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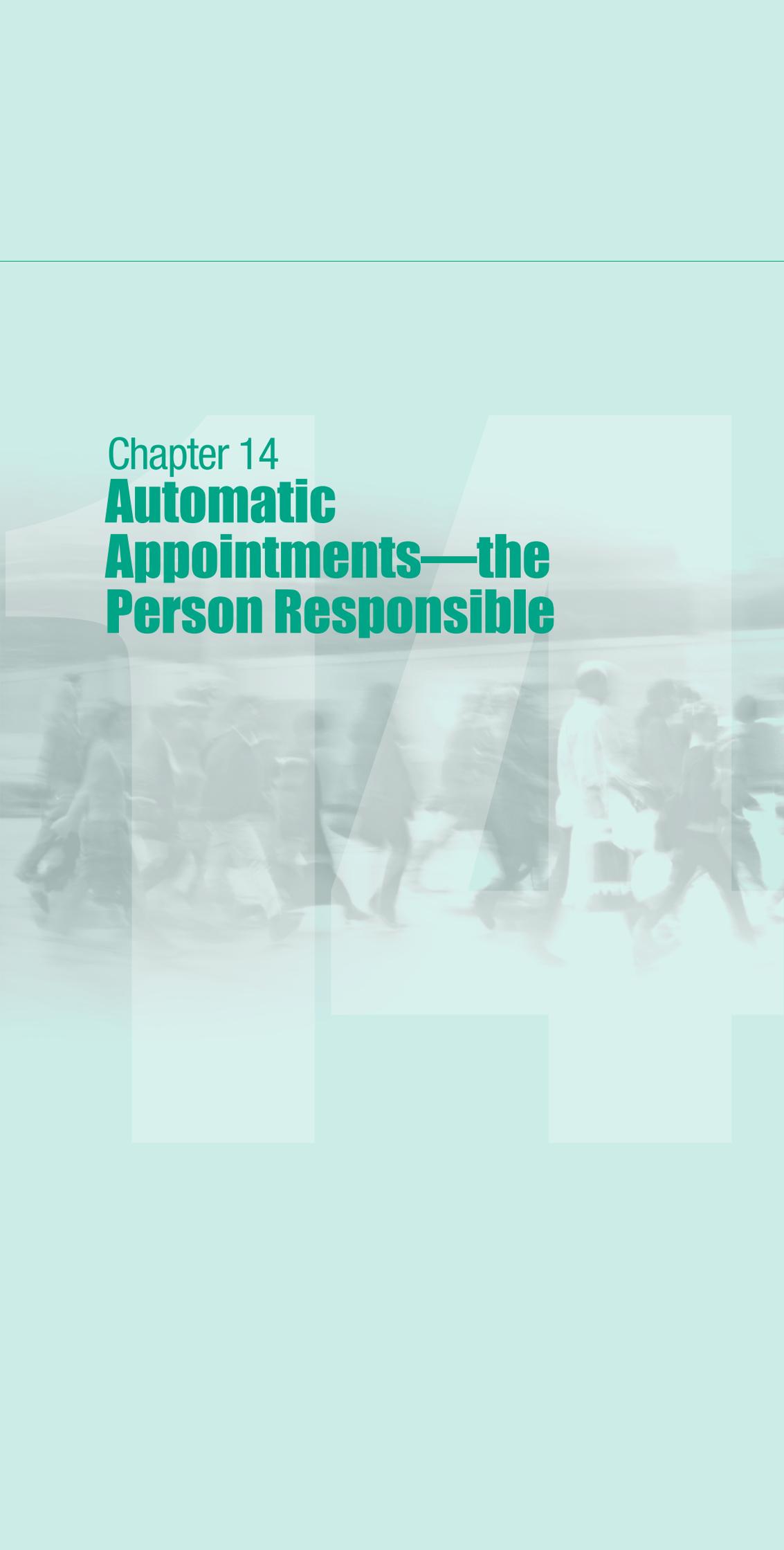
Part 6

Statutory Appointments

In this part, the Commission explores statutory appointments of substitute decision makers. In Chapter 14, we consider the ‘person responsible’ provisions in the *Guardianship and Administration Act 1986 (Vic)* (G&A Act) that provide for the automatic appointment of a substitute decision maker to consent to medical treatment. In Chapter 15, we discuss informal assistance provided to people with impaired decision-making capacity when living in the community. We explore whether the decision to admit vulnerable people to care facilities needs additional safeguards in light of a recent decision by the European Court of Human Rights, and consider whether a ‘person responsible’ scheme might be appropriate. In Chapter 16, we consider the interaction between the *Medical Treatment Act 1988 (Vic)* and those parts of the G&A Act that deal with consent to medical treatment.

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Chapter 14

Automatic Appointments—the Person Responsible

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Chapter 14

Automatic Appointments— the Person Responsible

INTRODUCTION

- 14.1 The *Guardianship and Administration Act 1986 (Vic)* (G&A Act) provides for the ‘automatic appointment’ of a substitute decision maker to make medical and dental treatment decisions for an adult who is unable to make their own decisions. The Act contains a list of people, described by virtue of their relationship to a person over the age of 18 who is incapable of giving consent to treatment. This hierarchical list consists of the person’s spouse, domestic partner or nearest relative. These people’s relationship to the person with impaired capacity automatically authorises them to consent to most medical and dental treatment. This occurs without tribunal or court appointment.¹
- 14.2 This chapter examines the operations of the automatic appointments system. In Chapter 15, we consider whether the automatic appointment system could be used, with appropriate changes, for decisions other than those involving medical or dental treatment.
- 14.3 The automatic appointment provisions were included in the G&A Act in 1999 primarily because ‘the uncertainty regarding consent [to medical and dental treatment] results in many applications being made to the Victorian Civil and Administrative Tribunal (VCAT) for relatively minor procedures’.² These provisions formally recognise the role family members and carers have long played when giving informal substitute consent to medical and dental treatment for a person who is unable to do so themselves.
- 14.4 This chapter discusses the concept of automatic appointment as a means of identifying a substitute decision maker. We discuss what the G&A Act means by medical and dental treatment, and the different types of procedures to which the person responsible can consent in Chapter 16. That chapter also discusses the roles and responsibilities of the person automatically responsible in relation to medical or dental treatment decisions.

CURRENT LAW

THE PERSON RESPONSIBLE

- 14.5 At common law, no person has the power to authorise medical treatment for an adult who is unable to provide consent. Medical practitioners can provide treatment without consent, or any other authorisation, in life-saving emergencies.³ Until recently, doctors often relied upon the informal ‘consent’ of next of kin when a person was unable to consent to their own treatment.
- 14.6 The automatic appointment provisions in the G&A Act sought to streamline the process of obtaining substitute consent for medical and dental treatment. The introduction of the G&A Act in the 1980s focused attention on the need for legally authorised substitute consent when medical treatment was proposed for a person who was unable to provide consent. The former Guardianship and Administration Board received many emergency applications for guardianship, often in the middle of the night, for appointment of guardians to consent to medical procedures. The person’s nearest relative, or next of kin, was often appointed as the guardian.
- 14.7 The need for a more practical system, coupled with concerns about the medical profession’s exposure to legal risk if treatment was performed without proper authorisation, led to the introduction of the automatic appointment provisions in 1999.⁴

14.8 The person who is automatically authorised to consent to medical and dental treatment for a person who is incapable of providing consent is referred to in the G&A Act as the ‘person responsible’. The ‘person responsible’ is defined in section 37 of the Act as the first person listed in that section ‘who is responsible for the patient and who, in the circumstances, is reasonably available and willing and able to make a decision’ relating to the various medical and dental procedures covered in that part of the Act. The people listed in the section, in order, are:

- a person appointed by the patient under section 5A of the *Medical Treatment Act 1988* (Vic)
- a person appointed by the tribunal to make decisions in relation to the proposed procedure or treatment⁵
- a person appointed under a guardianship order with power to make decisions in relation to the proposed procedure or treatment
- a person appointed by the patient (before the patient became incapable of giving consent) as an enduring guardian with power to make decisions in relation to the proposed procedure or treatment
- a person appointed in writing by the patient (being the person appointed last in time before the patient became incapable of giving consent) to make decisions in relation to medical research procedures that include the proposed procedure or medical or dental treatment, which includes the proposed treatment
- the patient’s spouse or domestic partner
- the patient’s primary carer⁶
- the patient’s nearest relative.⁷

14.9 The legislation contains a complex explanation of what it means to be a ‘primary carer’. Section 3 defines primary carer as ‘any person who is primarily responsible for providing support or care to a person’. Section 37(2) expands on this definition, explaining that ‘having the care of a patient’ includes either providing or arranging domestic services and support but excludes this being done ‘wholly or substantially on a commercial basis’.

14.10 Section 37(3) states that a person who provides care to another in a residential facility does not automatically become ‘the patient’s primary carer’. That role remains with the person in whose care the patient was ‘immediately prior to being cared for’ in the facility. The legislation seeks to ensure that when a person is in hospital, or some other institution, the person who had been caring for that person at home—typically, their ‘next of kin’—remains their primary carer and the ‘person responsible’ for providing consent to medical and dental treatment.

COMMUNITY RESPONSES

14.11 Community responses to the value of the G&A Act’s ‘person responsible’ provisions varied enormously. While there was widespread acceptance that the concept is a good one for medical treatment decisions,⁸ a number of issues appear to require attention.

- 1 *Guardianship and Administration Act 1986* (Vic) s 37.
- 2 Victoria, *Parliamentary Debates*, Legislative Assembly, 22 April 1999, 594 (Marie Tehan).
- 3 See *Rogers v Whitaker* (1992) 195 CLR 479 [14].
- 4 Victoria, *Parliamentary Debates*, Legislative Assembly, 22 April 1999, 594 (Marie Tehan).
- 5 Under the *Guardianship and Administration Act 1986* (Vic) s 42N(6)(a), the tribunal has the power to appoint a person as ‘person responsible’ for consenting to a proposed medical or dental treatment procedure, separately from its powers to appoint a guardian.
- 6 ‘Primary carer’ is defined in s 3 as ‘any person who is primarily responsible for providing support or care to a person’, although s 37(2) notes having the care of a patient is not meant to include providing services on a wholly or substantially commercial basis: *Guardianship and Administration Act 1986* (Vic) ss 3, 37(2).
- 7 ‘Nearest relative’ is defined in s 3 of the *Guardianship and Administration Act 1986* (Vic) as being either the person’s spouse or partner, or, if there is no spouse or partner, as the first person, aged 18 years or over, on the following list: son or daughter; father or mother; brother or sister; grandfather or grandmother; grandson or granddaughter; uncle or aunt; nephew or niece. If there is more than one relative in any category, the nearest relative is the oldest one.
- 8 See, eg, consultations with Disability Advocacy Resource Unit (5 May 2010) and Villamanta Disability Legal Centre (19 April 2010); Submission IP 56 (JacksonRyan Partners) 4.

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Chapter 14

Automatic Appointments— the Person Responsible



UNDERSTANDING THE PERSON RESPONSIBLE SYSTEM

- 14.12 One of the overriding concerns expressed in consultations and submissions was that the system is confusing and is often poorly understood, even by medical practitioners:

The G&A Act was amended in 1999 when the concept of a person responsible was introduced into the legislation in trying to devise a more practical means for health care practitioners to obtain consent for those patients lacking the capacity to give informed consent to medical or other treatments from a proxy.

Whilst in practice this should work well, the fact remains that many health care professionals are confused about the provisions of the G&A Act, the role of the Public Advocate, and the VCAT guardianship list.⁹

- 14.13 Another response was:

Person Responsible has been one of the worst changes to this Act because no one knows what a Person Responsible is. It carries no authority and when one states they are the Person Responsible the standard response is that I can't do this unless I have a guardian to give permission.

This causes huge costs because families have to keep applying for guardianship and are always forced to take a temporary order.¹⁰

THE WAY THE PERSON RESPONSIBLE IS IDENTIFIED IN THE LEGISLATION

- 14.14 As noted above, the 'person responsible' in a particular case is identified by using the 'hierarchy' in section 37 of the G&A Act. Some people questioned the universal application of this list—especially its relevance in some cultural settings¹¹—and the position of particular family members in the statutory hierarchy.¹²
- 14.15 Some people suggested that even though the automatic appointment model is good, because it formally recognises the role of next of kin, there should be a proper review mechanism in place.¹³

PROBLEMS WITH LAW AND PRACTICE

- 14.16 We have identified a number of legal and practical problems with the current automatic appointments scheme.

LACK OF UNDERSTANDING AND RECOGNITION OF AUTOMATIC APPOINTMENTS

- 14.17 The widespread lack of awareness of the automatic appointment process is concerning, especially because the system was introduced to make the process of obtaining consent to medical procedures more straightforward. It appears unlikely that these reforms have achieved that objective.
- 14.18 There are probably many reasons why the automatic appointment process appears to be poorly understood. The 'person responsible' provisions in the Act, especially those parts concerning their interaction with other laws, are difficult to comprehend, even for people with legal qualifications. In developing its options for reform, the Commission has operated on the assumption that while the law can be simplified, appropriate community education about those laws will still be a vital element in achieving this outcome.

LACK OF CLARITY ABOUT IMPLICATIONS OF CONFIDENTIALITY AND PRIVACY MATTERS FOR AUTOMATIC APPOINTMENTS

14.19 As with other substitute decision makers, there is a lack of clarity about the rights and responsibilities of automatic appointees in relation to confidentiality and privacy matters. We discuss this further in Chapter 18 and suggest some possible reform options.

CHOOSING AND SCRUTINISING AUTOMATIC APPOINTMENTS

14.20 There is, by definition, little rigour in choosing an individual substitute decision maker in a system of automatic appointment. A person who is automatically appointed to make decisions for another is not required to meet the suitability criteria in sections 23 and 47 of the G&A Act that VCAT must consider before making an appointment and might not be someone who the person concerned would have chosen to make decisions for them.

14.21 Different cultures have different concepts of the role of the family, and sometimes their broader community, in decision making. Some cultures are more inclined to recognise multiple decision makers and extended family, and some to recognise community elders. The Commission acknowledges the challenges in attempting to design a system of automatic appointments that is, on the one hand, adaptable to different cultural circumstances while, on the other hand, workable for third parties who need clarity about decision-making authority.

14.22 For example, a medical practitioner will generally need to be able to identify a person who has authority to consent to a proposed medical procedure for a person who is unable to consent. Models of collective decision making might not be workable in such a situation.

14.23 The issue of scrutiny of decisions by automatically appointed substitute decision makers merits further consideration. While VCAT has a broad supervisory role in relation to the use of automatic appointment powers, in practice it has no capacity to initiate any investigations. An interested party must draw concerns to VCAT's attention and provide it with evidence upon which to base an order.¹⁴

OTHER JURISDICTIONS

OTHER AUSTRALIAN JURISDICTIONS

14.24 New South Wales was the first Australian jurisdiction to respond to the problems associated with substituted consent for medical treatment.¹⁵ Other jurisdictions followed quickly and now the ACT,¹⁶ South Australia,¹⁷ Queensland¹⁸ and Tasmania¹⁹ all deal with automatic appointment of substitute decision makers for medical treatment in legislation similar to that operating in New South Wales and Victoria. Differences of note include:

- In South Australia, there is no recognition of a primary carer in their automatic appointment system, while the Board itself can consent to medical treatment upon application of anyone with a proper interest in the person's welfare.²⁰
- Tasmania also allows the Board to consent to medical treatment.²¹

- 9 Submission IP 22 (Epworth Foundation) 1.
- 10 Submission IP 3 (Stephanie Mortimer) 1.
- 11 Consultations with Respecting Patient Choices Team—Austin Hospital (6 April 2010), Advocacy Disability Ethnicity Community (21 April 2010), Mallee Family Care (28 April 2010) and Spectrum Migrant Resource Centre (12 May 2010).
- 12 Consultation with service providers in Morwell (29 March 2010); Submission IP 56 (JacksonRyan Partners) 4–5.
- 13 Consultation with Disability Advocacy Resource Unit (5 May 2010).
- 14 *Guardianship and Administration Act 1986* (Vic) s 42N.
- 15 See *Guardianship Act 1987* (NSW) s 33A.
- 16 See *Guardianship and Management of Property Act 1991* (ACT) pt 2A.
- 17 See *Guardianship and Administration Act 1993* (SA) s 59.
- 18 See *Guardianship and Administration Act 2000* (Qld) s 66 and *Powers of Attorney Act 1998* (Qld) s 63.
- 19 See *Guardianship and Administration Act 1995* (Tas) s 39.
- 20 *Guardianship and Administration Act 1993* (SA) s 59.
- 21 *Guardianship and Administration Act 1995* (Tas) s 45.

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- 14.25 In Queensland, a person known as the ‘statutory health attorney’ is automatically appointed to make decisions about health care matters if no person has been appointed under the *Guardianship and Administration Act 2000* (Qld) to make health care decisions. Health care matters must be dealt with first according to any health directive made by the person themselves, then by any guardian appointed by the tribunal, and then by any enduring appointment made by the person. If none of these appointments has been made, the ‘statutory health attorney’ appointed under the *Powers of Attorney Act 1998* (Qld) becomes the decision maker.
- 14.26 The legislation sets out a hierarchy of people who can be the ‘statutory health attorney’, being first the spouse of the person, then their unpaid carer, then their close friend or relative and then, finally, if none of those are available, the Queensland Adult Guardian.²²
- 14.27 In all of these jurisdictions, as in Victoria, automatic appointees can only make decisions about health care matters. However, in Queensland, admission to some nursing facilities is included in the list of health care decisions to which a statutory health attorney can consent.²³

ALBERTA, CANADA

- 14.28 While all of the Australian jurisdictions have some kind of ‘standing list’ of automatic appointees, the Canadian province of Alberta takes a different approach, permitting a third party—a medical practitioner—to choose who the appropriate decision maker should be.
- 14.29 In Alberta, a ‘specific decision maker’ is authorised to make various health care decisions. This person is a relative chosen by the health care provider applying criteria set out in the legislation. These criteria specify that the specific decision maker must be the nearest relative who:
- is 18 years of age or older
 - is available and willing to make the decision
 - is able to make the decision
 - has been in contact with the adult in the previous twelve months
 - has knowledge of the adult’s wishes respecting the decision to be made or of the beliefs and values of the adult
 - does not have a dispute with the adult that might affect the relative’s ability to comply with the duties of a specific decision maker.²⁴

Unlike the Victorian legislation, the Alberta model permits a degree of choice by requiring the health care provider to locate a substitute decision maker who meets a range of straightforward eligibility criteria.

- 14.30 A difficulty with the Alberta system lies in the perceived or actual conflict of interest in a law that allows health professionals to identify the person who is entitled to authorise a procedure that would be unlawful if performed without consent.

TRIBUNAL REVIEWS

- 14.31 Each Australian jurisdiction with an automatic appointments system provides for some limited tribunal review of the way in which the powers are exercised in a particular case. In Queensland, the actual appointment can be reviewed,²⁵ while in NSW the Guardianship Tribunal can be asked to consent to treatment that the person responsible has refused to authorise.²⁶

POSSIBLE OPTIONS FOR REFORM

RIGOUR OF APPOINTMENTS

Choice of appointment

14.32 The options below address the issue of who is appointed in an automatic appointee system and asks whether changes should be made to the current legislated hierarchy of substitute decision makers.

Option A: Amend the person responsible hierarchy to allow more appropriate automatic appointments to be made, including identifying people most suited to the role and taking into account cultural relevance

- 14.33 This option proposes introducing provisions into the system that allow for cultural differences. This might include, for example, allowing multiple appointments in cultures where families rather than individuals might make decisions. It might also include providing a place for community elders in cultures where they would be more likely to be the person respected as the appropriate decision maker. The option also involves looking at introducing some mechanism into the automatic appointment process for extra safeguards to ensure that the person appointed is right for the role. This could include something similar to the approach taken in Alberta, where there are criteria that a third party, such as a health care provider, could apply in choosing which person on the automatic appointment list is the most suitable one for the role.
- 14.34 The advantage of this option is that it would assist in identifying a suitable substitute decision maker without the need for a tribunal hearing. Its disadvantage, however, lies in the greater complexity it could produce. Allowing families to be appointed, for example, would be highly impractical for doctors or others who need to identify quickly a single person responsible for making the decision. Creating a system that seeks to accommodate the many different cultural notions of family and community could defeat the purpose of the provision altogether—that is, a quick and practical means of obtaining consent to medical procedures. Allowing a third party to choose from a range of possible automatic appointees could also create a potential conflict of interest for the person making that choice, who may be inclined to choose the person who will be most compliant.

Option B: No change, but clarify and strengthen provisions around the roles and responsibilities of the person responsible (preferred)

- 14.35 This option would involve retaining the Act's current hierarchy for identifying the person responsible, but with changes to the manner in which the powers are exercised. Automatic appointees would be required to follow a substituted judgment approach to decision making—to make the decision that the person themselves would have made, had they had the capacity to do so. We discuss this concept, and the circumstances in which it would be permissible to depart from a substituted judgment approach, in Chapter 17.
- 14.36 This is the Commission's preferred option.

- 22 *Powers of Attorney Act 1998* (Qld) s 63.
23 *Guardianship and Administration Act 2000* (Qld) sch 2 s 5.
24 *Adult Guardianship and Trusteeship Act*, SA 2008, c A-4.2, s 89(1).
25 *Powers of Attorney Act 1998* (Qld) s 113.
26 *Guardianship and Administration Act 1987* (NSW) s 44.



Question 70 Do you agree with the Commission's proposal (Option B) that the hierarchy for automatic appointees, as currently set out in section 37 of the *Guardianship and Administration Act 1986* (Vic), should be retained?

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Chapter 14

Automatic Appointments— the Person Responsible



Question 71 What alterations (if any) should be made to the list?

Question 72 Do you think new guardianship legislation should require an automatic appointee to take a substituted judgment approach to decision making?

Scrutiny of appointees

14.37 These options deal with scrutiny of the substitute decision-making activities of automatic appointees.

Option A: No change

14.38 This option proposes no change.

14.39 The advantage of this approach is that it leaves open the possibility of a guardianship application to VCAT if any interested party feels that an automatic appointee is not acting in the best interests of the represented person. The disadvantage of the option is that it provides no systematic external review of important decisions made by automatic appointees.

Option B: Introduce more scrutiny of automatic appointments

14.40 This option would involve additional measures for scrutinising decision making by automatic appointees. Random auditing of these decisions by a body such as the Public Advocate could be a way of bringing some external accountability to this role.

14.41 Another possible means of improving accountability would be to oblige third parties, such as medical practitioners, to notify the Public Advocate if they believe that a person responsible is not acting appropriately. While the G&A Act already allows an application to be made to VCAT in relation to any matter, question or dispute concerning medical treatment decisions, mandatory reporting to the Public Advocate could ensure that such matters are investigated appropriately. The Public Advocate, or any other party, could then take the matter to VCAT if this seems necessary following the investigation. This matter is also discussed in Chapter 20, where we consider the role of the Public Advocate.

14.42 The obvious advantage of this option is that it provides added safeguards to a system that allows significant decisions to be made by someone who has been appointed without any external scrutiny or screening. The disadvantage lies in the additional cost associated with more scrutiny of automatic appointees.

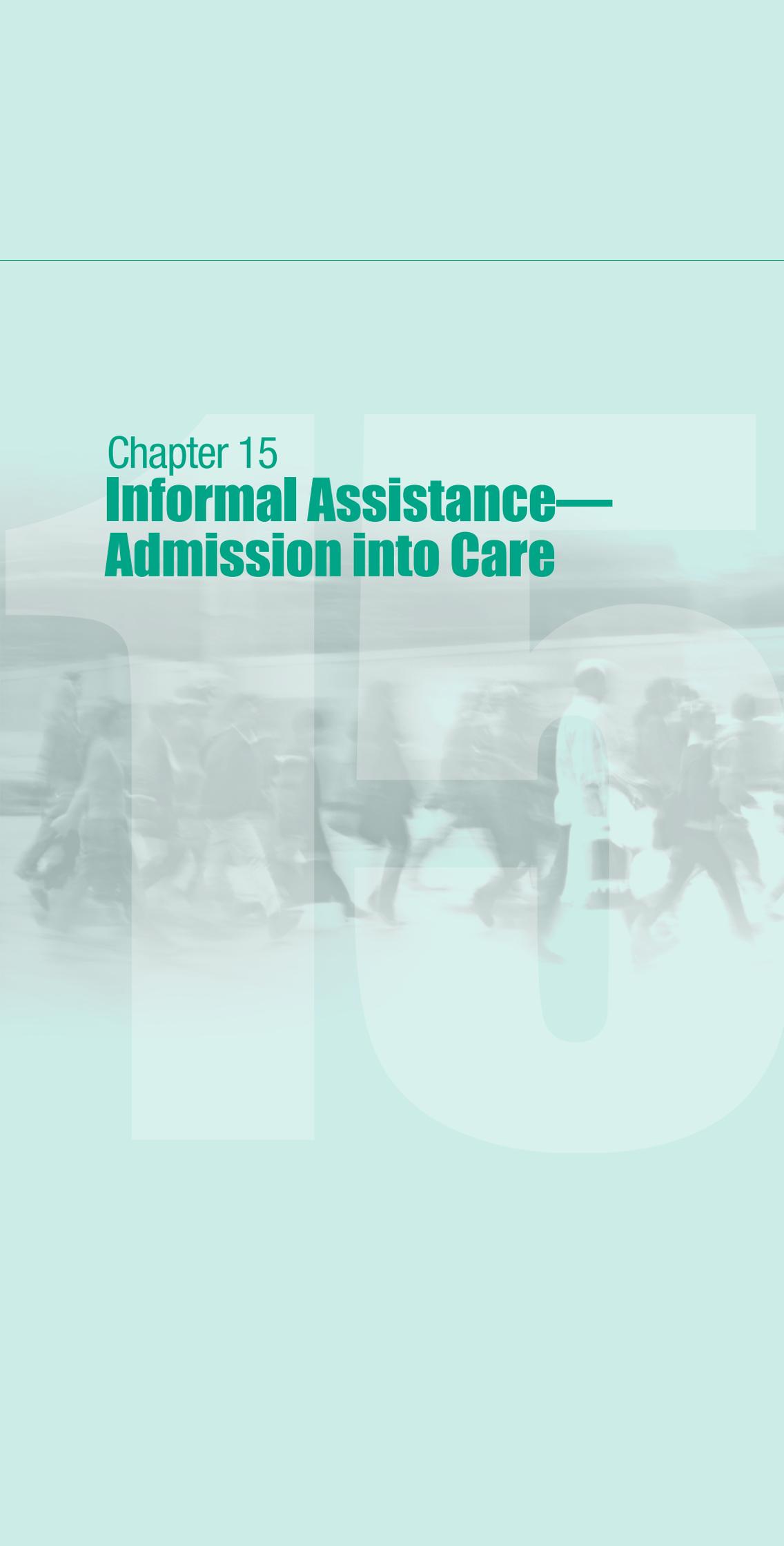


Question 73 Do you think that new guardianship legislation should contain additional measures for scrutinising the decisions made by automatic appointees? If so, what should those measures be?

USE OF AUTOMATIC APPOINTMENTS

14.43 The Commission believes consideration should be given to whether greater use could be made of automatic appointments so that they are used for matters other than substitute consent to medical or dental treatment. Automatic appointments can greatly reduce the stress, time and cost for people with disabilities and their families who would otherwise be required to go through a formal hearing process, even when appointing and choosing an appropriate substitute decision maker is uncontroversial.

- 14.44 Also, as discussed in Chapter 3, as a result of changing demographics there are growing demands on the tribunal appointment system. Automatic appointments could relieve this pressure.
- 14.45 Automatic appointments, coupled with effective accountability mechanisms, could be a means of authorising the admission of people to residential facilities who are unable to consent to this step. At present, most decisions of this nature are made informally and without external scrutiny. This issue is considered in the next chapter.



Chapter 15

Informal Assistance— Admission into Care

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Informal Assistance— Admission into Care

INTRODUCTION

- 15.1 In this chapter, we consider the use of informal arrangements in substitute decision making. Historically, there has been a strong emphasis upon promoting informal arrangements, with a substitute decision maker appointed only when there was a demonstrated need.
- 15.2 In recent years, the emphasis has shifted to promoting participation by people with disabilities in as many facets of life as possible and in providing appropriate safeguards when this is impossible. These changes, together with increased community concern about risk management, mean that it is necessary to reconsider the circumstances in which informal substitute decision-making arrangements should be used.
- 15.3 In this chapter, we consider the role of informal decision making in matters that have major implications for a person with impaired decision-making capacity. In particular, we consider whether informal decision making is an appropriate mechanism for people who are unable to consent to admission to, and continuing residence in, a particular facility, such as an aged care home, but who do not actively resist these living arrangements.

CURRENT LAW

- 15.4 The Minister's Committee on Rights and Protective Legislation for Intellectually Handicapped Persons (Cocks Committee),¹ which developed the policy for the original *Guardianship and Administration Act 1986* (Vic) (G&A Act) in 1982, reported that in many instances the parents of an adult with a disability who is unable to make particular decisions can provide informal consent to various actions without the need for a guardianship order:
- Though parents are not the legal guardians of their adult 'children', it is standard practice to seek their consent in relation to personal life matters such as medical care and place of residence. Their consent is an informal one, but it is functionally adequate. In the great majority of cases, this authority would not be challenged and an application for guardianship in such circumstances would serve no real purpose.²*
- 15.5 Disability policy and attitudes to legal risk have evolved quite substantially in the 29 years since the Cocks Committee delivered its report. It may no longer be appropriate to rely upon informal consent by family members when dealing with important matters, such as deprivation of liberty for the purpose of care and medical treatment, because of the lack of safeguards. In addition, some third parties may be reluctant to act upon the informal consent of a person who has no power to authorise actions taken in relation to a person with impaired decision-making capacity.
- 15.6 As noted in Chapter 3, an increasing number of Victorians are likely to need substitute decision makers in the next few years. The needs of an aging population who may be unable to make decisions due to dementia are of particular concern. Some form of substitute decision making is needed to make accommodation arrangements for those people who lack capacity to make their own decisions about residence in places such as secure nursing homes.

15.7 It is a challenge to devise fair, efficient and economical safeguards for the many people who are likely to need a substitute decision maker to decide where they will live. For example, a dramatic increase in the number of guardianship applications to provide guardians for all people with dementia who need substitute decision makers to consent to their stay in a secure nursing home would probably place an unsustainable demand on VCAT. It is important, therefore, to consider alternatives to guardianship orders that provide appropriate safeguards for the increased number of people who may need a substitute decision maker to authorise their accommodation arrangements.

PROBLEMS WITH CURRENT LAW AND PRACTICE

15.8 At present, there are a number of ways of formally appointing a substitute decision maker. These are personal appointments,³ which we discussed in Part 4, VCAT appointments of guardians or administrators,⁴ which we discussed in Part 5, and automatic appointments of substitute decision makers for consent to medical or dental treatment, which we discussed in Chapter 14.⁵ Guardianship legislation has also effectively encouraged the use of informal decision-making arrangements in many circumstances.

A LACK OF RECOGNITION OF THE IMPACT OF 'DE FACTO' GUARDIANS

15.9 The requirement in the G&A Act that neither a guardian nor an administrator should be appointed if a person's needs could be met in a less restrictive way was intended to be a means of safeguarding that person's freedom of decision making and action.⁶ A formal approach to decision making was considered unnecessary if informal means would suffice. Unsurprisingly, this 'less restrictive' requirement has meant that VCAT will often decide not to appoint a guardian or an administrator if other, less formal, mechanisms are in place and seem to be working well.

15.10 It is debatable, however, whether this 'less restrictive' approach always succeeds in preserving the freedom of the person concerned to make or influence decisions. In some circumstances, informal decision making for a person may actually restrict that person's freedom of action rather than safeguard it.

15.11 The extent to which informal mechanisms work well in practice is sometimes a contentious matter. Decisions for a person who has a disability that severely limits their independence and their decision-making capacity are often made by people associated with their daily living. Sometimes this will be a family member or other unpaid carer, and at other times staff working in a disability support service.

15.12 These people are, in effect, 'de facto' guardians. However, unlike guardians or administrators appointed by VCAT, there is no formal recognition of their role or scrutiny of these arrangements.

Accommodation decisions

15.13 At present, many people with impaired decision-making capacity are admitted to and reside in facilities, such as nursing homes, with the informal consent of a close family member. The number of people in this position is likely to grow quite substantially over the next two decades as the community ages and life expectancy increases.

1 Minister's Committee on Rights and Protective Legislation for Intellectually Handicapped Persons, Parliament of Victoria, *Report of the Minister's Committee on Rights and Protective Legislation for Intellectually Handicapped Persons* (1982).

2 *Ibid* 19.

3 *Instruments Act 1958* (Vic) pt XI (general power of attorney); *Instruments Act 1958* (Vic) pt XIA (enduring power of attorney (financial)); *Guardianship and Administration Act 1986* (Vic) s 35A (enduring guardian); *Medical Treatment Act 1988* (Vic) s 5A (enduring power of attorney (medical treatment)).

4 *Guardianship and Administration Act 1986* (Vic) ss 22, 46.

5 *Ibid* s 37 ('person responsible').

6 *Ibid* ss 22(2)(a), 46(2)(a).

Informal Assistance— Admission into Care

15.14 It is important to consider how the Victorian community wants decisions of this nature to be made in the future. Other countries, most notably the United Kingdom, have taken steps to move beyond informal decision making in relation to these accommodation authorisations because of concerns about lack of appropriate safeguards.

THE BOURNEWOOD CASE

15.15 The lack of adequate safeguards for people who are unable to consent to or refuse admission to an institution but do not resist this step became an important issue in the United Kingdom following the ‘Bournewood’ case.⁷ In response to the European Court of Human Rights’ decision in that case, the United Kingdom Government introduced the Deprivation of Liberty Safeguards, which came into force on 1 April 2009.⁸

Background

- 15.16 HL was a 48-year-old man with autism who was informally admitted to and detained at Bournewood hospital after he began exhibiting agitated, self-destructive behaviour at his day program.
- 15.17 HL did not resist his admission to Bournewood. He was compliant but lacked the capacity to consent or object to both medical treatment and his effective detention in hospital.
- 15.18 A series of cases in the United Kingdom, brought on behalf of HL by his carers, culminated in a House of Lords decision that a person who lacks the capacity to consent to their accommodation in hospital does not have to become an involuntary patient under mental health legislation, but could be detained in hospital as an informal patient relying upon the common law doctrine of necessity.⁹ At the time of this decision, there was no generic guardianship legislation in the United Kingdom.
- 15.19 Following the House of Lords decision, the matter was taken to the European Court of Human Rights.

European Court of Human Rights Decision: *HL v United Kingdom*¹⁰

15.20 The European Court of Human Rights found that the admission of HL to Bournewood hospital and his subsequent detention was a deprivation of his liberty and a violation of article 5(1) of the *European Convention for the Protection of Human Rights and Fundamental Freedoms* (European Convention).¹¹ The relevant parts of article 5(1) provide that:

Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law.

- 15.21 A number of qualifications apply to the right to liberty. One of these exceptions is ‘the lawful detention ... of persons of unsound mind’.¹² However, to be lawful, the detention must be ‘in accordance with a procedure prescribed by law’.¹³
- 15.22 In determining if HL had been unlawfully deprived of his liberty, the European Court of Human Rights considered the following three issues:
- Was HL detained?
 - Was HL of unsound mind?
 - Was the detention unlawful?

- 15.23 It found that HL was detained; the health care professionals treating and managing him ‘exercised complete and effective control over his care and movements’.¹⁴ He ‘was under continuous supervision and control and was not free to leave’.¹⁵
- 15.24 The Court also accepted that HL was of unsound mind.¹⁶ The remaining question was whether the detention was lawful.
- 15.25 The decision emphasises that the essential objective of article 5(1) of the European Convention is ‘to prevent individuals being deprived of their liberty in an arbitrary fashion’.¹⁷ The Court stressed that this objective, combined with the general requirement that the detention be ‘in accordance with a procedure prescribed by law’, required ‘the existence in domestic law of adequate legal protections and “fair and proper procedures”’.¹⁸
- 15.26 It determined that the detention was unlawful because there were insufficient procedural safeguards to guard against arbitrary detention. The Court emphasised the lack of fixed rules for the admission and detention of compliant people and the strong contrast with the extensive network of safeguards for involuntary patients under the *Mental Health Act 1983* (UK).¹⁹
- 15.27 The European Court of Human Rights also determined that there had been a breach of HL’s article 5(4) right to a speedy review of the lawfulness of his detention. Article 5(4) provides that:

*Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.*²⁰

Response to the ‘Bournewood gap’

- 15.28 The decision to admit HL to Bournewood informally complied with the Code of Practice under the *Mental Health Act 1983* (UK), which mandated informal admission when a person is mentally incapable of consent but does not object to entering hospital and receiving care or treatment.²¹ The Bournewood decision meant, however, that there was a large group of people who were potentially being deprived of their liberty contrary to article 5(1) of the European Convention.
- 15.29 The government sought to identify which groups of people were affected and in which settings they might be found. In addition to people like HL, who had been admitted to hospital informally, an additional group of people was identified as possibly falling within the ‘Bournewood gap’. This group of people lack capacity to consent to their admission to and confinement within a particular facility. This group includes many people with dementia who reside in non-hospital settings such as care homes.²²
- 15.30 The United Kingdom considered three possible responses to the Bournewood decision:
- introduce a new ‘protective care’ system to govern admission and detention procedures as well as reviews of detention and appeals.²³
 - extend the use of detention under the *Mental Health Act 1983* (UK) to the Bournewood group of patients²⁴
 - use existing arrangements for guardianship under the *Mental Health Act 1983* (UK).²⁵

- 7 *R v Bournewood Community and Mental Health NHS Trust; Ex parte L* [1999] 1 AC 458; *HL v United Kingdom* (2005) 40 EHRR 32. We refer to the European Court of Human Rights case as ‘Bournewood’.
- 8 We discuss the Deprivation of Liberty Safeguards in more detail later in this chapter: see [15.33]–[15.64].
- 9 *R v Bournewood Community and Mental Health NHS Trust; Ex parte L* [1999] 1 AC 458.
- 10 *HL v United Kingdom* 40 EHRR 32.
- 11 *Convention for the Protection of Human Rights and Fundamental Freedoms*, opened for signature 4 November 1950, 213 UNTS 221 (entered into force 3 September 1953), as amended by *Protocol No 11 to the Convention for the Protection of Human Rights and Fundamental Freedoms*, opened for signature 11 May 1994, ETS No 155 (entered into force 1 November 1998) (‘ECHR’).
- 12 ECHR art 5(1)(e).
- 13 *Ibid* art 5(1).
- 14 *HL v United Kingdom* (2005) 40 EHRR 32, 792.
- 15 *Ibid* 793.
- 16 *Ibid* 796.
- 17 *Ibid* 799.
- 18 *Ibid*.
- 19 *Ibid* 800–1.
- 20 Article 5 of the European Convention on Human Rights is expressed in very similar terms to the right to liberty and security of the person provided by the *Charter of Human Rights and Responsibilities Act 2006* (Vic) s 21(1)–(3), which is discussed in more detail later in this chapter: see [15.65]–[15.68].
- 21 See Department of Health (United Kingdom), *Bournewood Consultation: The Approach to be Taken in Response to the Judgment of the European Court of Human Rights in the ‘Bournewood’ Case* (2005) 3 [2.2] (‘*Bournewood Consultation*’).
- 22 See *ibid* 4, 22–3.
- 23 See *ibid* 8.
- 24 See *ibid* 13.
- 25 See *ibid* 14.

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15.31 Following consultations,²⁶ the United Kingdom Government decided to introduce a ‘protective care’ system in the *Mental Capacity Act 2005* (UK), which is the broad equivalent of the G&A Act. The ‘Deprivation of Liberty Safeguards’ came into force on 1 April 2009.²⁷

DEPRIVATION OF LIBERTY UNDER THE *MENTAL CAPACITY ACT 2005* (UK)

15.32 The *Mental Capacity Act 2005* (UK) applies in England and Wales.²⁸ It provides that it is only lawful to deprive someone of their liberty under the Act if:

- it gives effect to a relevant decision of the court²⁹
- it is to give life-sustaining treatment, or do a vital act,³⁰ while seeking a decision from the court³¹
- the deprivation is in a hospital (either public or private)³² or care home³³ for the purpose of giving care or treatment and an authorisation under schedule 1A is in force.³⁴

DEPRIVATION OF LIBERTY SAFEGUARDS

15.33 The Deprivation of Liberty Safeguards apply to people in care homes as well as hospitals and allow people to be detained for physical and psychiatric treatment.³⁵ They apply to people who:

*lack capacity specifically to consent to treatment or care in either a hospital or care home that, in their own best interests, can only be provided in circumstances that amount to a deprivation of liberty, and where detention under the Mental Health Act 1983 is not appropriate for the person at that time.*³⁶

15.34 The safeguards are intended to ‘provide a proper legal process and suitable protection in those circumstances where deprivation appears to be unavoidable, in a person’s own best interests’.³⁷ They do not cover deprivations of liberty in supported accommodation,³⁸ a private residence,³⁹ or for people under the age of 18.⁴⁰ They do not apply to people detained under the *Mental Health Act 1983* (UK).⁴¹

15.35 They provide for two types of authorisations for a deprivation of liberty: a standard authorisation⁴² and an urgent authorisation.⁴³

What is a deprivation of liberty?

15.36 The *Mental Capacity Act 2005* (UK) provides limited guidance as to what constitutes a ‘deprivation of liberty’, merely indicating that it has the ‘same meaning as in Article 5(1) of the Human Rights Convention’.⁴⁴ The *Deprivation of Liberty Safeguards: Code of Practice to Supplement the Main Mental Capacity Act 2005 Code of Practice* emphasises the point made in ‘Bournemouth’ that it is impossible to lay down a rigid formula for determining if there is a deprivation of liberty:

*[T]o determine whether there has been a deprivation of liberty, the starting-point must be the specific situation of the individual concerned and account must be taken of a whole range of factors arising in a particular case such as the type, duration, effects and manner of implementation of the measure in question. The distinction between a deprivation of, and restriction upon, liberty is merely one of degree or intensity and not one of nature or substance.*⁴⁵

15.37 The Deprivation of Liberty Safeguards Code suggests that it may be helpful to imagine a scale that moves from a restraint or restriction to a deprivation of liberty. It notes that an individual’s position on the scale ‘will depend on the concrete circumstances of the individual and may change over time’.⁴⁶

15.38 In the *Bournewood* case, the Court confirmed that a person may be deprived of their liberty even if a ward is not locked or lockable.⁴⁷ The Deprivation of Liberty Safeguards Code details a number of factors from United Kingdom and European Court of Human Rights case law that are relevant in determining if the line between restriction upon liberty and deprivation of liberty has been crossed. These include factors such as:

- physical control (eg restraint, including sedation)
- mental control (eg the exercise of complete and effective control over the care and movement of a person for a significant period by staff)
- a combination of mental and physical control (eg the refusal of a request by carers for a person to be released into their care).⁴⁸

The Code emphasises that the list is not exclusive and the concrete circumstances of each case must be considered.

15.39 The lack of any definitive guidelines as to what constitutes a deprivation of liberty and what is merely a restriction of liberty may make it extremely difficult for hospitals and care homes to determine whether a particular situation is likely to amount to a deprivation of liberty.

Overview of safeguards

15.40 The Deprivation of Liberty Safeguards seek to ensure that individuals who are or who may be deprived of their liberty in a hospital or care home are identified and the decision is externally reviewed and authorised, even if the person is not actively seeking liberty. Once a person in this situation is identified, an assessment process is carried out by between two and six assessors who each report separately to the supervisory body that commissions the assessments. If all the requirements are met, an authorisation must be issued. The safeguards are unusual because authority for a person's deprivation of liberty is effectively provided by these various clinicians rather than by a court, tribunal or statutory official.

26 Consultations took place between March and June 2005. The Government received 108 responses from a wide range of groups and individuals. See *Bournewood Consultation*, above n 21, 3, 17–20.

27 *Mental Capacity Act 2005* (UK) c 9, ss 4A, 4B, schs A1, 1A. The new legislative scheme was inserted into the *Mental Capacity Act 2005* (UK) c 9 by the *Mental Health Act 2007* (UK) c 12, s 50, schs 7, 8, 9.

28 We note that the safeguards apply slightly differently in England and Wales due to varying regulations. This chapter deals primarily with the scheme as it operates in England.

29 *Mental Capacity Act 2005* (UK) c 9, s 4A(3). Section 4(A)(4) provides that a relevant court decision is a decision made by an order under s 16(2)(a) in relation to a matter concerning the individual's personal welfare. Section 16(2)(a) allows for the court to make an order to decide the matter(s) on the individual's behalf.

30 *Mental Capacity Act 2005* (UK) c 9, s 4B. A vital act is defined in s 4B(5) as any act the person reasonably believes to be necessary to prevent a serious deterioration in the individual's condition.

31 It is only lawful to deprive someone of their liberty for life-sustaining treatment or to do a vital act if there is also a question about whether the person may be deprived of their liberty under s 4A (that is, to give effect to a relevant court decision or if an authorisation under sch A1 is in force): see *Mental Capacity Act 2005* (UK) c 9, s 4B(2).

32 *Mental Capacity Act 2005* (UK) c 9, sch A1 para 175(1).

33 Ibid sch A1 para 178 defines care home as having the meaning given by s 3 of the *Care Standards Act 2000* (UK). Under c 14, s 3 of this Act, an establishment is a care home if it provides accommodation, together with nursing or personal care, for any of the following people: (a) people who are or have been ill; (b) people who have or have had a mental disorder; (c) people who are disabled or infirm; (d) people who are or have been dependent on alcohol or drugs. An establishment is not a care home if it is a hospital, an independent clinic, or a children's home, or if it is of a description excepted by regulations.

34 *Mental Capacity Act 2005* (UK) c 9, s 4A(5), sch 1A.

35 In contrast, the *Mental Health Act 1983* (UK) c 20 only allows detention for psychiatric health purposes: see *GJ v The Foundation Trust* [2009] EWHC 2972 (Fam).

36 Ministry of Justice (United Kingdom), *Deprivation of Liberty Safeguards: Code of Practice to Supplement the Main Mental Capacity Act 2005 Code of Practice* (2008) 9 ('*Deprivation of Liberty Safeguards: Code of Practice*').

37 Ibid 9–10.

38 See *Salford City Council v BJ* [2009] EWHC 3310 (Fam).

39 See *Deprivation of Liberty Safeguards: Code of Practice*, above n 36, 14: 'It will only be lawful to deprive somebody of their liberty elsewhere ... when following an order of the Court of Protection on a personal welfare matter. In such a case, the Court of Protection Order itself provides a legal basis for the deprivation of liberty. This means that a separate deprivation of liberty authorisation under the processes set out in the Code of Practice is not required'.

40 This situation would generally fall under the *Children Act 1989* (UK) c 41, s 25. In some situations it would be appropriate to use the *Mental Health Act 1983* (UK) c 20: see *Deprivation of Liberty Safeguards: Code of Practice*, above n 36, 12.

41 *Mental Health Act 1983* (UK) c 20. The determination of whether someone is ineligible for the safeguards is made under *Mental Capacity Act 2005* (UK) c 9, sch 1A. For a recent discussion of the problematic relationship between the *Mental Health Act 1983* (UK) c 20 and the ineligibility provisions for the Deprivation of Liberty Safeguards contained in the *Mental Capacity Act 2005* (UK) c 9, sch 1A, see Neil Allen, 'The Bournewood Gap (As Amended?)' (2010) 18 *Medical Law Review* 78.

42 *Mental Capacity Act 2005* (UK) c 9, sch A1 pt 4. For guidance on how to apply the standard authorisation process in practice, see *Deprivation of Liberty Safeguards: Code of Practice*, above n 36, 28–66.

43 *Mental Capacity Act 2005* (UK) c 9, sch A1 pt 5. For guidance on how to apply the urgent authorisation process in practice, see *Deprivation of Liberty Safeguards: Code of Practice*, above n 36, 67–75.

44 *Mental Capacity Act 2005* (UK) c 9, s 64(5).

45 *HL v United Kingdom* (2005) 40 EHRR 32, 791; *Deprivation of Liberty Safeguards: Code of Practice*, above n 36, 16–17.

46 *Deprivation of Liberty Safeguards: Code of Practice*, above n 36, 17.

47 *HL v United Kingdom* (2005) 40 EHRR 32, 793.

48 *Deprivation of Liberty Safeguards: Code of Practice*, above n 36, 17.

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Chapter 15

Informal Assistance— Admission into Care



15.41 The majority of the safeguards aim to ensure compliance with article 5(1) of the European Convention⁴⁹ by ensuring that any deprivation of liberty is a lawful detention of a person of unsound mind and is in accordance with a procedure prescribed by law. The right to apply to the Court of Protection about the Deprivation of Liberty Safeguards aims to ensure compliance with article 5(4) of the European Convention,⁵⁰ which provides a right to a speedy review by a court of a detention's lawfulness.

15.42 The safeguards fall into two categories: those that protect the person prior to or during the process for the issue of an authorisation, and those that protect a person once an authorisation is in place.

Prior to authorisation

15.43 The main features of the safeguards that protect individuals prior to or during the process for the issue of an authorisation are:

- a duty on hospitals and care homes to identify people who are, or are likely, to be deprived of their liberty in the hospital or care home in the next 28 days and to meet all the qualifying requirements for a Deprivation of Liberty Safeguards standard authorisation⁵¹
- a duty on the 'managing authority'⁵² of the hospital or care home to apply for a standard authorisation from its 'supervisory body'⁵³ to detain the person⁵⁴
- a duty on the supervisory body of the hospital or care home to ensure that assessments are carried out to see if the person meets the six qualifying requirements for a standard authorisation. The six qualifying requirements are:
 - age requirement
 - mental health requirement
 - mental capacity requirement
 - best interests requirement
 - eligibility requirement
 - no refusal requirement⁵⁵
- a duty on the supervisory body to instruct an Independent Mental Capacity Advocate to represent and support the person⁵⁶ if there is an application for a deprivation of liberty authorisation and there is no one other than people engaged in providing care or treatment for the person to consult in determining what would be in the person's best interests⁵⁷
- the ability for a third party to ask the supervisory body to determine if there is an unauthorised deprivation of liberty.⁵⁸ Provided the request is not vexatious or frivolous and the matter has not been decided already with no change in circumstances, the supervisory body must appoint an assessor to determine if the person is a detained resident.⁵⁹ The assessment must be completed within seven days from the date that the supervisory body receives the request.⁶⁰ If the assessment determines that the person is a detained resident and the detention is unauthorised, a full assessment must be carried out.

After authorisation

15.44 After an authorisation is issued, the main features of the safeguards are:

- a duty on the supervisory body to appoint a representative for the person if a standard authorisation for deprivation of liberty is issued.⁶¹ The representative must maintain contact with the relevant person, and represent and support the relevant person in all matters relating to the Deprivation of Liberty Safeguards⁶²
- a duty on the supervisory body to instruct an Independent Mental Capacity Advocate to represent the person during any gaps in the appointment of a representative⁶³
- a duty on the supervisory body to instruct an Independent Mental Capacity Advocate if the relevant person does not have a paid representative and:
 - they or the representative requests that an Independent Mental Capacity Advocate is appointed, or
 - the supervisory body believes that instructing an Independent Mental Capacity Advocate will help ensure that the person's rights are protected⁶⁴
- a duty on the supervisory body to review a standard authorisation if a review is requested by the relevant person, their representative or the managing authority.⁶⁵ The managing authority must request a review if it believes that one or more of the qualifying requirements is reviewable⁶⁶
- a maximum period of 12 months duration for an authorisation⁶⁷
- a right to apply to the Court of Protection to determine questions about the lawfulness of the detention.⁶⁸

Authorisation

15.45 There are two types of authorisation, a standard authorisation⁶⁹ and an urgent authorisation.⁷⁰

49 ECHR art 5(1).

50 Ibid art 5(4).

51 *Mental Capacity Act 2005* (UK) c 9, sch A1 para 24.

52 The managing authority of hospitals and care homes is defined in the *Mental Capacity Act 2005* (UK) c 9, sch A1 paras 176–9. The Ministry of Justice (United Kingdom), *Deprivation of Liberty Safeguards: Code of Practice*, above n 36, 28–9 summarises these provisions as follows: 'In the case of an NHS (public) hospital, the managing authority is the NHS body responsible for the running of the hospital in which the relevant person is, or is to be, a resident. In the case of a care home or private hospital, the managing authority will be the person registered, or required to be registered under Part 2 of the *Care Standards Act 2000* (UK) in respect of the hospital or care home'.

53 A supervisory body of hospitals and care homes is defined in the *Mental Capacity Act 2005* (UK) c 9, sch A1 paras 180–3 as one of the following: a Primary Care Trust, a local authority, the Welsh Ministers or a local health board. For a more comprehensive explanation, see *Deprivation of Liberty Safeguards: Code of Practice*, above n 36, 28–30.

54 *Mental Capacity Act 2005* (UK) c 9, sch A1 para 24. The duty also applies if a standard authorisation has been given and is in force and there is, or is to be, a change in the place of detention (para 25).

55 *Mental Capacity Act 2005* (UK) c 9, sch A1 paras 13–20.

56 The general role and duties of an Independent Mental Capacity Advocate are detailed in the *Mental Capacity Act 2005* (UK) c 9, s 35. See also *Deprivation of Liberty Safeguards: Code of Practice*, above n 36, 36–8; Department for Constitutional Affairs (United Kingdom), *Mental Capacity Act 2005 Code of Practice* (2007) 178–201.

57 *Mental Capacity Act 2005* (UK) c 9, s 39A. The managing authority has a duty to notify the supervisory body of this when it submits the application for the deprivation of liberty authorisation (s 39A(2)).

58 *Mental Capacity Act 2005* (UK) c 9, sch A1 para 68.

59 Ibid sch A1 para 69.

60 *Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008* (UK) SI 2008/1858, reg 14.

61 *Mental Capacity Act 2005* (UK) c 9, sch A1 para 139.

62 Ibid sch A1 para 140.

63 Ibid s 39C.

64 Ibid s 39D.

65 Ibid sch A1, paras 102(2)–(3). The supervisory body may also carry out a review at any time on its own initiative (para 102(1)).

66 *Mental Capacity Act 2005* (UK) c 9, sch A1 para 103(2).

67 Ibid sch A1 paras 42, 51.

68 Ibid s 21A.

69 Ibid sch A1 pt 4. For details of how to apply the standard authorisation process in practice, see *Deprivation of Liberty Safeguards: Code of Practice*, above n 36, 39–66.

70 *Mental Capacity Act 2005* (UK) c 9, sch A1 pt 5. For details of how to apply the urgent authorisation process in practice, see *Deprivation of Liberty Safeguards: Code of Practice*, above n 36, 67–75.

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Standard authorisation

- 15.46 In general, a standard authorisation should be used. It should be applied for before the deprivation of liberty starts. A managing authority must request a standard authorisation if it appears likely that during the next 28 days, someone is likely to be accommodated in its hospital or care home in circumstances that amount to a deprivation of liberty and is likely to meet all the qualifying requirements for an authorisation.⁷¹
- 15.47 Once a supervisory body receives a request for a standard authorisation, it is required to ensure that six assessments are carried out to determine if the qualifying requirements are met.⁷² If all six qualifying requirements are met, the supervisory body must give a standard authorisation.⁷³ The written authorisation must detail:
- the duration of the authorisation
 - the purpose of the deprivation of liberty
 - the conditions imposed on the authorisation
 - the reasons that each qualifying requirement is met.⁷⁴

A deprivation of liberty authorisation should last for the shortest time possible and may not be issued for longer than 12 months.⁷⁵

Urgent authorisation

- 15.48 An urgent authorisation is used if a deprivation of liberty needs to occur before a standard authorisation can be completed. It makes the deprivation of liberty lawful for a maximum period of 14 days.⁷⁶
- 15.49 Only the managing authority may issue an urgent authorisation.⁷⁷ It can only be issued if a request for a standard authorisation has been made. This means that a managing authority should not issue itself an urgent authorisation unless it has a reasonable expectation that the six qualifying requirements will be met.⁷⁸

Assessments

- 15.50 The assessment process is both detailed and rigorous. The mental health assessor and the best interests assessor must be different people and there must be a minimum of two assessors.⁷⁹
- 15.51 The assessments must be carried out within 21 days from the date on which the supervisory body receives a request from the managing authority.⁸⁰
- 15.52 The 'age assessment' is to confirm that the person is 18 years or older.⁸¹
- 15.53 The 'no refusals assessment' is to ensure that there is no relevant refusal in place.⁸² There is a refusal if the person has made a valid advanced decision to refuse treatment.⁸³ There is also a refusal if the accommodation of the person in the relevant hospital or care home would conflict with a valid decision of either a court appointed substitute decision maker (deputy) or substitute decision maker personally appointed by the relevant person (donee).⁸⁴
- 15.54 The 'mental health assessment' is to establish that the person has a mental disorder within the meaning of the *Mental Health Act 1983* (UK).⁸⁵ A mental disorder is any disorder or disability of the mind excluding dependence on alcohol or drugs.⁸⁶ It includes all learning disabilities.⁸⁷ The mental health assessor must consider how the relevant person's mental health is likely to be affected by being a detained resident and report these conclusions to the best interests assessor.⁸⁸

15.55 The ‘mental capacity assessment’ is to establish that the person lacks capacity in relation to the question of whether or not they should be accommodated in the relevant hospital or care home for the purpose of being given relevant care or treatment.⁸⁹ A person lacks capacity in relation to a matter if, at the relevant time, they are unable to make a decision in relation to the matter because of the impairment of, or a disturbance of, the mind or brain.⁹⁰

15.56 The ‘eligibility assessment’ determines if the person is eligible for the Deprivation of Liberty Safeguards.⁹¹ A person is ineligible if their treatment is regulated by the *Mental Health Act 1983* (UK). The interaction between this Act and the *Mental Capacity Act 2005* (UK) is complex and the eligibility assessor must have a thorough understanding of both Acts. The determination as to whether someone is ineligible requires the assessor to consider an additional six-page schedule,⁹² as well as cross-refer to the *Mental Health Act 1983* (UK). The assessment concerns the person’s potential status under the *Mental Health Act 1983* (UK), not just their actual status.⁹³ If the *Mental Health Act 1983* (UK) is applicable, it must be used in preference to the *Mental Capacity Act 2005* (UK).⁹⁴ In general, a person will be eligible if the proposed deprivation is in a care home or in a hospital for non-mental health treatment.⁹⁵

15.57 The ‘best interests assessment’ is to establish that:

- the person is, or is to be, a detained resident
- it is in the best interests of the person to be a detained resident
- it is necessary for the person to be a detained resident to prevent harm to them
- detaining the person is a proportionate response to the likelihood of the person suffering harm and the seriousness of that harm.⁹⁶

71 *Mental Capacity Act 2005* (UK) c 9, sch A1 para 24. In some cases, a third party may request the supervisory body to determine whether there is an unauthorised deprivation of liberty. If an assessment has determined that the person is a detained resident and the detention is not authorised under s 4A, the standard authorisation procedure is followed as if the managing authority had applied: at sch A1 paras 67–73 for details of this process.

72 *Mental Capacity Act 2005* (UK) c 9, sch A1 para 33(2).

73 *Ibid* sch A1 para 50.

74 *Ibid* sch A1 para 55(1).

75 *Ibid* sch A1 paras 42, 51.

76 It is issued for a maximum period of seven days and can be extended once for a maximum of another seven days for exceptional reasons: *Mental Capacity Act 2005* (UK) c 9, sch A1 paras 77, 78(2), 84–6.

77 *Mental Capacity Act 2005* (UK) c 9, sch A1 para 74. It must make an urgent authorisation in situations where it is either required to make a request to, or has already made a request to the supervisory body for a standard authorisation and it believes that the need for the person to be deprived of their liberty is so urgent that deprivation needs to begin before the request is made, or dealt with by the supervisory body: at sch A1 para 76.

78 This is because the duty to request a standard authorisation only arises where the person is likely to meet the qualifying requirements: see *Mental Capacity Act 2005* (UK) c 9, sch 1A paras 24, 25. See also *Deprivation of Liberty Safeguards: Code of Practice*, above n 36, 67.

79 *Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008* (UK) SI 2008/1858, regs 4, 5; *Deprivation of Liberty Safeguards: Code of Practice*, above n 36, 41. The requirements for eligibility to be an assessor are rigorous. For example, in England a mental health assessment must be carried out by a registered doctor, who has completed standard training for deprivation of liberty safeguards and additional training relevant to their role as mental health assessor in the 12 months prior to selection (except in the 12-month period beginning with the date the doctor has successfully completed the standard training). The eligibility and selection requirements for assessors are detailed in the *Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008* (UK) SI 2008/1858, pts 2, 3.

80 *Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008* (UK) SI 2008/1858, reg 13. But note that the period for assessment is reduced if an urgent authorisation is in place under the *Mental Capacity Act 2005* (UK) c 9, sch A1 para 76. In this case, the assessments required for the standard authorisation must be completed within the period during which the urgent authorisation is in force: *Mental Capacity (Deprivation of Liberty: Standard Authorisations, Assessments and Ordinary Residence) Regulations 2008* (UK) SI 2008/1858, reg 13(2).

81 *Mental Capacity Act 2005* (UK) c 9, sch A1 paras 13, 34.

82 *Ibid* sch A1 paras 18–20, 48.

83 *Ibid* sch A1 para 19(1). Advance decisions are dealt with at ss 24–6.

84 *Mental Capacity Act 2005* (UK) c 9, sch A1 para 20(1). See: at ss 9, 16 for the appointment provisions relating to a donee or a deputy. In this context, a donee corresponds to an enduring guardian appointed under the *Guardianship and Administration Act 1986* (Vic) s 35A. A deputy corresponds to a guardian appointed under the *Guardianship and Administration Act 1986* (Vic) s 22.

85 *Mental Capacity Act 2005* (UK) c 9, sch A1 paras 14, 36.

86 *Mental Health Act 1983* (UK) c 20 s 1.

87 *Mental Capacity Act 2005* (UK) c 9, sch A1 para 14 provides that the exclusions in the *Mental Health Act 1983* (UK) c 20 for a person with a learning disability not to be regarded as suffering from a mental disorder do not apply.

88 *Mental Capacity Act 2005* (UK) c 9, sch A1 para 36.

89 *Ibid* sch A1 paras 15, 37.

90 *Ibid* s 2(1).

91 *Ibid* sch A1 paras 17, 46–8, sch 1A.

92 *Ibid* sch 1A.

93 *Ibid* sch 1A.

94 Justice Charles stated that ‘the MHA 1983 is to have primacy when it applies ... medical practitioners cannot pick and choose between the two statutory regimes as they think fit having regard to general considerations (eg the preservation or promotion of a therapeutic relationship with P) that they consider render one regime preferable to the other’: *GJ v The Foundation Trust* [2009] EWHC 2972 (Fam) [45]. For a critique of this judgment’s interpretation of the ineligibility assessment, and the primacy of mental health over mental capacity law see Neil Allen, ‘The Bournemouth Gap (As Amended?)’ (2010) 18 *Medical Law Review* 78. Allen notes that it is likely that the Deprivation of Liberty Safeguards could not have been used for HL in the paradigmatic case for which they were designed because it is likely that he would have been ineligible as an objecting mental health patient under the *Mental Capacity Act 2005* (UK) c 9 sch 1A para 2 (Case E). This means it is probable that his detention could only be authorised by the *Mental Health Act 1983* (UK) c 20.

95 See *Deprivation of Liberty Safeguards: Code of Practice*, above n 36, 48. But note there are circumstances in which a person is ineligible in these circumstances if the authorisation would be inconsistent with an obligation under the *Mental Health Act 1983* (UK) c 20, for example a requirement to reside in a particular place: see *Mental Capacity Act 2005* (UK) c 9, sch 1A paras 2 (Cases B, C, D), 3.

96 *Mental Capacity Act 2005* (UK) c 9, sch A1 paras 16, 38.

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15.58 The best interests assessment is extremely detailed. The Code of Practice recommends that the best interests assessment is undertaken last, once there is a reasonable expectation that the other five qualifying requirements will be met, because it is likely to be the most time-consuming.⁹⁷ It requires the assessor to undertake multiple tasks, including consideration of:

- the mental health assessor's conclusions about how the relevant person's mental health is likely to be affected by being a detained resident
- any relevant needs assessment
- any relevant care plan
- consultation with the relevant managing authority⁹⁸
- consultation with interested persons (if the assessor determines that the person is deprived of liberty or is likely to be a detained resident).⁹⁹

Problems with Deprivations of Liberty Safeguards

15.59 A number of people have expressed concerns about the Deprivation of Liberty Safeguards. While rigorous, the process is extremely detailed, time-consuming and resource intensive. Assessments take at least 10 hours for people who may be detained, but are likely to take up to 18 hours.¹⁰⁰ The Commission understands that some assessments take much longer than originally anticipated, leading to increased costs.¹⁰¹ These detailed assessments, which require at least two assessors, have the potential to cause a great deal of stress to the individual being assessed.¹⁰²

15.60 There are also inconsistencies in the application of Deprivation of Liberty Safeguards across England in the number and rate of applications. Some areas have a high number of applications, whereas others have very few.¹⁰³ This suggests that the safeguards may not actually provide protection to people, as they rely on a managing authority or concerned third party to initiate them. This step depends largely on the judgment of individual hospital and care managers and how they assess the distinction between a restriction and a deprivation of liberty.¹⁰⁴

15.61 In their first year of operation, the total number of applications for authorisations is significantly lower than expected (7157 in England, compared with the number predicted for both England and Wales, which was around 21 000), but the percentage of successful applications is higher (46.1 per cent, compared with the predicted 25 per cent).¹⁰⁵ Again, this may be because an application for assessment depends largely on the judgment of individual hospital and care managers and how they assess the distinction between a restriction and a deprivation of liberty. The fact that the percentage of successful applications is significantly higher than anticipated may suggest there are more situations that amount to a deprivation of liberty than anticipated.

15.62 Another issue is that it is unclear what deprivation of liberty means in the context of the Deprivation of Liberty Safeguards. The scale model suggested in the Code has been criticised both for its range (restriction to deprivation rather than liberty to deprivation) and the fact that a scale does not provide the type of yes/no answer required to the question 'is there a deprivation of liberty'?¹⁰⁶ Because of this, it may be difficult for a hospital or care home to identify a deprivation of liberty, but the efficacy of the safeguards depends on their ability to do so.¹⁰⁷

15.63 Furthermore, challenging an authorisation in the Court of Protection is likely to be both time-consuming and very expensive; the cost may be a limiting factor for many people.¹⁰⁸

15.64 Overall, the Deprivation of Liberty Safeguards have been criticised as being ‘complex, voluminous, overly bureaucratic and difficult to understand’ so as to amount to a ‘significant and costly error’.¹⁰⁹

POTENTIAL APPLICATION IN VICTORIA

15.65 The *Charter of Human Rights and Responsibilities Act 2006* (Vic) (the Charter) provides a right to liberty and security of the person. It provides that:

- every person has the right to liberty and security
- a person must not be subjected to arbitrary arrest or detention
- a person must not be deprived of their liberty except on grounds, and in accordance with procedures, established by law.¹¹⁰

15.66 It also provides that any person deprived of liberty by arrest or detention is entitled to apply to a court for a declaration or order regarding the lawfulness of their detention. The court must make a decision without delay and order the release of the person if it finds that the detention is unlawful.¹¹¹

15.67 These provisions are expressed in very similar terms to the right to liberty and security provided by article 5 of the European Charter that was found to be breached in ‘Bournewood’.

15.68 Given the similarities between article 5 of the European Charter and section 21 of Victoria’s Charter, it is possible that Charter proceedings against a ‘public authority’ in relation to a person without capacity, who is effectively detained in a hospital or nursing home by way of informal authorisation from a family member or carer, would produce a similar result to the Bournewood case.¹¹²

15.69 It is important that we consider appropriate safeguards for people who lack capacity to consent to their accommodation arrangements because it is extremely unlikely that these people will be in a position to pursue legal action on their own behalf. The Bournewood case only arose because HL’s carers objected to the arrangements made by hospital staff and undertook legal action on his behalf.

15.70 As mentioned throughout this paper, the population of older Victorians is increasing rapidly and there is an associated increase in the prevalence of dementia among the population.¹¹³ In many instances, people with dementia who live in Victorian hospitals or nursing homes are unable to consent to these arrangements, which are informally authorised by family members and carers.

15.71 In England, the majority of applications for authorisations under Deprivation of Liberty Safeguards have been made for people who lacked capacity because of dementia. From 1 April 2009 to 31 March 2010, a total of 7157 applications were made. Of these applications, 3645 were for people who lacked capacity because of dementia.¹¹⁴

COMMUNITY RESPONSES

THE BREADTH OF THE POWERS OF THE PERSON RESPONSIBLE

15.72 As noted in the previous chapter, the G&A Act confines the powers of the person responsible to decisions about medical and dental treatment. These powers are discussed in the next chapter, where we look specifically at substitute decision making for medical treatment.

15.73 Our information paper did not invite responses to the suggestion that the automatic appointment concept could be applied to decisions beyond medical and dental treatment.

- 97 *Deprivation of Liberty Safeguards: Code of Practice*, above n 36, 44.
- 98 *Mental Capacity Act 2005* (UK) c 9, sch A1 paras 38, 39. The requirements are in addition to the best interests principles in s 4, such as the requirement to consider the person’s past and present wishes and feelings.
- 99 *Mental Capacity Act 2005* (UK) c 9, s 4(7).
- 100 Damien Bruckard and Bernadette McSherry, ‘Mental Health Laws for those “Compliant” with Treatment’ (2009) 17 *Journal of Law and Medicine* 16, 21.
- 101 Consultation with Office of the Public Guardian (United Kingdom), Social Care Institute for Excellence and Department of Health (United Kingdom) (17 November 2010).
- 102 *Deprivation of Liberty Safeguards: Code of Practice*, above n 36, 41.
- 103 National Health Service Information Centre, Community and Mental Health, *Mental Capacity Act 2005 Deprivation of Liberty Safeguard Assessments (England): First Report on Annual Data 2009/10* (2010) 3 (*Mental Capacity Act 2005 Deprivation of Liberty Safeguard Assessments (England)*).
- 104 *Ibid* 5.
- 105 *Ibid* 3.
- 106 David Hewitt, ‘Off the Scale’ (2010) 154(8) *Solicitors Journal* 10, 10.
- 107 See Peter Lepping, Rajvinder Singh Sambhi, Karen Williams-Jones, ‘Deprivation of Liberty Safeguards: How Prepared Are We?’ (2010) 36 *Journal of Medical Ethics* 170, 170–1 on the difficulties associated with identifying a deprivation of liberty and the issue of whether the motive of the detaining authority is relevant in assessing whether a deprivation of liberty has occurred.
- 108 *Ibid* 170, 172. See also Richard Jones, *Mental Capacity Act Manual* (Sweet & Maxwell, 4th ed, 2010) v.
- 109 See Richard Jones, *Mental Capacity Act Manual* (Sweet & Maxwell, 4th ed, 2010) v. See also Peter Lepping, Rajvinder Singh Sambhi, Karen Williams-Jones, ‘Deprivation of Liberty Safeguards: How Prepared Are We?’ (2010) 36 *Journal of Medical Ethics* 170, 171. For example, Scotland has not introduced a similar scheme. Instead, it relies on guardianship applications and increased guidance for local authorities about the procedure to follow when making decisions for adults who lack capacity. For detail and a critique of the Scottish approach, see Gary Scot Stevenson, Tracy Ryan and Susan Anderson, ‘Principles, Patient Welfare and the Adults with Incapacity (Scotland) Act 2000’ (2009) 32 *International Journal of Law and Psychiatry* 120.
- 110 *Charter of Human Rights and Responsibilities Act 2006* (Vic) ss 21(1)–(3).
- 111 *Ibid* s 21(7).
- 112 The definition of ‘public authority’ in the *Charter of Human Rights and Responsibilities Act 2006* (Vic) s 4 is broad. Section 4(1)(c) includes entities that are exercising functions of a public nature on behalf of the state or a public authority.
- 113 Refer to Chapter 3 for more detailed information about Victoria’s ageing population and the increasing prevalence of dementia.
- 114 *Mental Capacity Act 2005 Deprivation of Liberty Safeguard Assessments (England)*, above n 103, 3.

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15.74 The Public Advocate identified deprivation of liberty as a key human rights concern:

OPA nominates as a key human rights topic of the next five years, the need for Victoria (and indeed Australia) to better regulate the means by which people with disabilities are subjected to some degree of 'deprivation of liberty' or are subjected to unregulated or under-regulated restrictive interventions.

The 'Bournewood' decision of the European Court of Human Rights gave rise to the development in England of 'deprivation of liberty safeguards' ... Such a development is overdue in Australia, and would be focussed in Victoria on people who suffer deprivations of liberty in a variety of settings (most notably in the disability and aged care sectors) and whose treatment is not auspiced by existing involuntary or coercive treatment laws.

While such 'deprivation of liberty safeguards' should not necessarily be housed in new guardianship legislation, the drafters of new guardianship legislation should certainly be mindful of this likely development.¹¹⁵

15.75 It is obviously preferable to provide adequate legal safeguards for people in this position in a planned way rather than in response to a significant court decision as has occurred in England and Wales with the Bournewood decision and the Deprivation of Liberty Safeguards.

OTHER JURISDICTIONS

15.76 In Queensland, an automatically appointed substitute decision maker called a 'statutory health attorney' can make decisions about health care matters.¹¹⁶ Like the 'person responsible' provisions of the G&A Act, the Queensland legislation sets out a hierarchy of people who may act as an automatically appointed statutory health authority. These are, in order, the person's spouse, their unpaid carer, a close friend or relative (who is not a paid carer).¹¹⁷ If none of these people are available and culturally appropriate to exercise power, the Adult Guardian is the statutory health attorney for the matter.¹¹⁸

15.77 An automatic appointment of a statutory health attorney will only take effect if there is:

- no relevant advance health directive giving a direction about the matter
- the tribunal has not appointed a guardian to deal with the matter or made an order about the matter
- the adult has not appointed an attorney for the matter.¹¹⁹

15.78 In Queensland, admission to high-level care in aged care facilities has been characterised as a health care decision.¹²⁰ This means that an automatically appointed statutory health attorney can consent to living arrangements of this nature.¹²¹

POSSIBLE OPTIONS FOR REFORM

CONSENT FOR RESIDENTIAL CARE ARRANGEMENTS

15.79 The following options consider ways of providing protection for individuals who do not have the capacity to make their own decisions about admission to, and in some cases confinement within, certain residential care facilities. Many people without capacity to consent to their accommodation arrangements live in residential care facilities in circumstances that do not amount to a deprivation of liberty. However, the living arrangements of people that result in them being effectively deprived of their liberty, such as in the Bournemouth case, may require additional safeguards even though the restrictive arrangements may be necessary to protect them from harm.

Option A: No change

15.80 This option would require no change to the current system of relying upon informal arrangements in most circumstances. This option would avoid the expense associated with providing additional legal safeguards to deal with those circumstances in which a person is effectively deprived of their liberty without any legal authorisation or review mechanism. It may be argued that public monies are better spent on improving the services for people living in these circumstances rather than on enhancing their legal rights.

15.81 The main disadvantage of this option is that it does not provide any mechanism for safeguarding against possible abuse of this very significant informal power to determine the living arrangements of a vulnerable person.

Option B: Use existing guardianship mechanism

15.82 This option would make use of existing guardianship provisions under the G&A Act. It would require that a guardian be appointed to provide consent to the admission and detention in residential care of someone who is unable to provide consent.

15.83 The advantages of this option are:

- it would close the 'Bournemouth gap'
- it builds on an existing scheme and does not require new legislation
- it could remove the difficulties associated with determining what is a 'deprivation of liberty' and when one is going to occur because it could apply to all admissions and detentions of someone who is unable to provide consent.

15.84 The disadvantages of this option are:

- the potential numbers of people who would need a guardian might place a great strain on the VCAT system
- it may be an unduly restrictive and disproportionate response
- the use of guardianship as a means of authorising detention runs counter to the 'least restrictive' and 'enabling' principles of the guardianship legislation.

115 Submission IP 8 (Office of the Public Advocate) 7.

116 *Guardianship and Administration Act 2000* (Qld) s 62.

117 *Ibid* s 63(1).

118 *Ibid* s 63(2).

119 *Ibid* s 66. There are also some situations where no consent is required—these are detailed at ss 62–4.

120 See Department of Justice and Attorney-General, Government of Queensland, *Health Care Decisions for Others* (29 June 2010) <<http://www.justice.qld.gov.au/justice-services/guardianship/making-health-care-decisions/healthcare-decisions-for-someone-else>>. See also *Powers of Attorney Act 1998* (Qld) sch 2 ss 4–5, which defines 'health matter' and 'health care'.

121 *Powers of Attorney Act 1998* (Qld) s 62.

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Option C: Introduce a new scheme of safeguards similar to the Deprivation of Liberty Safeguards scheme in England and Wales

- 15.85 This option would involve the introduction of a set of legal safeguards for the admission and detention of people who lack capacity to consent or refuse but are compliant with admission or detention. It could be similar to the Deprivation of Liberty Safeguards scheme that operates in England and Wales but be tailored to the Victoria context. As discussed above, the Deprivation of Liberty Safeguards seek to ensure that individuals who are or who may be deprived of their liberty in a hospital or care home are identified and the decision is externally reviewed and authorised, even if the person is not actively seeking liberty. Clinicians perform the assessment process and effectively authorise a person's detention when the Deprivation of Liberty Safeguards are met.
- 15.86 The primary advantage of this option is that it provides a tailored legislative approach to the issue of unauthorised restrictive living arrangements.
- 15.87 The disadvantages of the Deprivation of Liberty Safeguards approach are:
- they are unnecessarily detailed and inaccessible which makes them difficult to apply uniformly
 - the scheme is extremely resource intensive
 - there is no cost-effective oversight of the system by a court, tribunal or independent statutory officer.

Option D: Extend protection through other legislation

- 15.88 This option would involve extending an existing legislative scheme to provide rights protection for people admitted to, or continuing to reside in, residential facilities who are unable to provide consent because of impaired decision making capacity.
- 15.89 For example, the *Disability Act 2006 (Vic)* could be extended so that it applies to these circumstances by:
- extending the provisions relating to residential institutions, which include criteria for admission¹²² and a right to seek review at VCAT.¹²³ However, these provisions currently apply only to a limited number of state-run facilities¹²⁴ and only to people with an intellectual disability.¹²⁵ The Act could be amended to apply to a larger range of facilities and to a larger range of people whose disability impairs their decision-making capacity
 - ensuring that all of the compulsory treatment provisions that currently apply only to people with an intellectual disability¹²⁶ are extended to apply to any person who is unable or unwilling to consent to admission to a residential treatment facility
 - requiring that a support plan be offered to all people with a disability for whom support services are requested and who may lack the capacity to make their own decisions—a provision that currently applies only to people with an intellectual disability.¹²⁷
- 15.90 The principal advantage of this option is that it builds on safeguards that are already in place for some people. It places the obligation for ensuring rights protection more squarely in the domain of service provision and may promote more accountability and rights-awareness within the service provisions sector. It would also ensure that people have access to external review mechanisms.

15.91 A primary disadvantage of this approach is that it would be extremely expensive to extend Disability Act coverage to all people in publicly funded residential facilities who are unable to consent to their own continuing residence in one of those facilities.

Option E: Expand automatic appointment provisions to cover admission into some residential care facilities with additional safeguards

15.92 This option would extend the decision-making powers of automatic appointees (the 'person responsible' under section 37 of the G&A Act) so that they could consent to a person being admitted to and living in certain residential facilities.

15.93 The main advantage of this option is that it provides a family member or carer of a person with impaired decision-making capacity with the authority to make a decision about that person's place of residence in a way that is both efficient and economical. From a public policy perspective, it has the distinct advantage that it reflects what currently happens in practice, informally, in most cases.

15.94 A major disadvantage of this option is the relative lack of scrutiny of the actions of a 'person responsible'. When the person responsible model is used in the medical context, a doctor or dentist is involved in the decision making. Extra safeguards are provided by the ethical standards of those clinicians. This safeguard would not be present to the same degree if the person responsible model is used to automatically appoint someone to authorise a person's residence in a nursing home. Concerns about potential abuse of this power could be greatest in those cases where the person responsible might benefit if they cause an elderly relative to move from the family home to a residential care facility.

Additional safeguards

15.95 Additional safeguards are probably needed if the automatic appointments system were expanded to permit the person responsible to make decisions about residential care. The Commission has identified a range of safeguards that might be appropriate.

15.96 These safeguards could include medical certification that the person lacks capacity and is at risk of harm before the person responsible could exercise their powers. For example, certification that a person is at risk of harm without being accommodated in a secure place and that the person is unable to consent to this form of accommodation.

15.97 Notifying the Public Advocate that the person responsible has made a decision about accommodation could also safeguard against any potential abuse of power. The Public Advocate could be permitted to undertake random audits of the way that these decision makers have exercised their powers and responsibilities. The person responsible could also be required to reconsider the decision at regular time intervals to determine if this form of accommodation is still necessary.

15.98 The person who is being admitted or detained or any interested party should be able to challenge the consent given by the person responsible and have the decision reviewed by VCAT. A person responsible's consent could be deemed insufficient if the person was actively refusing, or resisting, admission to the facility, or was resisting staying there or actively requesting to leave. In these circumstances it would be necessary for VCAT to appoint a guardian in order to authorise the person's continuing residence in the facility.

15.99 If the person responsible were required to notify the Public Advocate that this power had been exercised, it could be possible for the Public Advocate to conduct some form of annual review of the on-going need for the restrictive living arrangements.

122 *Disability Act 2006* (Vic) s 87.

123 *Ibid* s 88.

124 *Ibid* s 86.

125 *Ibid* s 87.

126 *Ibid* pt 8.

127 *Ibid* s 55. The process or content of the support plan could then be the subject of a complaint to the Disability Services Commissioner under ss 109–11 of the Act.

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Chapter 15

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- 15.100 The automatic appointee could be required to consider a number of matters before consenting to admission to and detention in a residential facility. These matters might include the benefits of the placement for the person, whether a less restrictive alternative exists, and the period for which consent is given. The person responsible could be required to sign a declaration confirming that they have considered all these matters.
- 15.101 Another safeguard against potential abuse of power under this option could be a legislative requirement that the automatic appointment process would not apply if an admission or detention procedure under another piece of legislation was applicable, such as under the *Disability Act 2006 (Vic)* or the *Mental Health Act 1986 (Vic)*.
- 15.102 There may also be a need to place restrictions on the types of residential facility for which an automatic appointee's consent would be sufficient. These might be limited, for example, to those facilities that provide a level of health care or personal care, the need for which is relatively self-evident and for which there are likely to be few alternatives. A decision for admission to any other type of facility, where the decision to consent is less straightforward, or is more likely to be controversial, might still require the appointment of a guardian. For example, if the admission is to a facility that would generally be considered unable to provide appropriate services to the person in question, such as the admission of a young person with an acquired brain injury to an aged care home.
- 15.103 This option merits serious consideration because it is a practical, economic and broadly transparent means of responding to the issue of the growing number of people who remain in residential facilities without formal authorisation. While a tribunal appointment of a substitute decision maker is clearly a more rigorous option than a statutory scheme that automatically appoints a family member or carer to make important accommodation decisions, many people will suggest that public monies might be better spent on improving the living conditions of people in these circumstances rather than in establishing sophisticated substitute decision-making arrangements for them.



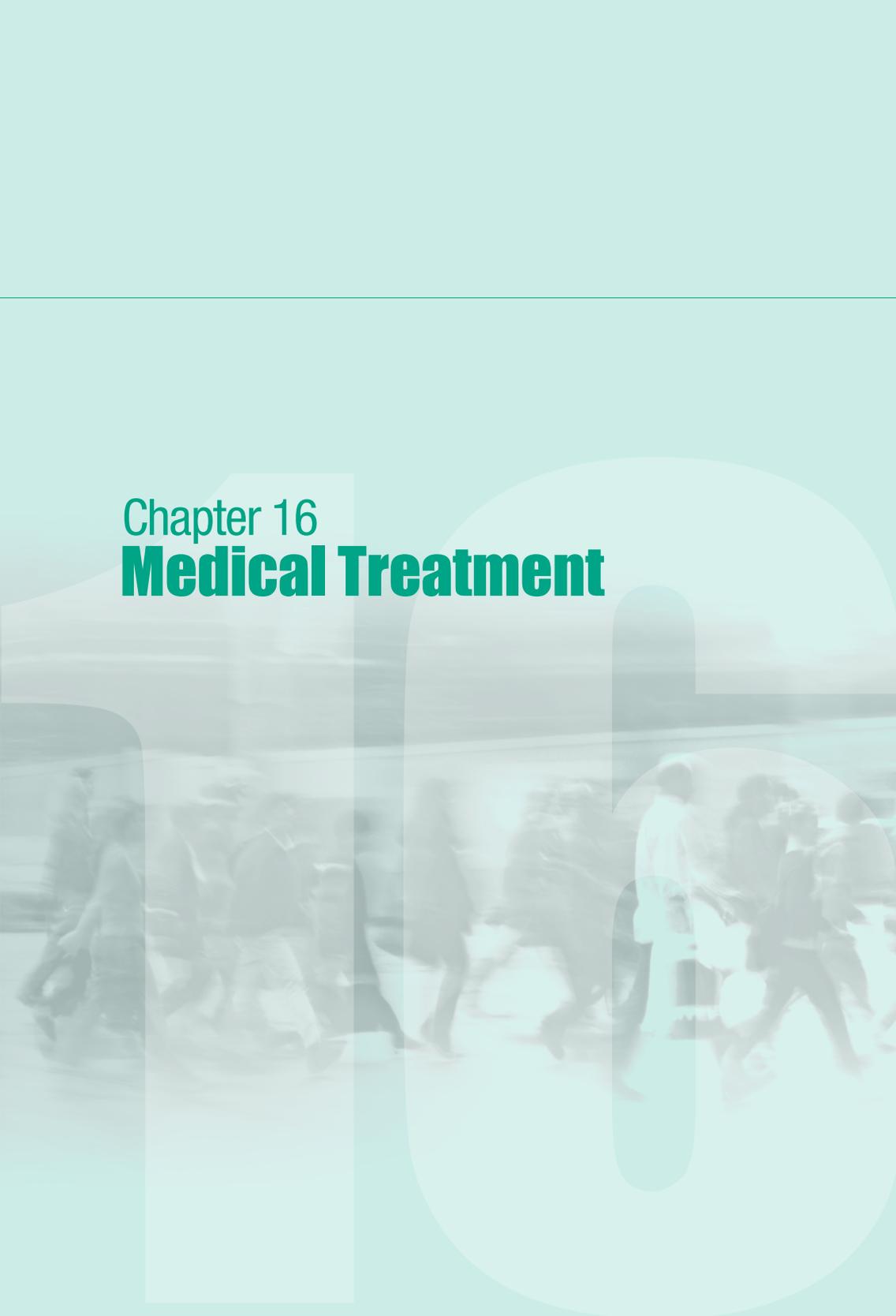
Question 74 Do you think there should be specific laws about people being admitted to and remaining in residential care facilities in situations where they do not have capacity to consent to those living arrangements but are not objecting to them?

Question 75 If yes, do you agree with the Commission's Option E that new guardianship legislation should extend the automatic appointment scheme to permit the 'person responsible' to authorise living arrangements in a residential care facility in these circumstances if there are additional safeguards?

Question 76 If the automatic appointment scheme is expanded to cover these circumstances, do you agree with any or all of the possible safeguards suggested by the Commission? Are there any other safeguards that should be introduced?

Question 77 If the automatic appointment scheme is expanded to cover these circumstances, should the hierarchy of automatic appointees be changed?

Question 78 If the automatic appointment scheme is expanded to cover these circumstances, what residential facilities should fall within the scheme?



Chapter 16

Medical Treatment

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INTRODUCTION

- 16.1 In this chapter, we consider the operation of part 4A of the *Guardianship and Administration Act 1986* (Vic) (G&A Act) that deals with substituted consent for medical treatment and its interaction with those parts of the *Medical Treatment Act 1988* (Vic) (Medical Treatment Act) concerning substituted consent for and refusal of medical treatment. Other statutes considered later in this paper—the *Mental Health Act 1986* (Vic) and the *Disability Act 2006* (Vic)—also deal with substituted consent for medical treatment for people with impaired decision-making capacity due to particular disabilities.
- 16.2 The law concerning medical treatment for people with impaired decision-making capacity is exceedingly complex. In order to explain its operation, it is necessary to describe the general law concerning medical treatment and to examine how it has been modified by guardianship legislation to deal with circumstances in which a person with impaired decision-making capacity is unable to authorise or refuse medical treatment.
- 16.3 This chapter commences with a broad overview of the current law concerning medical treatment. It then examines part 4A of the G&A Act and the relevant provisions of the Medical Treatment Act in some detail. Views expressed during consultations and in submissions are summarised, as are relevant laws in other jurisdictions. The chapter concludes with a discussion of options for reform.

CURRENT LAW

THE HISTORY OF VICTORIAN MEDICAL TREATMENT LAWS

- 16.4 The common law supports the right of all adults with capacity to make decisions about what happens to their bodies. This means that it is unlawful for any medical practitioner to treat an adult without their consent, other than in a life-saving emergency. These common law rules do not cater for those people who are unable to make their own medical treatment decisions because they do not allow an adult to authorise treatment for another adult in any circumstances.¹
- 16.5 In 1986, Victoria introduced the *Guardianship and Administration Board Act 1986* (Vic), which enabled the appointment of substitute decision makers for people with impaired decision-making capacity, including for health care and medical treatment.
- 16.6 In 1988, the Victorian Parliament passed the *Medical Treatment Act 1988* (Vic), which clarified and reasserted the common law right of people to refuse medical treatment. This Act was amended in 1990 to allow a person with capacity to appoint an agent to make medical treatment decisions for them—including the refusal of treatment—if they lose capacity in the future.
- 16.7 In 1999, the *Guardianship and Administration Act 1986* (Vic) was amended to allow:
- a substitute decision-maker to be appointed automatically, without requiring a Victorian Civil and Administrative Tribunal (VCAT) order, to consent to medical treatment on behalf of a person who is unable to consent themselves
 - a person, while having decision-making capacity, to appoint their own enduring guardian to make decisions on their behalf if and where they lose capacity to do so themselves in the future, including in relation to medical treatment and health care.
- 16.8 These various laws overlap. Because they were developed in response to different circumstances at different times, the ways in which they interact and overlap are not always clear and logical.

A SUMMARY OF THE CURRENT LAW

- 16.9 The law concerning medical treatment for people who do not have the capacity to make their own treatment decisions is complicated because it is necessary to consider a number of statutes, as well as the common law, in order to understand all of the relevant legal rules. While these laws do not always operate in complete harmony, the central principle is that all adults are autonomous beings who have the right to determine what happens to their bodies, unless the law authorises some interference with this right.
- 16.10 The logical starting point when examining this body of law is the common law of trespass to the person—most notably the law of assault and battery—that seeks to protect a person’s autonomy. This body of law, which makes unwanted interferences with a person’s bodily integrity unlawful, governs relations between health professionals and their patients.² In Victoria, the common law rules have been amended by statute in order to provide for circumstances in which people are unable to consent to treatment that may be beneficial³ and to clarify what should happen when a person with capacity wishes to refuse medical treatment at some time in the future when they may have lost capacity.⁴
- 16.11 The body of law may be summarised as follows:
- Any interference with the body of another adult, such as medical treatment, without the consent of that person or some other lawful authority, is unlawful unless it is medical treatment performed in a life-saving emergency.
 - No person may consent to medical treatment for another adult unless authorised by law to do so.
 - An adult who has decision-making capacity has the right to refuse any medical treatment, even though it may be disadvantageous to their health to do so, or result in their death. There is no Victorian law that authorises any interference with this right.
 - The Medical Treatment Act establishes a process that allows an adult with decision-making capacity to record their choice to refuse medical treatment for a current condition. The Act also makes it unlawful for any medical practitioner to knowingly provide medical treatment covered by the document.
 - The Medical Treatment Act also permits an adult with decision-making capacity to appoint an agent to give consent to or refuse any medical treatment on their behalf in the event that they lose capacity in the future. In some circumstances, VCAT may suspend or revoke the agent’s authority to refuse medical treatment.
 - Similarly, the G&A Act permits an adult with decision-making capacity to appoint an enduring guardian to give consent to or refuse⁵ medical treatment on their behalf in the event that they lose capacity in the future.
 - The G&A Act permits a number of people closely associated with an adult with impaired decision-making capacity to consent to most, but not all, medical treatment on behalf of that person. The Act establishes a process that ‘automatically’ gives a close associate of a person with impaired decision-making capacity the power to consent to most medical treatment.
 - Only VCAT is authorised to approve some types of medical treatment—sterilisation, abortion or donation of non-regenerative tissue—for an adult with impaired decision-making capacity.

- 1 See Ben White, Fiona McDonald and Lindy Willmott (eds), *Health Law in Australia* (Lawbook Co, 2010) Chapters 4–7.
- 2 Bernadette Richards, ‘General Principles of Consent to Medical Treatment’ in White, McDonald and Willmott (eds), above n 1, 93–111.
- 3 *Guardianship and Administration Act 1986* (Vic) pt 4A.
- 4 *Medical Treatment Act 1988* (Vic).
- 5 Whether an enduring guardian can actively refuse treatment, as opposed to simply declining to consent to it (a distinction that is explained later in this chapter) is a matter of controversy. The Commission’s reasons for arguing that the current law allows an enduring guardian to refuse treatment are also explained later in this chapter.

- If a person who is automatically appointed to make medical treatment decisions on behalf of a person with impaired decision-making capacity chooses to refuse some form of recommended treatment, the G&A Act authorises a health professional to administer that treatment if they believe, on reasonable grounds, that the treatment is in the best interests of the person concerned and if various procedural steps are followed that permit interested people to apply to VCAT for a ruling.
- The G&A Act permits a number of people closely associated with an adult person with impaired decision-making capacity to consent to most, but not all, medical research procedures involving that person if an ethics committee approves the research.

LEGISLATION

- 16.12 The Victorian Parliament enacted both the Medical Treatment Act and the the G&A Act in an attempt to clarify the issue of consent to medical treatment in some circumstances.
- 16.13 The Medical Treatment Act, which deals primarily with refusal of treatment, sought to clarify the common law, particularly when people were refusing treatment at the end of life. Initially, the Act applied only to people who had the capacity to refuse treatment themselves. In 1990, the Act was amended to enable a person, while having capacity, to appoint someone else to make decisions as their agent. The agent could be given authority to make medical treatment decisions on behalf of the patient in the event that they are unable to do so themselves at some time in the future.⁶
- 16.14 The G&A Act established a comprehensive system for the appointment of substitute decision makers for people who, because of disability, are unable to make their own decisions, including decisions about medical treatment. In 1999, the G&A Act was amended by including part 4A, which enabled medical practitioners to identify a person—known as the ‘person responsible’—who was authorised by virtue of their relationship to a person with impaired decision making capacity to consent to most medical or dental treatment for that person. The appointment of the person responsible was automatically triggered by the incapacity of an adult person to consent to their own treatment.
- 16.15 These new provisions in part 4A of the G&A Act enabled health practitioners to perform medical and dental treatment without making a guardianship application to VCAT—a requirement that had previously been unnecessarily cumbersome in some instances, and had resulted in a large number of applications to VCAT for relatively minor procedures.⁷
- 16.16 Both the Medical Treatment Act and part 4A of the G&A Act responded to the needs of medical practitioners. The Medical Treatment Act provided more clarity and security about potentially life-ending withdrawal of treatment, while part 4A of the G&A Act provided an efficient method of obtaining consent to treat patients who lacked capacity.
- 16.17 The way in which these two Acts operate together is a little unclear. While the Medical Treatment Act was initially concerned with end-of-life refusal of treatment, the 1990 amendment permitting a person to use an enduring power of attorney (medical treatment) to appoint an agent as a substitute decision maker when the person is incapable of making their own decisions appears to permit the agent to consent to (or refuse) *any* medical treatment. Even though the G&A Act’s provisions concerning consent to medical treatment by a person responsible give an agent under the Medical Treatment Act priority as a substitute decision maker, the G&A Act directs that only VCAT can consent to some medical treatment for a person who is unable to do so.

16.18 The Medical Treatment Act provides for the refusal of treatment, while the G&A Act provides for the withholding of consent. These overlapping concepts create a considerable degree of confusion about precisely what each means in relation to the other.

THE MEDICAL TREATMENT ACT 1988 (VIC)

The types of treatment covered

- 16.19 The Medical Treatment Act contains a very broad definition of ‘medical treatment’, describing it as the carrying out of an operation, the administration of a drug or other like substance, or any other medical procedure. It expressly excludes palliative care.⁸
- 16.20 The distinction between medical treatment and palliative care has been a matter of some controversy, despite the fact that the Medical Treatment Act contains definitions of both terms.⁹ In 2003, Justice Morris found that artificial nutrition and hydration via percutaneous endoscopic gastronomy (PEG) was medical treatment rather than palliative care.¹⁰ This finding permitted a guardian with powers to make decisions about a person’s medical treatment to refuse PEG for a represented person by relying upon the refusal treatment provisions of the Medical Treatment Act. The Commission sees no need to revisit this issue.

Who can consent to or refuse treatment

- 16.21 Three groups of people can make decisions about medical treatment under the Medical Treatment Act. They are:
- patients themselves¹¹
 - agents appointed by an enduring power of attorney (medical treatment)¹²
 - guardians appointed by VCAT, where VCAT has included the power to make decisions about medical treatment in the guardianship order.¹³
- 16.22 A person with capacity to make their own treatment decisions may appoint an agent ‘to make decisions about medical treatment’¹⁴ for them if and when they become ‘incompetent’.¹⁵ The appointment is made by using an enduring power of attorney (medical treatment). The reference to ‘decisions’ in this document, which must be used,¹⁶ clearly implies that the agent has the power to consent to and refuse medical treatment when the appointment comes into operation.

The procedure for refusing medical treatment

- 16.23 An agent or guardian must be informed about a patient’s current condition before they can refuse medical treatment on the patient’s behalf. This must be sufficient information that would allow the patient to make their own decision about whether to refuse the treatment.¹⁷ The agent or guardian can refuse treatment if it would cause unreasonable distress to the patient or if there are reasonable grounds for believing that the patient would consider the treatment unwarranted if they were able to make the decision themselves.¹⁸
- 16.24 When an agent or guardian decides to refuse treatment on behalf of a patient, a ‘refusal of treatment certificate’ must be completed.¹⁹ This certificate requires the agent or guardian to declare that:
- they are authorised to make medical treatment decisions for the patient
 - the patient is at least 18 years old
 - they have been informed about the patient’s condition
 - they understand this information
 - they believe that the patient would not want the treatment to be administered.

6 These are the provisions for appointment of an enduring power of attorney (medical treatment): see *Medical Treatment Act 1988* (Vic) s 5A.

7 Victoria, *Parliamentary Debates*, Legislative Assembly, 22 April 1999, 594 (Marie Tehan).

8 *Medical Treatment Act 1988* (Vic) s 3.

9 *Ibid* defines palliative care as including ‘the provision of medical procedures for the relief of pain, suffering and discomfort; or the reasonable provision of food and water’.

10 *Re BWV; Ex Parte Gardner* (2003) 7 VR 487, 504–5.

11 *Medical Treatment Act 1988* (Vic) s 5.

12 *Ibid* s 5A (1)(a)(aa).

13 *Ibid* s 5A(1)(b). The Medical Treatment Act does not refer to personally appointed enduring guardians.

14 *Medical Treatment Act 1988* (Vic) sch 2 [2].

15 *Ibid* s 5A(2)(b).

16 *Ibid* s 5A(2)(a).

17 *Ibid* s 5B(1).

18 *Ibid* s 5B(2).

19 *Ibid* s 5B(3).

This must be verified by two people, who certify that they are satisfied that the agent or guardian has been informed about, and understands, the patient's condition to the extent that the patient would need to be informed if they had the capacity to make the decision themselves. One of these two people must be a registered medical practitioner.²⁰

Consenting to medical treatment

16.25 The Medical Treatment Act does not set out any procedure for an agent to follow when consenting to medical treatment. The G&A Act provides, however, that an agent appointed under the Medical Treatment Act is the first person in the hierarchy of people eligible to be a 'person responsible' for a person who is unable to consent to their own medical treatment. Consequently, the procedures in the G&A Act govern consent to medical treatment by an agent.

Carrying out medical treatment when there is a refusal of treatment certificate

16.26 If an agent or guardian has completed a refusal of treatment certificate, the Medical Treatment Act only allows medical treatment to be undertaken if the power of the agent or guardian is suspended or revoked by VCAT. Any person who has a special interest in the affairs of the patient can apply to VCAT for this to happen, and VCAT can only suspend or revoke the power, or revoke the certificate itself, if it is satisfied that it would not be in the patient's best interests for the treatment to continue.²¹

THE GUARDIANSHIP AND ADMINISTRATION ACT 1986 (VIC)

The types of treatment covered

16.27 The G&A Act's definition of 'medical treatment'²² differs from that in the Medical Treatment Act, most notably because it expressly includes 'palliative care' and specifically excludes a number of matters including:

- a 'special procedure'
- a 'medical research procedure'
- non-intrusive examinations made for diagnostic purposes
- first-aid treatment
- administration of pharmaceutical drugs according to the prescription or, if it is a drug for which a prescription is not required, according to the manufacturer's instructions
- anything else set out in regulations.²³

Special procedures

16.28 Special procedures are defined as permanent sterilisations, abortions, and removal of non-regenerative tissue for donation, as well as any other procedures named in regulations.²⁴ Only VCAT can provide substitute consent for a special procedure.

Medical research procedures

16.29 Medical research procedures are defined in the G&A Act as procedures that are carried out for the purposes of medical research, such as clinical trials, the administration of medication or the use of equipment or a device, or anything else prescribed as medical research in regulations. The definition specifically excludes non-intrusive examination, observation of activities, undertaking a survey, collecting or using information or anything else excluded in regulations.²⁵ The procedures that must be followed when substitute consent is provided for participation in a medical research procedure differ from those that apply to substitute consent for a medical procedure or a special procedure.

Who can consent, withhold consent or refuse treatment

16.30 Section 37 of the G&A Act contains a list of people who are permitted to consent to 'medical (or dental) treatment' for an adult who is incapable of doing so. The first person on the list who is available, willing and able to make the decision has the authority to do so and is known as the 'person responsible'. The section 37 list is:

- an agent with an enduring power of attorney (medical treatment) appointed by the patient under the Medical Treatment Act
- a person specifically appointed by VCAT to make decisions about the proposed treatment
- a person appointed by VCAT under a guardianship order that includes authority to make decisions about the proposed treatment
- a guardian with enduring power of guardianship appointed by the patient and whose appointment includes authority to make decisions about the proposed treatment
- a person appointed in writing by the patient with authority to make decisions about the proposed treatment
- the patient's spouse or domestic partner
- the patient's primary carer
- the patient's 'nearest relative'.²⁶

16.31 If there is no person responsible available, or the medical practitioner cannot find out who the person responsible is, then the practitioner can make the decision to carry out the treatment without consent, providing they follow certain procedures, which are explained below.²⁷

Consenting to special procedures

16.32 Special procedures can only be carried out with the consent of VCAT. This means that the person responsible does not have the authority to consent to sterilisations, abortions or the donation of non-regenerative tissue, regardless of whether the person responsible is an agent appointed under the Medical Treatment Act, or an enduring guardian with the power to make all health care decisions.²⁸

16.33 If VCAT consents to a special procedure, it may give the person responsible authority to consent to future special procedures of a similar nature, or to the continuation of the special procedure.²⁹

Medical research procedures

16.34 The provisions in the G&A Act concerning substitute consent for medical research procedures are complex. The person responsible can consent to medical research procedures only under certain circumstances and only if certain processes are followed.³⁰

16.35 If a person responsible cannot be identified or contacted, the medical practitioner may consent to the medical research procedure but only under certain circumstances and only if certain processes are followed.³¹

20 Ibid sch 3.

21 Ibid ss 5C, 5D.

22 *Guardianship and Administration Act 1986* (Vic) s 3. The definition also includes 'dental treatment' that is defined to mean 'dental treatment (including any dental procedure, operation or examination) normally carried out by or under the supervision of a registered practitioner'. For ease of discussion, we use the term 'medical treatment' throughout this chapter when referring to what is described in part 4A of the Act as 'medical or dental treatment'.

23 There are currently no additional exclusions in regulations.

24 *Guardianship and Administration Act 1986* (Vic) s 3. There are currently no additional special procedures set out in regulations.

25 *Guardianship and Administration Act 1986* (Vic) s 3. There are currently no additional medical research procedures set out, or excluded, in regulations.

26 This term is defined in s 3 of the Act.

27 *Guardianship and Administration Act 1986* (Vic) s 42K.

28 Ibid s 42E.

29 Ibid s 42F.

30 Ibid s 42S.

31 Ibid s 42T.

Criteria and procedures for consent**Consenting to a medical procedure**

- 16.36 The person responsible must act in a person's best interests when deciding whether to consent to medical treatment. The Act requires the person responsible to consider a range of matters when making this 'best interests' determination. Those matters are:
- the wishes of the patient, as far as they can be ascertained
 - the wishes of any nearest relative or any other family members of the patient
 - the consequences to the patient if the treatment is not carried out
 - any alternative treatment available
 - the nature and degree of any significant risks associated with the treatment or any alternative treatment
 - whether the treatment to be carried out is only to promote and maintain the health and wellbeing of the patient
 - any other matters prescribed by the regulations.³²
- 16.37 Additional matters can be relevant if the patient is likely to be able to make their own decision within a reasonable time. If the patient objects to a nearest relative being involved in the decision, the person responsible is not required to take that relative's wishes into account.³³ In addition, the person responsible cannot give consent at all unless:
- the medical practitioner states in writing that they believe a further delay in carrying out the treatment would result in a significant deterioration of the patient's condition
 - there is no reason to believe that treatment would be against the person's wishes.³⁴
- 16.38 If the person responsible consents to medical treatment, that consent has the same legal effect as if the patient themselves had capacity and had consented.³⁵

Consenting to a special procedure

- 16.39 Only VCAT can consent to a special procedure. Like the person responsible, VCAT is required to consider whether the proposed special procedure is in the patient's best interests before consenting to that procedure. When making a 'best interests' determination, VCAT is required to consider the same range of matters that a person responsible must consider when deciding whether to consent to medical treatment.
- 16.40 An application for consent to a special procedure can be made to VCAT either by the patient's person responsible or by any other person who VCAT agrees has a special interest in the affairs of the patient.³⁶ The Public Advocate must be given notice of any application and is entitled to participate in the case.
- 16.41 As already noted, the Act also allows VCAT to give a person responsible the authority either to consent to a special procedure or to consent to further special procedures being carried out that are similar in nature to the one that VCAT initially consented to.³⁷
- 16.42 The Act provides quite severe penalties, including up to two years imprisonment and 240 penalty units, for any medical practitioner who carries out a special procedure without having obtained the proper consent.³⁸

Consent to a medical research procedure

- 16.43 The processes for consenting to medical research procedures where a patient is unable to consent themselves are set out in division 6 of part 4A of the G&A Act. The process for consent involves four main steps.
- 16.44 The first step requires that the research project be approved by the relevant human research ethics committee.³⁹
- 16.45 The second step involves determining whether the patient is likely to be able to consent to the research procedure within a reasonable time. If this is likely, then the research procedure should not go ahead until the patient is able to consent to it.⁴⁰ If this is unlikely, the third step involves obtaining the consent of the person responsible. The person responsible can consent to the procedure if they believe that it would not be contrary to the patient's best interests.⁴¹
- 16.46 The fourth step applies only to those situations where the person responsible cannot be identified or located. It allows a medical practitioner to carry out the research procedure, as long as they have signed a certificate affirming that they have considered a range of matters set out in the Act. Those matters include:
- best interests considerations
 - whether the ethics committee was aware that the research might involve people who are unable to consent
 - whether the procedure adds to risks the patient faces because of their medical condition
 - whether there is reasonable scientific likelihood that the patient will benefit from the research procedure.⁴²
- 16.47 The Act also includes considerations specific to medical research that need to be addressed when deciding whether a proposed procedure is in the patient's best interests. These involve taking into account:
- the wishes of the patient, as far as they can be ascertained
 - the wishes of any nearest relative or any other family members of the patient
 - the nature and degree of any benefits, discomforts and risks for the patient in having or not having the procedure
 - any other consequences to the patient if the procedure is or is not carried out
 - any other prescribed matters.⁴³
- 16.48 The Act allows the person responsible, or any other person with a special interest in the affairs of the patient, to make an application to VCAT about any matter, question or dispute relating to medical research and the best interests of the patient. When this happens, VCAT can make a range of orders, including clarifying who the person responsible is, appointing a guardian, changing any order or appointment that is already in place, or make any order about the procedure itself and whether it is in the best interests of the patient.

Withholding consent and refusing treatment

- 16.49 The powers of a medical agent under the Medical Treatment Act or guardian with appropriate powers differ from those of a person responsible under division 4A of the G&A Act, because a medical agent and a guardian may make a final and binding decision to refuse treatment for the represented person.

32 Ibid s 38(1). There are currently no additional matters prescribed by regulation.

33 *Guardianship and Administration Act 1986* (Vic) s 38(2).

34 Ibid s 42HA(2).

35 Ibid s 40.

36 Ibid s 42B.

37 Ibid s 42F.

38 Ibid s 42G.

39 Ibid s 42Q.

40 Ibid s 42R.

41 Ibid s 42S.

42 Ibid s 42T.

43 Ibid s 42U. There are currently no additional matters prescribed in the regulations.

16.50 Part 4A of the G&A Act does not deal expressly with substitute refusal of treatment for a person with impaired decision-making capacity. While the Act gives the person responsible the power to consent to medical or dental treatment, it also recognises a converse power to withhold consent because it permits a medical practitioner to proceed with treatment without the consent of the person responsible in some circumstances. This means that a withholding of consent by a person responsible will not amount to a refusal of treatment in many circumstances.

Carrying out medical treatment without consent

Emergencies

16.51 A medical or dental procedure, a special procedure or a medical research procedure can be carried out without consent in an emergency. An emergency exists when the procedure is necessary:

- to save the patient's life, or
- to prevent serious damage to the patient's health, or
- in the case of medical research or medical or dental treatment, to prevent the patient from suffering or continuing to suffer significant pain or distress.⁴⁴

When the person responsible is unavailable or withholds consent

16.52 If a medical practitioner is unable to identify or contact the person responsible, they may still carry out a medical treatment procedure, as long as they believe that the treatment is in the best interests of the patient and they give notice to the Public Advocate.⁴⁵

16.53 If the person responsible is contacted but withholds consent to the medical treatment, the medical practitioner can still proceed with the treatment if they believe it is in the patient's best interests to do so, and they advise both the person responsible and the Public Advocate of their intention. The medical practitioner cannot proceed with the treatment until the person responsible has been given at least seven days to apply to VCAT. If an application to VCAT is made, then the medical practitioner must wait for at least a further seven days for VCAT to hear the matter. VCAT can then make whatever order it sees fit in the circumstances. This can include a decision about whether the procedure should go ahead, or whether a guardian needs to be appointed.⁴⁶

COMMUNITY RESPONSES

16.54 Many people—both providers of medical treatment and consumers of those services—reported that they found the law concerning substitute decision making for medical treatment confusing.⁴⁷

16.55 Despite this confusion, the automatic appointment process received support. For example, Action for Community Living noted that the 'hierarchy of persons who are designated to act as Person Responsible under current guardianship legislation seems to work reasonably well in most situations'.⁴⁸

16.56 Nonetheless, it was also argued that the application of the concept in practice can be difficult:

The hierarchy list nominating the 'person responsible' is a sensible list and generally works well in practice. However, it can be onerous for medical staff to establish who is the appropriate person to be contacted and to actually establish such contact, as in many cases a hospital admission is not planned.⁴⁹

16.57 The Epworth Foundation said:

Parts of the law that do not work well, and are cumbersome and hard to understand, are those provisions of the G&A Act when there is no person responsible and the doctor or healthcare team wishes to proceed in the absence of someone able to give consent for the patient (acting in the patient's best interests). Here, it is submitted that the process needs to be streamlined, and made more user friendly, with new forms devised for easy use with perhaps an online system for communication established.⁵⁰

16.58 Other people and organisations reported:

- a lack of consistency in how emergency departments deal with issues of capacity⁵¹
- a widespread assumption that a person responsible who is neither a medical agent nor a guardian can sign a refusal of treatment certificate⁵²
- that doctors and dentists do not always understand the concept of capacity, and so can sometimes provide or withhold treatment because they rely only on the stated wishes of the person with the disability⁵³
- that there can be different people holding different appointments, such as one person with enduring guardianship and the other with enduring medical power of attorney, and this can lead to confusion and distress within families as to who the appropriate decision maker is⁵⁴
- a lack of recognition of the authority of the person responsible, resulting in carers having to go to a number of practitioners before finding one who will perform the procedure⁵⁵
- a lack of understanding about the extent of the powers of a person responsible, and that this is limited only to treatment that is being offered, rather than including an authority to demand treatment.⁵⁶

DEFINING MEDICAL TREATMENT

16.59 Community responses to our information paper expressed widespread concern about the statutory definitions of 'medical treatment', particularly in the G&A Act. As noted by the Public Advocate, for example:

The current definition of 'medical treatment' applies to treatment ... normally carried out by 'a registered practitioner'. OPA suggests that thought be given to broadening out the range of health professionals whose activities should specifically be subject to the consent and substitute consent provisions of the Act. These people would include nurse practitioners, naturopaths, physiotherapists, alternative/natural medicine practitioners and Chinese medicine suppliers.⁵⁷

16.60 The Public Advocate also suggested that the definition of 'medical treatment' in the G&A Act is unclear:

If we confine our attention just to the guardianship legislation, the definition of 'medical treatment' there gives rise to some questions. Among the many specific queries dealt with by OPA is the question of whether a mammogram, for instance, constitutes medical treatment (it has been viewed as such, but only when the mammogram is performed under the supervision of a medical practitioner, not when it forms part of a non-practitioner-scrutinised screening process). Likewise a query has concerned whether chemotherapy is medical treatment (or is it the administration of a pharmaceutical?) OPA has developed working definitions that guide our practice here, but greater legislative articulation is warranted.⁵⁸

- 44 *Guardianship and Administration Act 1986* (Vic) s 42A(1).
- 45 *Ibid* s 42K.
- 46 *Ibid* ss 42L–42N.
- 47 See, eg, Submission IP 22 (Epworth Foundation) 1.
- 48 Submission IP 50 (Action for Community Living) 10.
- 49 Submission IP 40 (Australian & New Zealand Society for Geriatric Medicine) 4.
- 50 Submission IP 22 (Epworth Foundation) 1.
- 51 Consultation with Royal District Nursing Service (10 May 2010).
- 52 Submission IP 43 (Victoria Legal Aid) 15.
- 53 Consultation with Gippsland Carers Association (25 May 2010).
- 54 Consultation with seniors groups (26 March 2010).
- 55 Consultation with carers in Hastings (8 April 2010).
- 56 Submission IP 8 (Office of the Public Advocate) 37.
- 57 *Ibid* 33.
- 58 *Ibid*.

DISTINGUISHING BETWEEN REFUSAL OF TREATMENT AND WITHHOLDING CONSENT

16.61 The law's distinction between refusal of treatment and withholding consent attracted adverse comments.⁵⁹ The Law Institute of Victoria wrote:

[A]n agent and a guardian appointed by VCAT may refuse medical treatment, including pharmaceuticals, under the Medical Treatment Act. If a medical practitioner considers the refusal is not in the best interests of the patient, they may take the matter to VCAT for adjudication (under s 5C).

A person responsible may only consent to treatment or withhold their consent. If consent is withheld and the medical or dental practitioner considers this is not in the best interests of the patient, they need serve a notice on the person responsible and the Public Advocate and, if there is no appeal to VCAT, the treatment may be undertaken after seven days.

Yet refusing treatment and withholding consent may mean the same thing for the patient.

There are, however, different criteria to be taken into account by the person responsible when making a decision to withhold consent (see s38 of the G&A Act) from those of an agent or guardian refusing treatment (see s5B(2) of the MT Act).

We understand that this complexity [is] due to the controversial history of these laws. However, the LIV submits that they are overly complex and should be simplified.⁶⁰

UNDERSTANDING BEST INTERESTS

16.62 While the G&A Act contains some guidance about matters to consider when determining whether a medical procedure is in the patient's best interests, it was suggested that more guidance is needed. One submission advocated

that a revised Act or Acts more clearly articulate the principles of what 'best interests' comprise. In regard to consent to or refusal of medical treatment, while some guidelines currently do exist, a clearer statement of the degree of being informed, of weighing and balancing of potential benefits and harms, consideration of the values and beliefs of the client (if known, and to what degree it is reasonable to try and find out), and that of immediate family (if any, and again reasonableness of effort to find out), and where significant ambiguity or serious conflicts of opinion still exist, consultation of an ethics committee or board, should be paramount. In our view, the current Act provides insufficient guidance as to the expected standard of conduct, nor clarity to the terms of dismissing a guardian or administrator for inappropriate conduct.⁶¹

PROCEDURAL CONSENT TO MEDICAL TREATMENT

16.63 It was suggested that the provisions in the G&A Act that allow a doctor to provide medical treatment without the consent of a person responsible if the Public Advocate is notified amount to a form of procedural consent. The Public Advocate noted that, '[i]n essence, the Victorian system does not so much require substitute consent as it more accurately requires the registration of a document in the absence of consent'.⁶²

16.64 The Public Advocate suggested that she is not the appropriate body to monitor these predominantly clinical judgments and reported that there appears to be a relatively low level of compliance with the reporting requirements of the Act.⁶³

16.65 It was also suggested that distinguishing between minor and major treatment, as occurs in the New South Wales legislation,⁶⁴ might overcome some of the problems in this area. The Public Advocate wrote:

OPA takes the view that where medical treatment is to be performed on a person without capacity to consent to it, and no person responsible is available to consent on the patient's behalf, that the following legislative changes should apply.

Victorian legislation, and accompanying regulations, should distinguish between 'minor and uncontroversial treatment' and major treatment, and should require substitute consent for the latter.

Minor and uncontroversial treatment should be able to be performed after a second practitioner agrees with the proposed course of action. This should be evidenced by a note on the patient's file which is supported by the signature of the second practitioner (this proposal was suggested to us by the VLRC in one of our meetings). Where the person is in a regional or rural setting, the giving of a second opinion may need to take place through a documented telephone call.⁶⁵

Treatment that is not 'minor and uncontroversial', or any treatment to which the person objects, should require the substitute consent of a guardian. The guardian may be any individual appointed by VCAT or, as a last resort, OPA. OPA recognises that this process is more laborious than that which exists in some other jurisdictions. But OPA would be concerned if VCAT were not involved in this process, as OPA's other substitute decision-making powers routinely require VCAT's authorisation, and OPA sees no reason why this should not also be the case with significant medical treatment decisions. In keeping with the tenor of this submission, any guardianship order made in these circumstances would restrict the authority of the guardian as much as possible to the power to make the particular medical decision that needs to be made.

Where OPA is empowered in this way to make a medical treatment decision, OPA of course would need to satisfy itself that the treatment was in the interests of the patient's personal and social well-being before agreeing to it.⁶⁶

ADMINISTRATION OF MEDICATION

16.66 The exclusion of the administration of pharmaceutical drugs from the definition of 'medical treatment' in the G&A Act was raised on a number of occasions. The Public Advocate dealt with this issue, which appears to be of particular concern when dealing with psychotropic medication:

[T]he standard administration of a prescription pharmaceutical will not constitute medical treatment under the guardianship legislation, and therefore substitute consent is not required (when the person cannot consent to it). And yet the standard administration of a prescription pharmaceutical will constitute medical treatment under the Medical Treatment Act and also often constitutes 'non-psychiatric treatment' under the Mental Health Act, meaning that substitute consent needs to be provided where the person cannot themselves consent.

59 We discuss the distinction in more detail below: see [16.73]–[16.77].

60 Submission IP 47 (Law Institute of Victoria) 33.

61 Submission IP 20 (Dying with Dignity Victoria) 1.

62 Submission IP 8 (Office of the Public Advocate) 34–5.

63 Ibid 34.

64 *Guardianship Act 1987* (NSW) pt 5.

65 As noted below, this is the approach currently adopted in New South Wales: see [16.85]–[16.86].

66 Submission IP 8 (Office of the Public Advocate) 35.

The confusion that can be caused by the various definitions in these three Acts can be seen in the following scenarios. An agent appointed by an Enduring Power of Attorney (Medical Treatment) under the Medical Treatment Act may seek to refuse the administration of a pharmaceutical to the donor, which the Medical Treatment Act defines as 'medical treatment'. Yet consent for the administration may not, according to the guardianship legislation, actually be required. Likewise, an agent may seek to refuse to consent to the administration of 'non-psychiatric treatment', in the form of a prescription pharmaceutical, under the Mental Health Act, but were the treatment viewed according to the guardianship legislation, such consent again may not actually be required.⁶⁷

- 16.67 The Public Advocate referred to the lack of a coherent policy in the definition of 'medical treatment':

The advantage of exempting the standard 'administration of a pharmaceutical' from the definition of 'medical treatment' in the guardianship legislation is that a person responsible does not need to be located in order to consent to routine tablet taking (by a person who is unable to give consent). But there are strong reasons why such protection should be required. Some pharmaceuticals constitute interventions that are more significant than some of the procedures that are currently captured by the definition of medical treatment, while some pharmaceuticals also carry possible side effects that are every bit as serious as the side effects that may flow from an operation.⁶⁸

- 16.68 The Law Institute of Victoria argued that providing clearer consent provisions around medical treatment would be simple:

Clearly there is a balancing here between what is appropriate and what is expeditious. However, it would be relatively straightforward for the person responsible to provide consent to prescribed medications and it would not seem especially onerous.⁶⁹

MEDICAL RESEARCH

- 16.69 The Australian and New Zealand Society for Geriatric Medicine and the Alfred Hospital's Ethics Committee and General Ethical Issues Sub-Committee made important comments about the medical research provisions in the G&A Act.
- 16.70 The Australian and New Zealand Society for Geriatric medicine drew attention to the cumbersome and confusing processes set out in the Act, as well as questioning the usefulness of provisions for emergency medical research procedures.⁷⁰
- 16.71 The Alfred Hospital submission drew attention to the ways in which the Act's requirements, especially those around contacting the person responsible, can be time-consuming and can compromise medical research.⁷¹ The Alfred Hospital submission also addressed the Act's provisions around procedural authorisation of medical research procedures, arguing that they are too restrictive:

Often ... 'preliminary' research involves minor/low risk procedures, such as taking small quantities of blood or other bodily samples for testing, so that while there is no benefit to individual participants there is also no harm. If the research is time-critical, consent may not be achievable before the procedure needs to be undertaken. However, because the procedure is not necessary and does not help the patient in any way, neither does the research fit within the 'medical emergency' (S42A) provisions which would allow it to be done without consent.⁷²

PROBLEMS WITH THE LAW AND PRACTICE

16.72 Many of the problems with the current law concerning medical treatment decisions for people with impaired decision-making capacity have been well-articulated in the community responses to our information paper. The problems can be summarised in this way:

- a complicated interaction of two pieces of legislation—the G&A Act and the Medical Treatment Act—that produces widespread confusion about who can make what decisions, and how those decisions should be made, and may cause decisions to be made in practice without regard to either piece of legislation
- a widespread lack of awareness of the law among both medical practitioners and the community
- inadequate guidance about determining best interests
- inadequate safeguards where medical practitioners wish to administer a medical procedure without consent
- inadequate definitions of medical treatment, especially in relation to the administration of medication
- lack of provision for advance directives
- cumbersome and confusing provisions in relation to medical research.

THE DISTINCTION BETWEEN WITHHOLDING CONSENT AND REFUSING TREATMENT

16.73 As noted in our overview of community responses, the distinction between ‘withholding consent’ to medical treatment and ‘refusing treatment’ is confusing. Because the G&A Act and the Medical Treatment Act were developed at different times and for different purposes, they do not deal with the complex issue of lack of consent for medical treatment in a clear and consistent manner.

16.74 The Medical Treatment Act seeks to protect the interests of both a person and their medical practitioners when that person, or their agent, makes a positive decision to refuse medical treatment. Part 4A of the G&A Act seeks to protect the interests of both a person who is in need of medical treatment and their medical practitioners when that person is unable to consent to treatment because of impaired decision making capacity. The Medical Treatment Act is primarily concerned with processes for refusing treatment, while part 4A of the G&A Act is primarily concerned with identifying a person to provide substitute consent for medical treatment so that it may be given expeditiously.

16.75 The differences between the two pieces of legislation are:

- To refuse treatment under the Medical Treatment Act, either the patient or their agent or guardian must complete a ‘refusal of treatment’ certificate according to the requirements set out in that Act, whereas no certificate or similar authorisation is required to be completed when a person responsible decides not to consent to treatment under the G&A Act.
- A medical practitioner can carry out a procedure for which a refusal of treatment certificate has been completed only if VCAT has suspended or revoked the authority of the agent or guardian who completed the certificate, or if VCAT orders that the certificate itself be revoked.
- If the person responsible under the G&A Act decides not to consent to the proposed medical treatment, the medical practitioner can provide the treatment if they notify the Public Advocate of their intention and do not proceed until the person responsible has been given seven days to appeal to VCAT.

67 Ibid 33.

68 Ibid.

69 Submission IP 47 (Law Institute of Victoria) 32.

70 Submission IP 40 (Australian & New Zealand Society for Geriatric Medicine) 4.

71 Submission IP 57 (Alfred Hospital Ethics Committee and the General Ethical Issues Sub-Committee) 3–4.

72 Ibid 5.



- 16.76 There is also debate about whether an enduring guardian, appointed by a person under division 5A of the G&A Act, has the authority to refuse treatment for the represented person, or may only withhold consent, thereby allowing a medical practitioner to use the powers in the G&A Act to treat without consent. While the Medical Treatment Act permits only a competent adult, an agent appointed under the Act, or a guardian appointed by VCAT to refuse treatment by completing a refusal of treatment certificate, the Medical Treatment Act also provides that it 'does not affect any right of a person under any other law to refuse treatment'.⁷³ A competent adult has the power at common law to refuse medical treatment.⁷⁴
- 16.77 An enduring guardian can be given the same powers as those of a guardian appointed by VCAT.⁷⁵ A guardian appointed by VCAT (with the appropriate powers) can refuse treatment for the represented person under the Medical Treatment Act or by relying upon common law powers. While it seems highly likely that an enduring guardian (with general health care powers) can refuse treatment for the represented person by relying upon common law powers, confusion exists because the form used to appoint an enduring guardian refers only to the power to 'consent to any health care'.⁷⁶ While the form cannot alter the meaning of provisions in the G&A Act, it is clearly capable of producing uncertainty in practice. This issue must be resolved so that the powers of substitute decision makers are quite clear.

THE RELATIONSHIP BETWEEN MEDICAL AGENTS AND ENDURING GUARDIANS

- 16.78 The relationship between medical agents (appointed under the Medical Treatment Act) and enduring guardians (appointed under the G&A Act) is unclear. Both appear separately on the person responsible list set out in section 37 of the G&A Act, with the medical agent appearing at the top of the list and the enduring guardian as the fourth person in the hierarchy.
- 16.79 At present, there will probably be some instances where a person feels the need to appoint both a medical agent and an enduring guardian with health care decision-making powers, especially if they have strong views about refusing treatment at particular times. It seems undesirable as a matter of policy to have two separate mechanisms for personally appointing a substitute to make decisions about the same matter—health care—governed by two different pieces of legislation.

HUMAN RIGHTS IMPLICATIONS FOR MEDICAL TREATMENT AND RESEARCH

- 16.80 Section 10(c) of the *Charter of Human Rights and responsibilities Act 2006* (Vic) (the Charter) provides a modern legislative affirmation of the right of all people to not be subject to any medical experimentation or treatment without their free and informed consent.
- 16.81 The G&A Act detracts from this right because it permits people to be given medical treatment and to participate in medical research procedures without their consent. However, section 7(2) of the Charter allows human rights to be limited to the extent that

can be demonstrably justified in a free and democratic society, based on human dignity, quality and freedom and taking into account all relevant factors including:

- *the nature of the right; and*
- *the importance of the purpose of the limitation; and*
- *the nature and extent of the limitation; and*
- *the relationship between the limitation and its purpose; and*
- *any less restrictive means reasonably available to achieve the purpose that the limitation seeks to achieve.*

16.82 In many cases, the purposes for which medical treatment might be carried out without the consent of the patient—namely to relieve pain and suffering or to cure an illness—will justify the departure from section 10(c) of the Charter. It is arguable, however, that these benefits are not so readily apparent when dealing with medical research. This issue merits further debate.

OTHER JURISDICTIONS

16.83 As noted in Chapter 14, all other Australian jurisdictions, except the Northern Territory, have legislation similar to the Victorian G&A Act that provides for automatic appointees to make medical treatment decisions for adults with impaired decision making capacity.

16.84 It is useful to consider some of the important points of difference. In New South Wales, South Australia and Tasmania, the tribunal itself is able to consent to medical treatment, not just to special procedures.⁷⁷

16.85 In New South Wales, as in Victoria, a doctor may carry out a medical treatment procedure without the consent of the person responsible if they are unable to identify or contact the person responsible, but in New South Wales this can only happen if the procedure fits the Act's definition of minor treatment.⁷⁸ Major treatment would require a guardian to be appointed, or an application to the tribunal for its consent. Minor treatment is any treatment (other than special treatment or clinical trials) not defined by regulation as being major treatment.⁷⁹

16.86 The New South Wales regulations, in summary, describe major treatment as being:

- injection of long-acting hormones for contraception or regulating menstruation
- administering a drug of addiction
- administering a general anaesthetic or, in some cases, a sedative
- any treatment to eliminate menstruation
- certain treatments that affect the central nervous system
- treatments that have a high level of risk in relation to death, brain damage, paralysis, scarring, distress, prolonged recovery, etc.
- any test for HIV.⁸⁰

16.87 In Queensland, minor and uncontroversial treatment may be carried out without consent, as long as the health practitioner believes it will promote the patient's health and wellbeing and that there are no objections to it. The Act does not actually define 'minor and uncontroversial', leaving this to be determined on a case-by-case basis.⁸¹

16.88 Unlike Victoria's G&A Act, the South Australian Act's definition of medical treatment includes the prescription or supply of drugs.⁸²

16.89 Western Australia includes provisions for advance health directives in its guardianship legislation.⁸³ In Queensland, these are provided for in its powers of attorney legislation.⁸⁴

16.90 The ACT legislation includes principles that are to guide the decisions made by any substitute decision maker, and any decision about medical treatment must be made according to those principles.⁸⁵ The Queensland Act complements its broad decision-making principles with specific health care principles.⁸⁶

73 *Medical Treatment Act 1988* (Vic) s 4(1).

74 See Richards, above n 2, 104–5.

75 See, eg, *Guardianship and Administration Act 1986* (Vic) s 35B(2) which provides that, where the instrument appointing the enduring guardian has not specified the matters in relation to which the guardian is to have authority, the enduring guardian has the same powers as a plenary guardian under s 24 of the Act.

76 *Guardianship and Administration Act 1986* (Vic) sch 4.

77 *Guardianship Act 1987* (NSW) s 44; *Guardianship and Administration Act 1993* (SA) s 59; *Guardianship and Administration Act 1995* (Tas) s 45.

78 *Guardianship Act 1987* (NSW) s 37.

79 *Ibid* s 33.

80 *Guardianship Regulation 2005* (NSW) r 10.

81 *Guardianship and Administration Act 2000* (Qld) s 64.

82 *Guardianship and Administration Act 1993* (SA) s 3.

83 *Guardianship and Administration Act 1990* (WA) pt 9B. For a fuller discussion of advance directives, see Chapter 9.

84 *Powers of Attorney Act 1998* (Qld) ch 3 pt 3.

85 *Guardianship and Management of Property Act 1991* (ACT) s 32E.

86 *Guardianship and Administration Act 2000* (Qld) sch 1.



- 16.91 The ACT legislation also includes a provision specifically requiring health professionals to give certain information to a health attorney (that jurisdiction's equivalent of Victoria's person responsible).⁸⁷ The Act also requires a health attorney to inform the Public Advocate if they are consenting to a particular medical treatment procedure for a period longer than six months.⁸⁸ In Chapter 14, we discuss whether automatic appointees, including those making medical treatment decisions, should be placed under some sort of external scrutiny if they are exercising their decision-making authority over an extended period.
- 16.92 The Queensland legislation also includes provisions relating to the consent to sterilisation of children, allowing for such consent to be provided by the tribunal.⁸⁹
- 16.93 New South Wales' definition of medical treatment includes treatment carried out in the course of a clinical trial, including the administration of a placebo. In this respect, consent to participation in medical research is dealt with in the same way as consent to any other medical treatment.⁹⁰ The New South Wales Act also allows the tribunal to approve clinical trials that are to involve people with disabilities, but such approval is not to be taken as approval for any particular patient to participate in the trial.⁹¹

POSSIBLE OPTIONS FOR REFORM

PROMOTING AWARENESS OF THE LAW

- 16.94 As noted throughout this chapter, there appears to be a lack of awareness among the medical profession and in the broader community about the law concerning substitute consent for medical treatment. This observation is not startling given the complexity of this body of law. In Chapter 6, we discuss the need for more community education about all aspects of guardianship law.

HARMONISING THE SUBSTITUTE MEDICAL DECISION MAKING LEGISLATION

- 16.95 In Chapter 8, we discuss options for harmonising the Medical Treatment Act and the G&A Act to overcome the confusion arising from related provisions in the two Acts concerning the powers of substitute decision makers.

Removing the distinction between refusal of treatment and withholding consent

- 16.96 As discussed in this chapter, the distinction between refusal of treatment and withholding consent causes unnecessary confusion. Harmonisation of the two Acts will remove or limit this distinction.

Replacing the dual appointments of medical agents and enduring guardians with a single appointment

- 16.97 A further benefit of harmonising the Medical Treatment Act and the G&A Act is that the unnecessary distinction between medical agents and enduring guardians with medical treatment decision-making authority could be removed. This would enable a person to invest any or all medical treatment decision-making authority in an enduring guardian, rather than having two separate instruments—and two separate appointments—to do the same thing. This option for reform is considered in Chapter 8.

DEFINITIONS OF MEDICAL TREATMENT

- 16.98 These options address concerns that the definition of 'medical treatment' in the G&A Act is too narrow.

Option A: No change

Option B: Broaden the definition of medical treatment to include a wider range of procedures

- 16.99 If the definition is broadened, it is necessary to determine those procedures that should be added. These may include the prescription and administration of medication, as is the case in New South Wales, and it may also include a range of paramedical and complementary medical procedures.
- 16.100 An advantage of broadening the definition is that it would make substitute decision makers rather than health professionals responsible for a larger range of health care decisions, many of which are contentious, than is currently the case. A disadvantage lies in the risk that the system could become unworkable if a decision maker needs to be consulted for too wide a range of procedures, particularly those that are uncontroversial.



Question 79 Do you think that the definition of medical treatment should be broadened?

Question 80 Should a broader definition include the prescription and administration of pharmaceutical drugs?

Question 81 Should it include paramedical procedures, such as physiotherapy? Should it include complementary health procedures, such as naturopathy and Chinese medicines? What else should it include?

ENABLING MORE MINOR MEDICAL PROCEDURES TO BE UNDERTAKEN WITHOUT CONSENT

- 16.101 These options explore whether a medical practitioner should be required to obtain formal consent from the patient or the person responsible for minor and uncontroversial medical procedures.

Option A: No change

- 16.102 This option 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, if the patient is unable to consent themselves. If the medical practitioner wishes to perform the procedure without the person responsible's consent or if they are unable to contact the person responsible, they can only do so if they notify the Public Advocate under section 42K of the G&A Act.⁹²

Option B: Create distinctions between minor and other medical procedures and allow minor medical procedures to be undertaken without consent if certain procedural conditions are met, but require formal consent for other medical procedures

- 16.103 This option would permit a medical practitioner to perform minor and uncontroversial medical procedures without consent as long as procedural requirements are met. The option leaves open the question of what those procedural requirements should be. These could include notification to VCAT, obtaining a second opinion, or noting the decision to perform the procedure without consent, and the reasons for doing this, in the patient's clinical file.

87 *Guardianship and Management of Property Act 1991* (ACT) s 32G.

88 *Ibid* s 32J.

89 *Guardianship and Administration Act 2000* (Qld) ch 5A.

90 *Guardianship Act 1987* (NSW) s 33.

91 *Ibid* s 45AA.

92 *Guardianship and Administration Act 1986* (Vic) s 42K.



- 16.104 The option of carrying out minor procedures without consent could apply in any situation where a medical practitioner believes the procedure is necessary and in the patient's best interests, or it could be limited only to those situations where a person responsible cannot be located, or is unable or unwilling to make a decision.
- 16.105 In cases where the person responsible does not consent to minor medical procedures because they cannot be contacted or are unable to make a decision, the Commission proposes that the medical practitioner be required to note in the patient's clinical records that the procedure is being undertaken without consent but that they believe it is in the patient's best interests. There could also be a requirement that the medical practitioner obtains a second opinion from another medical practitioner. In the case of major procedures, or minor procedures where the person responsible is withholding consent, the matter could be taken to VCAT, who could either appoint a guardian to make the decision, if one is not already appointed, or could make its own decision about the matter.
- 16.106 The option also leaves open the question of how the distinction between minor and other medical procedures is made. This could be legislatively defined, as it is in New South Wales, or left undefined as it is in Queensland. Definitions could focus on things such as the treatment's level of risk and long-term consequences, or the degree of controversy about the treatment, or they could list actual procedures, or they could do both. The concepts could be left defined more broadly, as in the Queensland legislation, which refers only to 'minor and uncontroversial' health care. The distinction between minor and other medical procedures would need to be made carefully so that it does not allow a large number of potentially serious medical procedures to be undertaken without consent, but also does not lead to an inordinate number of matters proceeding to VCAT when the decision of the medical practitioner is highly likely to be endorsed.
- 16.107 An advantage of introducing change in this area is that it addresses the Act's current seemingly ineffective requirements around notification to the Public Advocate. The Commission's preferred approach allows more clinically oriented monitoring of minor procedures, while putting in place the stronger safeguard of VCAT—either through the appointment of a guardian or through VCAT giving consent—when a more major procedure is at stake or where there is conflict about a minor procedure.
- 16.108 A major disadvantage of this change is the difficulty in making a coherent and principled distinction between minor and other medical treatments.



Question 82 Do you think a distinction should be made between minor and other medical procedures when a person is unable to consent? If yes, how should the distinction be made between minor and other procedures?

Question 83 Do you agree that minor medical procedures should not require substituted consent if certain safeguards are met? Do you agree with the safeguards suggested?

Question 84 Do you believe the law should retain the requirement that a medical or dental practitioner must notify the Public Advocate where a person responsible does not consent or cannot be identified or contacted and the practitioner still wishes to carry out the procedure? If not, are there any other safeguards that might be more appropriate in these circumstances?

MEDICAL RESEARCH

16.109 The Commission has identified two options to address the issue of substitute consent for participation in medical research trials. We are keen to explore additional options with medical researchers and other interested people.

Option A: Retain current medical research provisions but simplify the legislation

16.110 The existing provisions in Division 6 of Part 4A of the G&A Act are complex. Clearer drafting might promote greater accessibility and increased understanding.

Option B: Have the same process for consent to medical research as medical treatment

16.111 This option would allow a person responsible to consent to medical research in the same way that they could consent to medical treatment. The same considerations would need to be taken into account when the person responsible is deciding whether to consent. This may mean that the notion of 'best interests' would need to be reframed because, in most cases, the immediate benefits of the research procedure to the patient are likely to be negligible.

16.112 If the Commission's option to create a distinction between minor and other medical treatment were adopted, medical research that is a minor medical procedure could be undertaken without consent when certain procedural safeguards are met. Medical research that is a more major medical procedure would require the consent of the person responsible or notification of the Public Advocate.



Question 85 Do you believe the process for obtaining substituted consent to participation in medical research procedures should be the same as the process for obtaining substituted consent for medical treatment?

Question 86 If the process is the same, what factors should the person responsible be required to consider before giving substituted consent to participation in a medical research procedure?

