberty and long-term restraint measures as part of medical treatment in hospital wards.

- The definition of 'medical treatment' in the new G & A Act should specifically exclude treatments that involve deprivations of liberty, seclusion or the long-term use of restraints. In a similar way to the requirements for 'special procedures' in the current G & A Act, new legislation should prescribe specific procedures for the authorization, continuing use and review of medical treatments that involve confinement or long-term restraint measures in hospital wards.

I would also support option A to questions 82, 83, that would retain the current requirement that a medical practitioner must obtain the person responsible's consent to conduct a medical procedure, no matter how minor. I strongly support the reasons provided by Victorian Equal Opportunity and Human Rights Commission's submission (3 June 2011, pgs 48 – 49) in relation to these issues. My concern is that a secure low stimulation unit involving confinement and isolation for example, could be classified by a hospital or treating physician as 'minor'. Question 84 - Current safeguards are minimal for persons where there is no person responsible. I believe that procedural safeguards for persons in these circumstances should be extended and not relaxed for the sake of expedience.

Anne Kennedy