REPORT OF PROCEEDINGS BEFORE

STANDING COMMITTEE ON SOCIAL ISSUES

INQUIRY INTO SUBSTITUTE DECISION MAKING FOR PEOPLE LACKING CAPACITY

At Sydney on Thursday 5 November 2009

The Committee met at 9.04 a.m.

PRESENT

The Hon. I. W. West (Chair)

Dr J. Kaye
The Hon. T. J. Khan
The Hon. M. S. Veitch

CHAIR: Good morning, Ms Doyle, and thank you for being with us today. Welcome to the fourth public hearing of the Standing Committee on Social Issues inquiry into substitute decision making for people lacking capacity. Today we will be hearing from Ms Doyle, Provincial Director of the Office of the Public Guardian in Alberta, Canada, Professor Duncan Chappell, Associate Professor Cameron Stewart, representatives from the Aged-Care Right Service, and Public Advocates from both Victoria and Western Australia. I will ask members of the Committee to introduce themselves.

The Hon. MICHAEL VEITCH: Good morning. I am Mick Veitch.

Dr JOHN KAYE: Good morning, I am John Kaye.

The Hon. TREVOR KHAN: Good morning, I am Trevor Khan.

BRENDA LEE DOYLE, Provincial Director, Office of the Public Guardian, Alberta, Canada, sworn and examined by teleconference:

CHAIR: Could you please state the capacity in which you give evidence before the Committee? Are you conversant with the terms of reference of the inquiry?

Ms DOYLE: I am familiar with the terms of reference, thank you. I am the Provincial Director of the Office of the Public Guardian for the Ministry of Seniors and Community Support of the Government of Alberta. I have held this position for six years.

CHAIR: You have a presentation that you would like to give us. We are looking forward to hearing that.

Ms DOYLE: Okay. Thank you so much. The slides will be appearing in front of you and I will go through the slides. As I get to the next slide I will just say "Next slide". Thank you very much for the opportunity. It is delightful to be part of your process. Minister Mary Anne Jablonski, who is the Minister for Seniors and Community Supports, was hoping to be here today, but unfortunately she is unable to. I am sending her greetings on to you today. She was the MLA who introduced the legislation into our Legislature last year. I understand some of your Committee members may be also familiar with Cindy Ady, who is the MLA from Calgary-Shaw, and who was appointed to do some consultation. She visited New South Wales in 2006. I think this is a nice collaboration between Australia and Canada.

The first slide is just to give you a background on the Adult Guardianship and Trusteeship Act, which is the replacement of the 30-year old Dependent Adults Act. When we started this process back in 2005, we had a very comprehensive consultation process. There was a public survey that was completed by 3,600 Albertans. We had 1,100 public meetings that were held across the Province, and there were also 43 stakeholder consultations with stakeholders such as lawyers, physicians, family members and people who are acting as a private guardian and the trustee. We also had a series of meetings with dependent adults who currently had either public or private warrant, and we had a roundtable of stakeholders from the Western Provinces who participated. The whole focus of the Act was really around how to make sure that some of the decision-making options were reflective of societal values in Alberta, particularly a growing focus on having more choice and more autonomy. Next slide, please.

What I would like to do today is go through the legislation and provide you some of the common themes throughout the legislation, talk about the guiding principles, and focus on capacity assessment. Next slide.

The context—I will just give you a little background on the Canadian context. The Dependent Adults Act, back in 1978 I think, was a significant development in the area of guardianship and trusteeship for Canada. A lot of other jurisdictions built on the Dependent Adults Act, both here in Canada and also in other parts of the world. But what happened in the nineties was that there was also significant development in Ontario and in British Columbia looking at informed consent and providing for an ability to make one-time decisions for healthcare and for placement. There were legislative reforms in other areas such as the North-west Territories and the Yukon that introduced other kinds of supportive types of decisions.

At the time when the Dependent Adults Act was written, there was charter of rights in Canada. That came into place in the eighties. There was a growing need and a more conscious group of Canadians and Albertans who were focusing on how they would have more choice and be more informed about their rights. We also saw in Canada a growing transition of people living in families not necessarily staying in the same place. You could have people living in Alberta, because Canada is so broad, who may have their children living in the east coast. People were very transient and not necessarily in the same community. Next slide, please.

Alberta has a population of 3.5 million. It is a fairly young demographics group. We have a lot of young people living in Alberta compared to other provinces. We have the second-youngest population. But for our seniors population, that is increasing and continues to grow. We have a lot of people who often come to Alberta and may bring their parents with them, their elderly parents. We have a lot of immigration coming to Alberta, particularly you may be familiar with some of our oil resources. A lot of people are moving to Alberta for employment. Certainly what we are seeing in Alberta is the changing roles of families—a lot of responsibilities of people taking care of elderly parents—but also they may be taking care of young children, and sometimes young adults with disabilities.

We also found when we did the consultation the impact of changing technologies. People have access to a lot more information than they ever had before. The Internet has opened up a lot of sources for people to question the decisions that are being made—whether they are healthcare decisions or whether they are options around legal matters. They are often more informed. These are some of the issues that we were facing in the consultation. Next slide, please.

Under the Dependent Adults Act, there are primarily two choices: There is guardianship, which is for personal matters, and it had 10 different areas of personal matters from health care to where to live, right down to diet and dress. On the trusteeship side, it was the ability for a person to manage a person's financial estate, both of the personal property, real estate property as well as the financial assets. There is always a preference under the Dependent Adults Act for families to act first, acting either as a guardian or as a trustee. For the public bodies, the Guardian and the Trustee were seen as a last resort when there was no-one else able to act for the person, or where there was a significant dispute.

Under the Dependent Adults Act there was a certificate process that allowed for doctors to appoint the Public Trustee to act for a person as a trustee without having to go before a court. There was always the ability under the Dependent Adults Act that any interested person could trigger a court review of the order. All of the appointments under the Dependent Adults Act were under the Queen's Bench. Next slide.

Key concepts: I will just go on quickly to the next slide. All of the rest of the slides are dealing with the new Act, the Adult Guardianship and Trusteeship Act. This Act was passed by the Legislature last fall and it was proclaimed on Friday, 30 October. What you are getting is very new. If you have some questions that I cannot answer, it means that we just have not had the experience yet.

CHAIR: I think we would prefer you to complete your presentation. We are writing down our questions.

Ms DOYLE: Okay.

CHAIR: Please do not think that because we are not asking questions we are not getting questions ready for you.

Ms DOYLE: Okay. That is fine. One of the key concepts of the Adult Guardianship and Trusteeship legislation is that capacity is seen on a continuum. So a person is neither capable nor incapable; there are more gradients to it. You will notice very much a focus on a targeted approach to capacity assessment with very much a domain-specific process. You will also see that tied to a person's ability to make decisions, their capacity, are different types of decision-making options. I will go through those in detail. The whole spirit here is that people should make decisions for as long as possible. The next concept is very much allowing a person to make as many decisions as possible based on their autonomy and balancing that with the need for some protection. The next slide is the Guiding Principles. The next slide, I do not know if you have a copy of the Adult Guardianship and Trusteeship Act with you, but we can certainly send you some copies.

CHAIR: We would appreciate that. We can get them.

Ms DOYLE: We can also send all our regulations too. They are available on our website. One of the first and most significant developments of the Adult Guardianship and Trusteeship Act is the inclusion of four guiding principles. All of the decision-making tools are interpreted through the guiding principles. So the first guiding principle is that an adult is presumed to be capable unless they have been determined not capable through a capacity assessment. This was a very important concept to say that it does not matter if a person is 89 years old or if a person has a developmental disability, they are presumed to be capable unless they have gone through a full capacity assessment and have been determined to require a substitute through the court.

The next guiding principle is around communications. This is really tied back to our Charter of Rights focusing on the quality piece. So that a person's communications method is not relevant to the determination of capacity. Just because a person cannot verbally communicate or not in a language that the capacity assessor may be looking at, the focus is that whoever is assessing capacity has to ensure that the person has the best opportunity to make their capacity known. That could be through translation services, through communication devices. The next slide is really the heart of the legislation, "autonomy is to be maintained through least intrusive and least restrictive measures". The focus is to try a little help first before you go and remove someone's decision-making rights. There has to be some evidence before you go to that level. That is why there is the introduction of a new tool called supported decision-making authorisation, which allows a person to have legal assistance, someone to access information, but allows the adult to make decisions, right up to the point that you are into guardianship and trusteeship as more formal intrusive measures.

The last guiding principle is around how to make decisions when you are a substitute, such as a guardian, a co-decision maker or a trustee. Its focus is that decisions are based on the best interests of the adult and what the adult would have done if they were capable. It takes into account any wishes that a capable person would have made during their lifetime before they had incapacity. It may be the adult had a stroke but it was known what they would have liked to be done or taking into account their values and beliefs. We thought about defining "best interests" in the legislation but this is how far we have gone as having it as a guiding principle. "Best interests" is extremely difficult to define. The next slide shows "Personal Decision-making Options". The next slide, I hope that you have on your screen the "Continuum of Decision-Making Choices".

CHAIR: Yes, we do.

Ms DOYLE: This is a visual picture. Capacity is below the arrow and above the arrow are the different types of decision-making choices. A person who is fully capable can make decisions about their personal affairs, house decisions or their financial affairs; that is just a given. What is new in the adult guardianship and trusteeship legislation is the tool called supported decision-making authorisation where a capable person can enter into an agreement, an authorisation, which allows a person to take on some roles such as assisting them in making decisions, attending doctor's appointments, an ability to access personal information, an ability to communicate on their behalf. It is a very simple tool. It is a regulated form. They have to use the form and it is just two pages. We think that supported decision-making will really make a big impact in providing just enough help for the person.

Next on the continuum is "Significant Capacity Impairment". This is when a person perhaps has had an acquired brain injury from a motor vehicle accident. They have not completely lost their ability to make decisions but they need somebody else to make decisions with them and provide appropriate guidance. In those situations it is a court application and the person will have had to go through a capacity assessment. If they go through that capacity assessment that says they have a significant impairment in certain areas, an application is made to court and a co-decision maker order would be appointed. I know you have quite a few questions around co-decision making, so I will get into that little bit later.

Moving on in the continuum you see a "temporary lack of capacity". This could be a situation where a person has had a sudden stroke, they have come into the health system and there is a need for someone to make decisions fairly quickly. But the adult has been assessed as not being able to make that decision for themselves; they cannot provide informed consent. In those situations a healthcare provider will be able to select either a family member or as a last resort the Public Guardian's Office to make a decision. Another option is if a person has been in an accident and they are coming in unconscious or unable to make a decision. Then we have the ability for a physician to make emergency decisions. Continuing on the capacity chain, you see at the end is the person has a long-time loss of capacity. In those situations you see that there is a remedy to get in court quickly for a guardianship or trusteeship order without a capacity assessment, or if there is time to do a capacity assessment, which is the more typical experience, it will go to a capacity assessor, there will be a court application and a person would apply for guardianship or trusteeship. That is the continuum.

I will go to the next slide. The first and the least intrusive of the decision-making options is supported decision-making. We looked at the model that was in the Yukon for supported decision-making and we tried to simplify it. Again the spirit is a capable adult who can make their own decisions but they just need a little support. As I mentioned, it is a regulated form. We are working very closely with the Association of Community Living, which is an organisation for people with developmental disability. That organisation is finding that supported decision-making is going to be an extremely helpful tool. Again the supporter has very limited authority. They can communicate, they can visit, they can attend appointments, they can advocate and they can access information. But they have no decision-making powers.

The next slide is co-decision-making. It is a court order, so it is through the Queen's Bench. As I mentioned before, a formal capacity assessment has been done. The criteria is that a person has a significant impairment. That is defined by regulation to mean that a person has some type of mental disorder that impacts their ability to make decisions and it has been impaired but they are still able to make decisions with another person. It is the idea that the co-decision maker and the assisted adult will make decisions together. For the decision-making order it is a bit unusual in that the adult has to agree to the order and so does the co-decision maker. The adult has the ability to withdraw their consent. When that order is granted the order terminates. I will get into that a little bit more during the questions you have supplied.

The next slide is guardianship. This is where a person has been assessed as lacking capacity and a court application has been made. Under the Adult Guardianship and Trusteeship Act basically what we have done is modernise guardianship that was available under the Dependent Adults Act. All the people who were currently under private guardianship will continue to be under the Adult Guardianship and Trusteeship Act. So we have grandfathered all of the existing ones. In Alberta we have about 9,000 family members and friends who act as a guardian. The Public Guardian acts for about 2,000 individuals as a last resort.

The next slide you will see there is a new application process. Mrs Ady when she was in your area was very intrigued with the tribunal model. She was very impressed that the adults had such a prominent role. In Alberta under the Dependent Adults Act it was primarily a desk application, so there are a lot of applications and forms to be filled out. The adult was notified of the application. They would receive a package of information and they had the ability to trigger a hearing. But what we heard from dependent adults is most often they did not understand the materials. So they may not have taken any action, they may not have had a lawyer. They felt that often when a guardian or a trustee was appointed they did not realise that they had any role in the process and it came as a surprise that somebody else was making the decisions. The process under the Adult Guardianship and Trusteeship Act is still under the Queen's Bench but instead of people applying directly to court there is a process of desk applications and hearing applications that will come through the Office of the Public Guardian. Our office will review the applications for completeness. For new guardians, trustees or decision-making, there is—

CHAIR: Sorry, we are losing you; you voice is going in and out.

Ms DOYLE: I will come a little closer to the phone. There is a suitability process. The person who is applying to be a decision-maker has to supply—

CHAIR: Your voice is going out again. Perhaps if you start that slide again and we will let you know if you are cutting in and out?

Ms DOYLE: That is great. The new process under the Adult Guardianship and Trusteeship Act for court applications is that someone would provide their application package to the Public Guardians Office. Our staff would review it for completeness, make sure that there is a capacity assess—

CHAIR: You are gone again.

Ms DOYLE: I am wondering if I should just pick up the phone.

CHAIR: If you try it with the handpiece and see how that goes?

Ms DOYLE: I can hear you fine. Can you hear me okay?

CHAIR: We can hear you now.'

Ms DOYLE: The new process is that if someone were to put their application in to the Public Guardians Office, we would also ask them for two character references, a criminal records check, as well as a credit check, if they are applying for trusteeship. Another responsibility of one of our staff would be to go out and personally serve the adult. They will sit down with the person and explain that someone is making a court application to become their decision-maker. They will ask for their views on the application and provide them with their right that they can ask for a hearing.

Our staff, who is called a review officer, then will take all that information, plus the suitability information—also they have the responsibility for notifying family members—and provide a review officer report to the court. One of the feedbacks that we have received from judges is that they want more comprehensive information about people who are applying to be decision-makers and they want to know the adult views of the application. We have been working really closely with court services to make sure that this is a smooth process and we will see in time how effective it is.

The next slide is specific decision-making. This is the ability for a healthcare provider to assess an adult to see whether or not they can make informed consent either for healthcare matters or for residential placement. The healthcare provider, a physician, nurse practitioner or a dentist if it is for dental treatment only, will do a mini-capacity assessment of the adult to see if they can provide informed consent and if they cannot, they can go to a ranked list of nearest relatives. The nearest relatives have to make a declaration to say that they are suitable and can make the decision. There is a process involved that the specific decision-maker will have to consult with the adult and then a decision is made.

The adult has the remedy if they are not happy, that they believe they are capable of making decisions, they can ask for a full capacity assessment or they can ask for a court review. This is really in response to some of the needs from the healthcare community around having a more timely and efficient decision-making process when having to go for guardianship.

The next slide is emergency decisions. The Dependent Adults Act always had the ability for physicians to make a decision in an emergency situation. This is being modernised under the Adult Guardianship and Trusteeship Act to allow for a physician to make decisions and if there is not a second physician, they can have a nurse to provide a second opinion.

The next slide is around the financial decision-making options. Under the Adult Guardianship and Trusteeship Act the trustee provisions that were under the Dependent Adults Act have been modernised. It is all about financial and security decision-making. The trustees are appointed with full authority, though they can be provided more limited authorities around real property. There is no continuum for financial decision-making. You are either capable of making your own decisions about your finances or you are incapable and a trustee is appointed. In Alberta we also have an enduring power of attorney so if a person wants to plan ahead and appoint someone to make decisions if they lose capacity, you can appoint a power of attorney. The trustee is for individuals who have not planned ahead.

One of the new benefits of the Adult Guardianship and Trusteeship Act for financial affairs is that an applicant will have to submit a trusteeship plan as part of the application, or file it soon thereafter. The idea is that a person is going in, knowing that they are going to be managing a business, managing a property, taking care of income or investing, and they would put that in a trusteeship plan. The judge, when they are appointing a trustee, would be able to look at that plan and have a good idea of what is going on. The adult also would have a copy of the trusteeship plan.

Previously trustees were only appointed if they lived in Alberta. That residency requirement has been relaxed, so trustees can live anywhere in the world. An added protection to that may be the posting of a bond. Also, trustees now, instead of making investments based on certain trustee lists, will be able to make broader investments through a prudent investor standard.

The next slide is capacity assessment. One of the topics we heard the most during all of our consultation was dissatisfaction with the way that the assessment had been done under the Dependent Adults Act. We heard very much from seniors that they were scared that someone was going to assess their capacity at a moment when they were not at their best; they were on medication, maybe they had delirium because of an infection. So there was a great deal of concern that they would be assessed at a moment when they were not able to show their capacity.

Under the Adult Guardianship and Trusteeship Act capacity is very much looked at for court applications. The first step in the process is that physicians have to meet with the adult to screen out that there is no temporary or reversible condition that may be causing incapacity. The spirit is you are not trying to assess while they are in acute care, while they are coming out of surgery or they have some infection. The idea is to wait until the person—

CHAIR: Sorry, we have lost you again.

Ms DOYLE: I will just wait a moment. The physician screens for those reversible conditions and the idea is to get a person at their optimum of health before they go through a capacity assessment. The next stage of the capacity assessment is an interview. The interview is expected to last about two hours. It focuses on the person's ability to make decisions through a cognitive and a functional inquiry. There are a lot of safeguards put in the capacity assessment process. The purpose of the assessment is explained to the adult. They have the right to consent to the assessment or to refuse. They have the ability to have an observer present and feel comfortable. They also have the right to have translation services or communication devices such as their hearing aids in place before the assessment occurs.

In the regulations we have put in a lot of guidelines for how the capacity assessment is to be conducted and we have new capacity assessment forms that are quite detailed. There are different groups of health professionals who can conduct capacity assessments. We have grandfathered in physicians and psychologists so that they are able to do capacity assessments. They have been doing it for over 30 years under the Dependent Adults Act. Now we have allowed by regulation for registered nurses, registered psychiatric nurses, registered occupational therapists and registered social workers who complete a three-day training and have passed an exam to be designated by the Minister as capacity assessors, so we have put a lot of process around making sure whoever assesses capacity has been well trained.

The next slide is protective measures—investigation. There is a process under the Adult Guardianship and Trusteeship Act that if a person has concerns about the actions of a codecision-maker, guardian or trustee, that they can make a written complaint. They do not have to take it to court. It can be a written complaint where they can talk about what they are concerned about. It has to meet certain criteria in the Act. It has to be that the decision-maker is not following their duties or following the court order and it is causing either physical or mental harm or financial loss.

The written complaint goes in to a complaint officer, who is independent of the Public Guardian and the Public Trustee, who screens it to ensure whether or not it meets the standard Act. If it does not, if it is an unfounded complaint, then a letter is provided to the complainant stating the written reasons. If it meets the criteria in the legislation, then it will be assigned to an investigator. If it is a matter around codecision-making or guardianship for private individuals, then the Public Guardian will investigate it. If it is a complaint about the Public Guardian, then an independent investigator will be assigned and the same would go for trusteeship if it were about the Public Trustee. If it is concern about the actions of a trustee, then an investigator through the Public Trustee would be assigned.

There is a process in the legislation that if it comes to the attention of the Public Guardian that a private guardian has put an adult at significant risk—that is the idea that they are doing something that is causing a life-threatening situation—then the Public Guardian has the ability to apply to the court for a temporary protection order to have that person removed and taken to a place of safety. We are not expecting that is going to come up too often but we have certainly had situations like that in the past.

The investigation process is built on a restorative model. The idea is getting a person back on the right track. An investigator will make a recommendation to provide education and assistance, if it is a founded complaint, or they can make a recommendation for alternative dispute resolution, or if it is a very serious matter they can make a recommendation to have the guardian, co-decision maker or trustee removed, and the Public Guardian would then make that application.

The last slide is called "New Choices and their compatibility with other planning tools" in Alberta. There are a number of boxes. If you look on the left side you will see "Personal Decisions" and in the upper column "Planning Tools". In Alberta any person can write a personal directive if they have capacity and that is a very simple tool of two pages where they can name a future decision maker if they lose their capacity. That would be called an agent. They can also provide written instructions, so it is an advance directive. What is new with the Adult Guardianship and Trusteeship Act is that now a person can plan ahead by writing a supported decision-making authorisation for while they have capacity and need assistance. We believe that having supported decision-making and a personal directive for a future time when they may lose their capacity and an enduring power of attorney will be all that Albertans will need and they will never have to enter into the court system, in the whole spirit of the less people have to pay for these resources through keeping away from court, the better it is, so the more people plan.

The next section of the slide is the court tools. The assumption is that a person was not able to plan ahead or they had a significant impairment. Under the Adult Guardianship and Trusteeship Act, for personal decisions the new tool is the co-decision-making tool for people with significant impairment. As well, there is guardianship for people who lack capacity. For financial decisions, the court tool is trusteeship. If you follow the diagram along to look at emergency decision-making, what is new in the Adult Guardianship and

Trusteeship Act is a modernised emergency decision-making tool, a new tool for informed consent called "specific decision-making" and the ability to act quickly by getting to court for a temporary guardianship or trusteeship order.

Referring to the last part on the right, the protective measures, under the Dependent Adults Act if anyone had a complaint about a guardian or a trustee they had to take an application back to court. There was no other method of resolving that. Now, with the Adult Guardianship and Trusteeship Act, if they have a complaint about a co-decision maker, guardian or trustee they can use the complaint process or they can take it back to court for a review.

CHAIR: Thank you very much for that very comprehensive slide show. We will start questions with Mr Veitch.

The Hon. MICHAEL VEITCH: Thank you for that. It was very comprehensive. It is quite exciting to see that sort of legislation. It must be quite exciting having to work within that new framework.

Ms DOYLE: It is very exciting.

The Hon. MICHAEL VEITCH: In our deliberations we have had a lot of evidence about the United Nations Convention on the Rights of People with Disabilities. Your legislation appears on face value to accommodate a lot of the articles in that convention. Can you talk us through how you have given attention to the United Nations Convention?

Ms DOYLE: Yes, very much when we were doing the consultation with the public we had submissions from disability organisations around the UN Convention, so we were very sensitive during the development process of the Act to be in compliance with the UN Convention. I was also involved with our Human Rights Commissioner around Alberta's position and Canada's position on the UN Convention. A whole spirit of having supportive tools in the legislation is tied directly back to the Convention.

The Hon. MICHAEL VEITCH: There is also a paradigm shift in regard to determining capacity as opposed to incapacity. In your presentation you spoke about the assessment process and the qualification arrangements. One of the concerns that have been raised with us is that the assessment of capacity is conducted at a particular time on a particular day in someone's life. Do you have any arrangements whereby someone could request a reassessment or there is a trigger for another assessment at some later stage?

Ms DOYLE: The physician is kind of the gatekeeper of the capacity assessment process so you cannot move to have a full assessment unless the physician says they have ruled out any temporary reversible conditions because sometimes you do have good days and bad days, so the focus is you need to be on the best day in order to assess capacity.

The Hon. MICHAEL VEITCH: How do you determine that?

Ms DOYLE: As part of the capacity assessment training process the capacity assessors are trained in looking at triggers for when is the right time for capacity assessment. They are also very sensitive to the environment where the capacity assessment takes place, trying to make it as comfortable and supportive to the adult as possible. That is why there is the inclusion of the observer. If the capacity assessor is in the middle of a capacity assessment and it looks like the adult is not functioning very well they have the right to discontinue the assessment at that time and continue it at another time. The adult can ask for that. The idea is it may take a couple of times to meet with the person in order to complete a full assessment.

The Hon. MICHAEL VEITCH: You mentioned earlier it is a two-hour assessment.

Ms DOYLE: That is correct.

The Hon. MICHAEL VEITCH: It does not have to be all done at the one time; it can be done over a series of meetings.

Ms DOYLE: Yes. The idea here is that by now having certain healthcare professionals who are designated as capacity assessors they will want to take the time to do it in a very standardised fashion. Before, when it was physicians who were exclusively doing it, we found that psychologists took a lot of time to do a very good capacity assessment but for physicians who had a very busy practice the assessments tended to be much shorter and what was on the report [*connection dropped out*]—so on the forms under the Dependent Adults Act we sometimes found that doctors were filling in comments such as "Prognosis poor. Diagnosis dementia. Incapable." It was not a lot of information for the judge to make a decision. Now there is a lot more information required as part of the capacity assessment report.

The Hon. MICHAEL VEITCH: Is that a standardised assessment tool that you are using?

Ms DOYLE: Yes, the report is standardised. We do not say that there is a particular test to use, like a psychological test, but there is a standardised interview.

The Hon. MICHAEL VEITCH: Are we able to get a copy of one of those or an example?

Ms DOYLE: We can send you a guide as well as all the capacity assessment forms.

The Hon. MICHAEL VEITCH: Thank you. That would be good.

Dr JOHN KAYE: Can I take you to the slide on page 23 of your excellent presentation? I am sure I am talking for my colleagues when I say that it really was very informative and also quite expanded the horizons. I want to go to the financial decision-making options. There is a dot point that says, "No continuum of capacity; you're either capable or incapable" when it comes to financial decision-making. We have heard some evidence that there is a range of capacity in financial decision-making. For example, some people could handle a credit card with a $1,000 limit but would not be capable of making investments with respect to their property or managing larger portfolios. What was the thinking behind having a yes or no answer to the capacity question when it came to financial decision-making?

Ms DOYLE: It was part of the consultation on whether or not there should be more supportive tools for financial management. There is in Alberta the ability for a person to appoint someone to manage their pension income—a pension trustee—or if a person is receiving some type of income through a disability program there is the ability to appoint a family member to administer their funds coming in. There are a number of informal processes already in Alberta. When a person is appointed as a trustee under the Adult Guardianship and Trusteeship Act the trustee has the ability for the adult to set up a bank account and manage it. The trustee will still have the responsibilities for all the decisions but they can allow the adult to make as many decisions about the small amounts of funds themselves. The idea is that the more complicated decisions such as investments will be what the trustee would focus on but it would still allow autonomy for a client to operate a bank account.

Dr JOHN KAYE: Does your office, the Office of the Public Guardian, act as a guardian and also overview other guardians? Is that correct?

Ms DOYLE: We have two roles: One is that we make decisions when we are appointed as a guardian—that is for those 2,000 individuals—but we also have a role in supporting private guardians. We provide training sessions and we assist them in the court application process and now we have an oversight function in providing more comments to court as part of the suitability, but also to investigate complaints about them.

Dr JOHN KAYE: Do you also act as a financial guardian or trustee?

Ms DOYLE: That is the Public Trustee. They are in a different ministry. Cindy Bentz is the Public Trustee. Unfortunately she was not able to join us today but I have agreed that if you have more questions on trusteeship she would be delighted to provide you with some responses.

Dr JOHN KAYE: Thank you very much.

The Hon. TREVOR KHAN: I refer to your final slide and the left-hand columns, particularly those dealing with the planning tools. Dealing first with planning directives, are those planning directives supported by legislation or underpinned by legislation?

Ms DOYLE: Yes, it is called the Personal Directives Act, which is for the personal side, and the Power of Attorney Act, for the financial side.

The Hon. TREVOR KHAN: Let us deal with the personal directives side. What is anticipated to be covered in a personal directive if a person chooses to make one?

Ms DOYLE: We have a standardised form on our website. I will send you a package of information because we administer that Act as well. The form allows a person to appoint a decision-maker. It allows for them to provide instructions such as around end of life and it allows them to attach any relevant information. So that is basically how the form is laid out. Adults can also go to a lawyer and the lawyer would create it. For an order for a personal directive to be valid, it has to be in writing, it has to be dated and it has to be witnessed.

The Hon. TREVOR KHAN: Do I take it that it does not require any certification of capacity by, for instance, a doctor?

Ms DOYLE: You can write a personal directive presumed to be capable, but in order for the personal directive to be activated and the decision-maker to kick in, you have to go through a capacity assessment. That capacity assessment involves either a doctor or psychologist or someone named in the personal directive. So you can name your wife to assess your capacity if you are comfortable with your wife or you can have another service provider, a second person, to assess capacity.

The Hon. TREVOR KHAN: I direct you to part 3 division 1 of the new Act, and I think it is on page 68 of the copy of the bill I have been provided with.

Ms DOYLE: Okay.

The Hon. TREVOR KHAN: It is the section or that part that deals with specific decisions and emergency health care.

Ms DOYLE: Okay.

The Hon. TREVOR KHAN: In the light of the existence of a legislative bat—personal directives—where in that part of the Act is there a reference to personal directives?

Ms DOYLE: Good question. If a person has a personal directive, then the intent is you do not use specific decision-making.

The Hon. TREVOR KHAN: I would think not.

Ms DOYLE: The healthcare provider would activate the personal directive and the agent would make the decision.

The Hon. TREVOR KHAN: But if I look at section 86 of the Act, that does not seem to be one of the criteria that kicks in. It would seem that a healthcare provider could appoint an alternative decision-maker without reference to the agent?

Ms DOYLE: Yes. If you go to the next section, the limit on the appointment and authority, it says there that a specific decision-maker may not be selected to make and has no authority to make decisions if the person has a personal directive.

The Hon. TREVOR KHAN: Right. That is excellent.

Ms DOYLE: Now, for a guardian, the idea is you go to who the person selected or a legally appointed guardian. The scheme applies if you do not have either.

The Hon. TREVOR KHAN: What does the healthcare provider do if there is some issue with the interpretation of the personal directive or the validity of the personal directive? I am thinking of specific circumstances. For instance, there was a recent decision in New South Wales and the Hunter New England Area Health Service dealing with a Jehovah's Witness not wanting dialysis. There was an issue with regards to the existing document. In that case the area health service went off to the Full Bench of the Supreme Court. Is there a similar mechanism for the healthcare provider under your legislation?

Ms DOYLE: Somewhat, but I will explain. Of course, if a person's wishes are known and they have written them in a personal directive and a healthcare professional has a copy of the personal directive and they know that a person would not want blood products or would not want dialysis, then they should be following the instructions in the personal directive. If they go ahead and do it knowing that there were written instructions, then they probably do not have very much liability protection. If the healthcare professional does not know there is a personal directive and does not know that the person is a Jehovah's Witness and provides an emergency response to keep the person alive and they had no idea about the person having made that objection before, then they are allowed to in the Act. But under the emergency provisions, if it is known that the person had very clear issues not to receive something, then the healthcare provider is not allowed to provide it.

The Hon. TREVOR KHAN: Is that dealt with in that part of the Act or in the personal directives legislation?

Ms DOYLE: In the Personal Directives Act, but also under the emergency provisions it is laid out there that the healthcare professional cannot provide something that they know the person has objected to.

The Hon. TREVOR KHAN: Are you able to answer questions about the second part of that first column, that being enduring powers of attorney, or is that best dealt with by questions on notice?

Ms DOYLE: I am happy to provide any answer I can and if you need more details, I will have Cindy Bentz provide it.

The Hon. TREVOR KHAN: Dealing with the enduring power of attorney, I think you have already indicated that that is obviously based on a piece of legislation?

Ms DOYLE: Yes.

The Hon. TREVOR KHAN: Is the form that is used a prescribed form?

Ms DOYLE: No. There is no prescribed form. One of the modernisations being looked at with several of the western provinces is to have a consistent standard form for enduring power of attorney. The law commission is looking at that right now. But at this point there is no standard form. Most people, if they are going for an enduring power of attorney, go to a lawyer.

The Hon. TREVOR KHAN: Is there an actual inquiry being undertaken at the present time by the law commission?

Ms DOYLE: There is.

The Hon. TREVOR KHAN: What is the full name of the commission?

Ms DOYLE: It is the Law Reform Commission of Alberta and I can certainly send Jonathan some of the contact names. Peter Lown is the Executive Director there.

The Hon. TREVOR KHAN: That would be excellent. Thank you.

The Hon. MICHAEL VEITCH: It has been proposed in New South Wales to have a community guardian program where members of cultural and linguistically diverse backgrounds would be trained and supported in delivering guardianship services within their communities of origin. Do you have a similar process in Alberta? Do you see any benefits as to how this would improve the substitute decision-making processes?

Ms DOYLE: I think it is very exciting. One of the things we heard during the consultation particularly with Aboriginal people is that the more they can have someone who comes from their cultural and linguistic environment, the better decisions are made. There is a greater comfort level that people share the same values and that people would be in tune to that. We also heard, because Alberta has a lot of immigration, a lot of people moving to Alberta, that there is a need for having materials translated into a number of languages. We provide all of our materials in eight different languages so that people can understand the legal tools in a method that is as easy to understand as possible. We certainly strongly encourage whenever someone is coming for a guardianship that they know the values and beliefs of the adult who they are representing. We have had discussions with different cultural groups around taking on the role of guardian or agent, but we do not have anything formal like a community guardian program.

The Hon. MICHAEL VEITCH: I have two questions that relate to definitions within the Adult Guardianship and Trusteeship Act. The third definition of "an interested person" says, "any person who is 18 years of age or older and who is concerned for the welfare of a person in respect of whom decision-making orders" et cetera are made or obtained. That is a very broad definition. I know your Act is very new, but do you feel there may be an opportunity for some issues around that definition?

Ms DOYLE: This is the same definition that we have had in the Dependent Adults Act for the past 30 years. An interested person is basically anyone who has an interest in the person. An interested person has a number of key roles in the legislation. They can trigger a court review or they can make a complaint. We went broadly with the idea that there is more protective value in having it open to a larger group rather than trying to narrow it. We have not had difficulty with that definition in the past 30 years.

The Hon. MICHAEL VEITCH: If an interested person were to trigger that legal process or that appeal process, who pays?

Ms DOYLE: They do.

The Hon. MICHAEL VEITCH: So they are responsible for the cost?

Ms DOYLE: Yes. They would make an application and they can ask for costs against the Crown and the judge can determine whether or not that is appropriate. But any upfront costs, they are picking it up themselves.

The Hon. MICHAEL VEITCH: If you have a private guardian appointed, an individual, what is the process in the event that that person passes away?

Ms DOYLE: One of the recommendations that we make if people are making applications is to appoint an alternate. If there is an alternate private guardian at the death of a private guardian, the alternate steps into the shoes. If there is no alternative appointed in the order, then the Public Guardian automatically becomes the guardian.

The Hon. MICHAEL VEITCH: Of last resort?

Ms DOYLE: Yes.

CHAIR: In circumstances where capacity loss is considered temporary, what measures are in place to review orders and reassess people to determine if and when capacity may return? What happens when a person refuses the capacity assessment?

Ms DOYLE: Good questions. These are ones we struggled with a great deal. Because the Act is built on the assumption of capacity and the guardian principle of the least intrusion, the idea is that you do not ask for a capacity assessment unless it is needed for a court application. The idea is if someone is just having a temporary loss of capacity and cannot provide decision-making, then the specific decision-making scheme should be used. The idea is that someone can assess for that particular decision and someone can step in to make that decision. So, if it was cancer treatment, then a specific decision-maker would be appointed just for that decision. The idea is that once a person recovers, they still have their legal status as a capable person and you do not have to undo anything in the court, but they receive the treatment that they need. Under the capacity assessment process, the capacity assessor has to have in their report whether or not they believe that the adult would regain their capacity. If they do, when do they believe their capacity should be assessed? That is looked at as part of every court application and then if there is a recommended review date, the judge, as part of the legislation, will put that that is when the court order has to be reviewed. The spirit is also that the decision-maker, whether a guardian or a codecision-maker or trustee, always should be thinking about the capacity of the person. If they notice that the person has regained capacity or looks like they have regained capacity, then they can trigger a capacity assessment and take it back to court.

CHAIR: But with financial decision-making options the continuum of capacity is much more rigid. I am a bit confused there.

Ms DOYLE: It is. Financial is much more rigid. With personal decision-making there is a lot more options. One of the reasons why financial is much more rigid is that we had a lot of feedback from the banking community and the financial community that they wanted certainty. They wanted to know who had the authority to make financial decisions. That was one of the driving factors in having kind of capable or incapable.

CHAIR: It is interesting to see that in Alberta the financial sector has similar capacities to those here in Australia?

Ms DOYLE: I think you have picked up my message very well.

Dr JOHN KAYE: Brenda Lee, I think I may have called you Debra Lee earlier on and for that I apologise, on slide 11, and also in section 2 of the Act, the principles talk about the communication method not being relevant to the determination of capacity—that is to say, capacity can be determined via any medium of communication. What the Committee has heard in evidence so far is that it is just not the medium of communication but also how the questions are posed—that is to say, the person assessing capacity needs to facilitate communication in respect of the individual's range of capacities. Is that something you have been looking at as well—that you need to facilitate the communication? The sort of questions you ask and the way the questions are asked need to respect the variety of capacities that present themselves?

Ms DOYLE: Yes, absolutely. The idea is that you are sensitive to the needs of the individual and you are making sure that they have the best opportunity to demonstrate their capacity. The goal is to demonstrate capacity rather than focus on incapacity. So by making sure that services are provided, that they have their hearing aids or assisted communication devices, the observer, all of those factors are taken into the idea of creating a good environment. The capacity assessor, as part of their training, is trained around how to ask questions that are appropriate. So it is not just asking one question but is kind of approaching it in a number of different ways.

The Hon. TREVOR KHAN: I return to the issue of personal directives. Are you aware of whether the introduction of the legislation that underpinned personal directives followed an inquiry from an organisation such as your Law Reform Commission?

Ms DOYLE: The personal directive legislation has been around since 1997. It was really legislation that came out of the living will movement and the need for informed consent. I will have to go back to see if there is a Law Reform Commission. We also oversaw amendments to the Personal Directives Act that were just proclaimed, so I could certainly provide you with some of the consultation documents because we did the Personal Directives Act and the Dependent Adults Act at the same time.

The Hon. TREVOR KHAN: I would be most grateful, thank you.

Ms DOYLE: We wanted to make sure they were compatible.

CHAIR: Brenda Lee, time has caught up with us. The Committee greatly appreciates your contribution. Alberta came to us as being a world leader in this area and your presentation has not let down that belief.

Ms DOYLE: No problem. I will be happy to send along a package of information to you. Thank you for your time.

CHAIR: A number of questions on notice will no doubt be sent to you by the Committee secretariat in the near future.

Ms DOYLE: Excellent.

(The witnesses withdrew)

STEPHEN FRANCIS NEWELL, Principal Solicitor and Manager, Legal Service, The Aged-care Rights Service, Level 4, 418A Elizabeth Street, Surry Hills, New South Wales, 2010, and

MARGARET ANNE SMALL, Solicitor, The Aged-care Rights Service, Level 4, 418A Elizabeth Street, Surry Hills, New South Wales, 2010, sworn and examined:

CHAIR: Thank you both for your attendance before the Committee today. Would either of you like to make some opening comments before commencing questions?

Mr NEWELL: Yes, just briefly. We are appearing before you as advocates and solicitors for The Aged-care Rights Service and our comments are based on our experience and the anecdotal evidence we have collected as advocates. The aim of our service—and I commend this Committee on its endeavours—or goal is to achieve the balance between the rights of what I shall call protected persons, or people lacking capacity, with the responsibility of the substitute decision-makers either appointed directly or by tribunals or courts. It is a balancing act that is sometimes hard to achieve. As I say, our submissions are based on our experiences as advocates taking calls from members of the public. Our demographic really is older persons in the community who are economically or socially disadvantaged.

CHAIR: It is estimated that by 2050 approximately 1.3 million Australians will be affected by dementia. What provisions, if any, should New South Wales be making to accommodate the likely increase in demand for substitute decision-making from this group of people?

Mr NEWELL: There are a couple of things, some are covered in our submissions, but something that occurred to us recently was this. To attempt to accommodate the increasing number of aging people and also, by definition, those that will require some form of substitute decision-making, I think one of the difficulties is to be able to process those applications. Our experience is that a lot of the disputation arises out of siblings, family members and the like putting forward their view of what they think is best for the person in need of protection. If the situation is that there is no dispute between the family members, if a process could be put in place were effectively a form of consent order could be put to, say, the Guardianship Tribunal or to a decision-making body to overcome the need to make an application.

The tribunal, I know, is clogged with applications now. It is something that they did in the local courts, and have done it in courts generally, to streamline the process. My understanding is that at the end of the day you still need some authority that the person that the third party is dealing with actually has the authority to speak on behalf the person that requires protection, and they need some evidence of that. If that came through some sort of a paper process, where the parties could simply file a consent order in the tribunal and perhaps that could be processed in chambers, it may alleviate the backlog. That was one thing that sprang to mind.

The Hon. TREVOR KHAN: Who would be the parties?

Mr NEWELL: The parties I think would be the family members—those that would object to a person or persons acting on behalf of the protected person. Because our experience is that the difficulties and the disputes come from the surrounding members of the family. The view that the Guardianship Tribunal generally takes, as I understand it, is if the parties agree it is quite happy to appoint a family member as the guardian or as the financial manager but it is only when there is argument between the families about who will be appointed that a public person is appointed.

The Hon. TREVOR KHAN: But you still have to determine initial issue—that is, the capacity or incapacity of the person?

Mr NEWELL: Indeed, yes. This is probably the second phase of it, if capacity is not in question but who is going to act is where I am coming from here. The actual judging of capacity is always going to be that vexed question and is going to be based on medical evidence effectively. You are aware, no doubt, of the capacity tool kit that has been produced by the Attorney General's department. From our perspective, and I think Meg will agree with me, that is a great tool and indicator for tribunals and for members of the public. Because it has always been a fairly subjective thing as to whether somebody has capacity or does not have capacity. And, in fact, what capacity they have, because capacity is task specific. You may not have capacity to understand or run complicated financial issues but you may well have capacity to understand where you want to live and whom you want to live with. So it is a matter of degrees. I am talking about a situation here where the person has not granted a power of attorney or guardianship document in their time. In other words, it is too late, they have lost capacity and then the issue arises, or they are losing capacity and the issue arises, and that is your question, I think, that area in between.

CHAIR: And that area where there is constant change of capacity, for example, where the family member is not taking his medication and the family is concerned they are going to lose social contact with family, friends, job, but that person is saying, "I do not need this medication." That is a classic.

Mr NEWELL: We see that, exactly.

CHAIR: How do you deal with it?

Mr NEWELL: How do you deal with it?

CHAIR: With great difficulty?

Mr NEWELL: The problem is that it is a question of degree and from our point of view as advocates we are effectively bound by the decisions of the medical people because at the end of the day it is a medical/psychiatrist/psychologist-type decision.

CHAIR: Well, is it? It is also that particular individual's right to make a bad decision.

Mr NEWELL: Absolutely.

CHAIR: So, it is medical and it is also a social issue?

Mr NEWELL: Yes, it is.

CHAIR: It is also a question of changing capacities?

Mr NEWELL: That is the practical difficulty. It is a difficulty we face when we try to speak to people and advise people about this, that it is ever-changing, especially in the area where there is a progression to losing capacity and at what point.

CHAIR: The case I am citing is not a progressive case towards, it is ever-changing capacity, in and out, not a progressive loss of capacity. So, that creates all sorts of other issues in regard to how you deal with a person who has the right to make a decision as to their medication but the social consequences are such that they lose family, friends, job and social contact. The decision is clearly not in their best interests but the person has a right to make a decision that is not in their best interests. So, how do we as a community deal with that?

Mr NEWELL: That is a valid point and a very good point, and one that we strike all the time. The point you make, the right to make a bad decision, is very much a right. What is a bad decision to me might not be a bad decision to you. People have the right to do that. The balance is if that bad decision is going to affect third parties. Again, it is a question of degrees. My view as an advocate is that is something that falls into the hands of the experts, whoever they happen to be—bearing in mind, of course, that the person does have a right to voice that request, "This is what I want to do." It is akin to a court decision. At some point an authority has to be able to override that in all the circumstances, the reasonableness of the circumstances of the case have to be taken into account.

The Hon. MICHAEL VEITCH: You just mentioned advocacy and the role of an advocate. We have heard a lot of evidence, and taken written evidence too, that there needs to be a Public Advocate in the New South Wales jurisdiction. I do not think we have heard anyone say we should not have one.

Mr NEWELL: We are not going to join the ones who say you should not have one.

CHAIR: It is the form one should take.

The Hon. MICHAEL VEITCH: The issue for us, if that was to be the case, just exactly what will the Public Advocate do? What is the role of the Public Advocate? When we asked people this, I do not know whether a great deal of thought has gone into what the role would be.

Mr NEWELL: I think you are right.

The Hon. MICHAEL VEITCH: What do you see as the role of the Public Advocate if there were to be one? Is it some of those functions already undertaken by other tribunals, capacities, in New South Wales?

Mr NEWELL: There are a number of disability advocacy services out there. They all serve various roles. I guess the question really is how effective are they and what sort of authority do they have. I think my view is, and I think Margaret might agree with me, there should be some sort of a Public Advocate, I think there is a need for it, because our experience is quite often you can advocate but you have no authority, you have no power—authority is the word, I suppose—to open doors, and to make things happen. Certainly one of the real issues I think is the inability to investigate the circumstances around the allegations of incapacity or the allegations of making a bad decision. We, as an advocacy service—I think any advocacy service—cannot go and knock on the door and kick the door in and say, "We are here to find out what is really going on." We get a lot of evidence and a lot of allegations from interested parties, some well-meaning and some self-interested, and it is extremely frustrating from our point of view to try to get to the bottom of it. How do you get to the bottom of it, because we do not have the authority even to ring the police and ask them to look at what is happening here. As I understand it, I think some of the aged care assessment teams have some sort of right, is that correct, to enter?

Mrs SMALL: They do not have the right, but they can be asked by an anonymous person to go and see if a person is all right but they can be ordered off the property if the person is not the landowner or they have given their guardianship to somebody else.

The Hon. MICHAEL VEITCH: What sort of legislative platform or authority would the Public Advocate need?

Mr NEWELL: It is a good question, and it is one that I should have given more thought to, along with everybody else by the sound of it.

The Hon. MICHAEL VEITCH: I am happy for you to take it on notice.

Mr NEWELL: Why do we not do that? It is a role that is certainly needed and in our submission we talked about core communities and the need for culturally specific—

The Hon. MICHAEL VEITCH: Yes, the community guardians. My next question was to do with community guardians and what role they would have. Do you see that role clashing with the role of the Public Guardian or complementing the role of the Public Guardian?

Mr NEWELL: I would like to think it would complement.

The Hon. MICHAEL VEITCH: Again, what do you see as the role of the community guardian?

Mr NEWELL: The main role that springs to mind is a point of contact. A common complaint we get is the community merry-go-round that goes on. They ring us, we refer people on, people refer people to us. If there is an identified person to go to with some authority who can open some doors, who can ask some questions—not police powers, I am not talking about that, I am just talking about somebody who can ask the questions with some sort of authority. Quite often I think that would really serve a purpose. Quite often the people you are dealing with—and I am generalising here but anecdotally we see situations where quite often it is a matter of perception. In a case where there is an allegation of financial abuse or neglect, it is a matter of perception. One person might see it as financial abuse, the other person might see it as their right because they stay home and look after mum and they have given up their job and it is going to cost mum or dad a certain amount of money to be looked after anyway. The other one of course is, "I am going to inherit it in any event."

The Hon. MICHAEL VEITCH: An advanced inheritance?

Mr NEWELL: Inheritance impatience.

CHAIR: The other one added to that is mum and dad saying, "I am all right, I do not want any help."

Mr NEWELL: Yes. The other one, if I might add, is trying to get mum or dad to complain about their children. That is, if it is a case of stealing money, to have their children charged. They will not do it.

CHAIR: The question also arises then, why should they?

Mr NEWELL: Exactly. It is a bad choice, but it is their choice. You are quite right.

CHAIR: Most parents have been defending their children from day one.

The Hon. MICHAEL VEITCH: Can you take on notice the fleshing out of the role of the Public Advocate, and I would appreciate your comments about what sort of legislative support that role would require, but also the community guardian, and that role?

Mrs SMALL: Can I just add something to that one? I think particularly in regional and remote areas it would play a very important role, particularly in some areas where there are quite high indigenous populations. I have worked reasonably with indigenous groups. They are quite tribal, they wish to keep it within their community and I think it would be a place for that.

Dr JOHN KAYE: I think you were present in the room when we heard from Brenda Lee from Alberta. One of the things I think Mr Veitch and I expressed surprise at, in terms of financial decision-making it was all or nothing. You either had capacity or not. Would you like to comment on that from your experience? Is it your experience that people will present to you with a range of capacities within the financial area? Would you be recommending that we not follow the Albertan path in respect of that issue here in New South Wales?

Mr NEWELL: I have not read their legislation and I think I was going in and out when that was going on. But I think I get the drift of your question. I think there was a recommendation by the Attorney General to segment part of the State. Did I understand that correctly?

Dr JOHN KAYE: In the terms of reference?

Mr NEWELL: Yes, in your terms of reference, I think it was. It talked about amending the Trustee and Guardian Act 2009 to allow the relevant court or tribunal to exclude parts of an estate from financial management.

The Hon. MICHAEL VEITCH: That is the letter that supported the reference.

Mr NEWELL: We made some comment about that in our submission. I would support that because I agree with Mr Chair, there are degrees. There are degrees of capacity in financial affairs as well. We have struck this because we are quite often a separate representative for protected persons before the Guardianship Tribunal and also the Administrative Decisions Tribunal. We are appointed to effectively ensure they get a fair hearing. The siblings are fighting amongst themselves. We are appointed to speak to the protected person, get their views, and there certainly is a range of them. That is why I make the point, people can be quite definite about where they want to live and with whom they want to live but it is quite clear even from our conversation that they really do not understand the depths of their finances. For instance, we had a situation where there was a guardianship order and a financial management order and it was being run by the Protective Commissioner and the Public Guardian. But the person just had no concept of that, although they could turn the roughly how much money they had, and the like, so it really was a matter of degrees. I support that recommendation.

An example—not one that we gave, but one that I read—was in an acquired brain injury situation where somebody is compensated are large sum of money. Clearly—when I say "clearly", it was based on medical evidence they were not capable of managing a large sum of money—on the basis that they might make some really bad decisions, they just simply give it away despite its being given to them to last them a lifetime It does not mean that they do not have the ability to go and buy food for themselves or pay the rent or undertake simple financial tasks. I think then it is a good move to segment or separate parts of an estate. It is practical.

Mrs SMALL: Yes. I support the submission put in by the Griffith group in relation to training people how to manage their money in those situations. If you segment that and can provide the training as well, you are giving those people a sense of importance and a much bigger right as to what they can do.

Dr JOHN KAYE: And greater autonomy.

Mrs SMALL: Yes.

The Hon. MICHAEL VEITCH: Which is important, as is supported decision making.

Mr NEWELL: Yes. One of the things that flows from this, of course, is that if orders are made by the Guardianship Tribunal, it is always open to go back, because it is a varying thing, and ask for a review of that order. You can apply for a review or revocation of the order for good reason. Sometimes people do come out of it, not as often as we would like, but it happens if it is attached to some other illness.

Dr JOHN KAYE: How often does that need to be reviewed? How often do we need to go back and look at whether an order should be revoked? We have heard a variety of evidence on that, down to one person saying every 12 months for every order.

Mr NEWELL: I think that is the view that the tribunal takes now, is it not?

Mrs SMALL: It is one year, one year and then three years. That is my understanding.

Mr NEWELL: Right. They generally only make an order for 12 months, which means that they are obviously mindful of the fact that it is a varying landscape, if you like. It protects a person in a way because if their circumstances improve, they can make application. I think the problem probably is how quickly they can get in to get that review made. I cannot really tell you what the waiting list time is in the tribunal.

The Hon. MICHAEL VEITCH: Dr Kaye has been talking about the regimented time frame of 12 months, and the one year, one year and three years which the tribunal uses, but do you think there may be a case to set up predetermined trigger points as opposed to established time frames?

Mr NEWELL: Yes. Why not? You are talking about medical trigger points?

The Hon. MICHAEL VEITCH: Yes. You could actually establish what they would be in determining the order and then when someone obtains greater capacity—

Mr NEWELL: More specific orders?

The Hon. MICHAEL VEITCH: Yes.

Mr NEWELL: For example, "This order remains in force until a review by", for instance, "Dr So-and-so, who has already given a report of the proceedings."

The Hon. MICHAEL VEITCH: Yes.

Mr NEWELL: Or, on the application being made.

The Hon. MICHAEL VEITCH: Yes.

Mr NEWELL: I think you could make a far more specific order. I think the tribunal could make far more specific orders, yes.

The Hon. MICHAEL VEITCH: Personally I can see in some particular instances that would be much more beneficial than the time frame, and in other cases they can see that if there is now to be improved capacity, or maybe even deterioration in capacity, it may be a matter of time.

Mr NEWELL: The only reason I would question a little bit not having the automatic review is that in situations when people do not have people fussing over them, they would be neglected and left in the system. If there was somebody who is an interested party who wants a review before the 12-month period, or on the happening of an event, they would very quickly push that. But if there was somebody who did not have an advocate or a family member or whatever to say, "Excuse me, this is happening, he or she is better now or has reached this point", then it would not happen because there would not be an automatic review.

Mrs SMALL: This could be important in cases in which you have people who are on medication, but they are accepting a three-monthly intravenous or something like that, and you could have your doctor's report stating, "Okay, he has been on the medication. He comes in regularly", and maybe you could see a need there for either leaving it not to be reviewed, or maybe allowing access to some of the money.

Mr NEWELL: Medication is a definite example of when it would be plural.

Dr JOHN KAYE: Can I ask you about a recommendation that came from the Public Guardian? The Public Guardian recommended that the New South Wales Police Force be given powers to use all reasonable force under certain circumstances for persons who are under guardianship to move them from one place of residence to another. We have heard a variety of responses to that. How do you respond to the idea, when you have somebody and it is sensed that they need to be moved on to another place, that the police can come in and use all reasonable force?

Mr NEWELL: I can answer both sides of the question, or I will put both views to try to balance it. On one view, you would say if that had to happen, it is always open to the police or whatever to go to the tribunal and get that order, if it is that bad, and clearly the person is objecting to it or is fighting it, or whatever. It can still go back to the tribunal. But again I am aware of the fact that there are delays in that. The other side of the argument is when it says "reasonable force". "Reasonable" obviously means reasonable in all circumstances. Whether that is going to happen practically is another thing. The term "reasonable" implies that all of the circumstances will be taken into account, and that would hopefully include the wishes of the person, the impact on the person, and all of the circumstances.

Mrs SMALL: And the right to take risks.

Mr NEWELL: And the right to take risks, exactly—all of those. But I understand your question because I think practically that often does not happen, especially if there is a set of circumstances and someone rings the police and they decide, "We are going to move a person from place A to B. Go and get them." I do not know how much time the police have to sit down, think about it, and review that. If you wanted to err on the side of caution, it would say that if that is happening and it is being resisted strongly by the person, perhaps a specific order should be sought.

The Hon. TREVOR KHAN: I will take you to that section of your submission that deals with powers of attorney. What sort of express duties and obligations would you envisage being included in the Act, and being required to be explained to people?

Mr NEWELL: That is a good question, and I did not bring with me the Queensland Act. I hate to push the Queensland Act, but even without the benefit of it being here, is just far more prescriptive. Again, from our point of view as an advocacy service, we often get calls from people who simply do not understand what it is they should be doing. This involves inheritance impatience, and quite often they think that they are doing it for good reason. They do not think they are hurting anybody, and possibly they are not; but technically they are.

It is something that, again, thought should be given to and to be far more prescriptive about exactly what an attorney can or cannot do and what is in the best interests. The Act talks generally about acting in the best interests of the donor. The best interests of the donor is not me buying a new car, or it may be in circumstances where I have to drive the donor somewhere. In our view it really needs to be more prescriptive than it is. I am sorry, I cannot be more specific now, but it is something that I think we should all turn our minds to. It has to be more prescriptive about what acting in the best interests of the donor is.

The Hon. TREVOR KHAN: It is just a thought that came to me. I am wondering if one of the difficulties with the power of attorney is that they were created as a document for commercial purposes whereas what we increasingly see is that it is a financial planning instrument for aged care or health circumstances.

Mr NEWELL: Yes, indeed. That was supposedly or partly overcome by the new Act or the 2003 Act taking it out of the Conveyancing Act where it used to sit.

The Hon. TREVOR KHAN: They took it out, but it did not actually make that much difference.

Mr NEWELL: It did restrict a little the actions of some attorneys. Acting in the best interests of the donor and acting for the benefit of the donor or the benefit of third parties—that area was prescribed a little bit more. At least it was included in the document to make people think about it and to either cross it out or to think about which third-party you might spend the donor's money on. It was good or positive from our point of view.

The Hon. TREVOR KHAN: This is not a dorothy dixer: Is there a need for the prescribed witness in an enduring power of attorney to, in a sense, certify a more specific range of advices being given to the donor?

Mr NEWELL: Again, I am in two minds about that. From a practical point of view, you do not want to increase the complexity of the document because it will stop people from doing it. You do not want to put up any more barriers to people. You want to encourage people to do it. Clearly, if people do grant powers of attorney and the like, it does take away a lot of these issues where there is no power of attorney and a person loses capacity. Again, I correct myself there because sometimes the appointed person is in dispute with other members of the family. That still ends up before the Guardianship Tribunal, and it is not uncommon when they do not agree with the mum or dad's choice of attorney. I would shy away from—I do not know if you are heading this way—certifying that the person understood what they were signing.

The Hon. TREVOR KHAN: I do not think many lawyers would like to go there.

Mr NEWELL: No.

The Hon. TREVOR KHAN: I think we tried that at one stage.

Mr NEWELL: In relation to financial matters, yes.

The Hon. TREVOR KHAN: That is right. We all just refused to do it, basically.

Mr NEWELL: Yes. From that point of view, I would be cautious, yes. In our submissions I think we talked about placing equal weight on the revocation of the attorney rather than on the granting of it. A lot of arguments we strike come about in relation to the capacity of a person to revoke the power of attorney. Even the Guardianship Tribunal cannot really look at that. They can look at it as an application for a financial management order, but not the revocation of the existing power of attorney. It is a practical difficulty, and it may—and I emphasise "may"—be cured by some third party simply saying, "I spoke to the person and they appeared"—again, appeared—"to understand. I explained to them." For the same reason that it is certified when it is given, at least a third party should be there. There are circumstances when the appointment is revoked purportedly in circumstances where there are no witnesses, or the only witness is the interested party.

CHAIR: What would be the percentage of requested revocations? I am thinking from a bean-counter/resource point of view. If there was an ability to have some sort of review, whether it is in chambers or some more formal mechanism of revocation of the powers of attorney when there is a dispute as to its validity, what is the percentage of powers of attorney that are disputed?

Mr NEWELL: I could not answer that mainly because I just do not know how many are made.

CHAIR: Roughly, ballpark, would it be 80 per cent?

Mr NEWELL: Oh, no. I would not say it is anywhere near that.

CHAIR: We just do not know how many powers of attorney there are out there in solicitors' drawers.

Mr NEWELL: That is right.

The Hon. TREVOR KHAN: I know how many I did.

Mr NEWELL: As a solicitor in private practice I did thousands of them. Quite often they were done and put in the bottom drawer and there they remained. They were never ever used, never needed.

CHAIR: Of the thousands you did, in your personal experience how many came to notice?

Mr NEWELL: None.

CHAIR: None were ever questioned or revoked?

Mr NEWELL: None.

The Hon. TREVOR KHAN: I would have done one or two.

CHAIR: One or two in 20 years. There is a straw poll.

Mr NEWELL: I did none in almost 20 years. Again, that was in private practice. But as an advocacy service we are dealing with the people who are disputing them. Quite often, the people disputing them are not the appointees. That is the problem. It is not a large number. We are skewed because we are talking to them.

CHAIR: Are you suggesting if there were an ability to have some more formal review of revocation it would not bankrupt the State?

Mr NEWELL: No more so than signing it, for instance. It could be a chamber magistrate or an authorised person, some sort of public person that simply witnesses it. Whether they have to satisfy themselves that the person knew what they were doing. I guess you are getting away from the circumstances where junior wheels mum or dad in and says, "Mum or Dad wants to revoke their power of attorney." That again adds complexity because there would have to be a contemporaneous record of it.

The Hon. MICHAEL VEITCH: Self-interest test.

Mr NEWELL: That is right.

The Hon. TREVOR KHAN: You heard me asking questions of Ms Doyle from Alberta about personal directives or advanced care directives. Has your organisation a view in relation to a legislative framework for advanced care directives?

Mr NEWELL: Personally I do not have a view. Margaret might disagree with me there. The fact that it now at least has been recognised by the courts in this recent case in the Hunter Valley is a good thing. I have been on committees and the like with some general practitioners and they are concerned about it. They want to know from a professional indemnity point of view whether they should be recognising them or not. This case really says if there is a document there then in all the circumstances and in all reasonableness you should take notice of it.

The Hon. TREVOR KHAN: Indeed, the document they were looking at there was a document that was not signed.

Mr NEWELL: Yes, but again there were circumstances around it. I do not want to cavil about the facts of it because I do not really know it in that much detail. You would have to take into account all the circumstances. It is much the same as wills and the like now where the formal requirements are being relaxed. So long as the intent is there and the surrounding circumstances support it, it is not as prescriptive.

The Hon. TREVOR KHAN: Not as onerous.

Mr NEWELL: Not as onerous.

The Hon. TREVOR KHAN: Do you have a view, Mrs Small?

Mrs SMALL: Yes, I do. There was a session run by Sydney South West Area Health Service. They invited us to go along to talk about powers of attorney and guardianship. It was all about planning ahead. They had a doctor there that explained the advantages and disadvantages of any decisions you make. We certainly get inquiries about advanced healthcare directives. We do not have a format that we send out to anybody. But there are a couple around. Do you know this one from the Southern Cross University?

CHAIR: Would you tender that document?

Mrs SMALL: Yes.

The Hon. TREVOR KHAN: The area health services now have a document.

Mrs SMALL: Yes. Then there is another one "My Health, My Future, My Choice" from the Advanced Care Directives Association. I have not seen that one. So there are a couple there. Then the Sydney South West Area Health Service put out a brochure on the basics of advanced care planning. When anybody makes an inquiry in relation to advanced care planning I tell them that they need to talk it over with their doctor before they do anything. The problem with a lot of these documents, they are very cumbersome, they are far too long. People, if they are really are concerned about it, need to carry one with them—if they are going to be knocked down by a car, which is a possibility. It is a matter of whether they are accepted or not. Anecdotally somebody told me that she went to register in hospital for an operation and they handed her one. I cannot tell you what hospital it is, I cannot remember. I just remember that she told me. From a personal perspective, and it is only one and I am sure that one person was not the only person taken into consideration, my 90-year-old mother did one and the hospital was very thorough with it. They had copies with the file, at the bed, at the desk. I am sure she was not the only one that they were going to take notice of with it. That is my input into the situation with them.

The Hon. TREVOR KHAN: In some states of Australia there is legislation—I think South Australia and a couple of other States.

Mrs SMALL: Yes. Queensland has one.

The Hon. TREVOR KHAN: I think the South Australian legislation provided for the establishment of a register.

Mrs SMALL: Yes.

Mr NEWELL: Yes, that is always a vexed question as well. The same question has been raised about powers of attorney and guardianship appointments as well.

The Hon. MICHAEL VEITCH: The registration?

Mr NEWELL: Yes. The problem there is where, who, what. I cannot really give you the answer. There was something raised about putting it with Medicare registration or some form of registration where you note if you do have a power of attorney. You do not actually leave it with them but you note that you have one. So in the event of emergency people know that they have to at least look for one. Whether you actually stored the document I do not know. That would create logistical problems, I imagine. The problem in a lot of cases is that people simply do not know that one exists and they do not know where to look.

Mrs SMALL: The trouble with that is if they are revoked they might not revoke it on the register.

Mr NEWELL: That is right. In relation to the whole registration, you are no doubt aware, there are strong arguments for and against. I am somewhere in the middle.

The Hon. MICHAEL VEITCH: Mrs Small, do you think there is enough education and awareness in society about the need to plan ahead and the various mechanisms that can be used to plan ahead for various circumstances?

Mrs SMALL: No, I do not. We certainly have a fair demand on our service. It is not that well known because we have been going only for a short time—the Older Person's Legal Service. But we have fairly constant demand for legal education. If you are talking about advanced care directives, we do not involve a doctor with it. It is just us because they usually want it to fit within a certain time frame. I just discuss the basics of what it is and then quite often we might get call backs on the advice line for information in relation to it.

Mr NEWELL: If I could chime in, part of the aim of our service is very much an education focus to get the idea out there so at least people will think about it. One of the presentations we do, which Margaret wrote, was a thing called "Six Serious Senior Issues". It covers wills, powers of attorney, funeral arrangements and the like. It is really just getting people to give thought to these things, especially the advanced care directives and the like—not what should be in it but at least to think about it, at least go and make some inquiries. But education is the crux of it.

The Hon. MICHAEL VEITCH: Is that one of the possible roles for a public advocate or a community guardian?

Mr NEWELL: Yes.

The Hon. MICHAEL VEITCH: The Public Guardian also has recommended that the Guardianship Act 1987 be amended to allow the Public Guardian to assist people with decision-making disabilities without the need for a guardianship order. What are your views about that proposal?

Mr NEWELL: I hark back to that consent order concept. I am not sure I really understand the question, to be honest with you. To what degree do you assist? That really comes back in a way to the public advocate or an advocacy service to assist with the decision. At the end of the day the difficulty quite often is the third party that is dealing with that person, are they going to accept that direction? I think that is where the problem lies. Again, it is a matter of degree. It is not something we really come across or have had dealings with the concept. I know in some States there is some sort of arrangements where people are assisted.

The Hon. MICHAEL VEITCH: In Queensland. Do you have a view, Mrs Small?

Mrs SMALL: No.

Mr NEWELL: The short answer is, from our perspective, no, we do not really have a view on it that we could assist you with at this point. Again, it is something we could turn our minds to.

The Hon. MICHAEL VEITCH: Harking back to Mr. Khan's questions about powers of attorney, as a lay person who has never been involved in a power of attorney until very recently when my brother almost killed himself in a truck accident, the qualifications to be appointed a power of attorney we were told yesterday were you had to be over the age of 18 and not declared bankrupt and that is it. Do you think that is sufficient?

Mr NEWELL: Yes because the attorney is still able to get advice as a member of the public does. You do not have to be a rocket scientist. Maybe that comes back to being a little more prescriptive about the roles and responsibilities. Perhaps one of the things to be prescribed is to take advice where appropriate or some such thing. Again, you do not want to put barriers in front of people. That is something I am always cognisant of because people do. I know again from private practice just even the word "attorney" people would not do it because it is going to cost money. It is really quite a simple process generally to do. But I am really aware of putting barriers up to people to go ahead and do that because it really does alleviate a lot of problems down the track.

Mrs SMALL: Are you aware of these documents? They are the forms the Guardianship Tribunal sends out to people with information on how to fill out the form and the actual document. With powers of attorney, the people who accept to be an attorney did not have to have their signatures witnessed, whereas in the guardianship they do. There is also a revocation from in the guardianship one as well. This forms part of the schedule and it is part of the Act. If they had to have their signatures witnessed by a barrister or a Clerk of the Court that surely would have to be explained to the people when they sign, whereas at this point in time they just say, "Yes, I will do the job." Because it is a very powerful document I think that is something that really needs to be looked at.

The Hon. MICHAEL VEITCH: You have answered my next question. I was going to ask you about signatures and witnessing of the signature.

Mrs SMALL: Do you want me to tender those?

CHAIR: Thank you, we greatly appreciate it. There are no more questions. Thank you for your attendance today. We may have some questions on notice that we wish to send you. If so, the Committee secretariat will be in touch with you within the next few days.

Mr NEWELL: Thank you, Mr Chair, for the opportunity to come and speak with you.

(The witnesses withdrew)

(Short adjournment)

CAMERON STEWART, Associate Professor and Director, Centre for Health, Governance, Law and Ethics, New South Wales Law School, University of Sydney, 2006, sworn and examined:

CHAIR: Would you like to make some opening comments before we go to questions?

Professor STEWART: Yes. Firstly, I would like to thank the Committee for the opportunity of speaking before it about these issues. These issues are one of the most important sets of issues that New South Wales has to deal with and if we do not deal with them, people will suffer. That is the bottom line. Our current system of law does not operate with regards to certainty or fairness and we can fix it quite easily. So this is a rare opportunity for a great difficult issue to be resolved quite simply and effectively by Parliament.

In relation to these issues I think we need to keep in mind two things: firstly, the ageing of the population—and I am sure the other people who have given evidence before the Committee have spoken about that, so I do not need to say anything about that, apart from the fact that we have a tsunami of ageing-related disability coming our way and we are not ready for it. The second point is to emphasise the importance of autonomy in decision-making. Whilst we need to have access and respect for the health professions, a key factor in the way that they operate, the service that we provide to people with disabilities has to be based upon the concept of autonomy and giving people as much power as possible in their decision-making. They are the two things that I would like to begin with and I invite questions. Hopefully I can answer them as best as I can.

The Hon. MICHAEL VEITCH: Thank you for coming. In your submission you note that not allowing substitute decision-makers to consent to the withdrawal of medical treatment proved "completely unworkable and impractical" when it was trialled in Queensland. Why was that the case?

Professor STEWART: To give you some background first, the Queensland legislation was a two-stage process. It began with the Powers of Attorney Act, which was passed in 1998, which recognised a statutory form of advanced care directive. It also gave rise to a concept that was similar to our person responsible legislation, which they call the statutory health attorney. The second stage of that passed in 2000, which was the Guardianship Administration Act. The first version of that Act made it a compulsory requirement that all decisions regarding refusal, withholding, withdrawal of medical treatment go before the Guardianship and Administrative Tribunal of Queensland. It only took about three weeks before they realised that that was not going to work. Because of the volume of the amount of work that was going before the committee, they could not deal with it. Very quickly the Minister said that he was going to change the legislation; I think it was within four months the legislation was changed.

The Hon. MICHAEL VEITCH: That is pretty quick.

Professor STEWART: Yes. I am not sure why they put it in, in the first place. I am not sure that they really thought through the consequences. So many people die in institutional care these days; the percentage of people who are dying are dying in institutional care, the vast majority of them, and to require all of them to go before a centralised third party decision-maker is impractical. Not only that, it basically says, "In your society you cannot trust family members and medical professions to work together to make a decision in the best interests of patients". I think that is a bad starting point.

I think your starting point should be, "We have a good system of medical care. We can trust families to make good decisions, so we need a system where there are checks and balances so that if there are situations of abuse or there are situations where the best interests of the patients are not being served, any one of those decision-makers can then trigger a third-party intervention." That is the better system; that is the system they now have in Queensland, Western Australia, Victoria and we should have here.

The Hon. MICHAEL VEITCH: So you are a fan of the model they now have?

Professor STEWART: Yes, I am, with some exceptions about the way they have some of their tests, but generally speaking, yes, I think we need to adopt legislation that is similar to what they have in Queensland and Western Australia.

The Hon. MICHAEL VEITCH: What are the exceptions to the test?

Professor STEWART: I think there are some problems with the Queensland legislation. The main problem is that it is open to medical professionals to have the final say about withdrawing treatment on the basis that continued treatment has to be inconsistent with good medical practice. There are a number of problems with that. Firstly, the way that the test is stated, it makes it difficult to get over that hurdle, although in practice the Guardianship Tribunal has been able to navigate its way around that particular problem.

The second problem is good medical practice. We actually do not know what that is, apart from leaving it up to individual doctors to work that out. Not a lot of statements and guidelines have come out from bodies like the Australian Medical Association—they do have some but they are not particularly useful in determining what is good medical practice in particular situations. The Western Australian legislation does not have that test in it at all, and I think that is probably what we should be doing in New South Wales as well.

The Hon. MICHAEL VEITCH: So you would advocate for that process as opposed to the Queensland process?

Professor STEWART: Yes.

The Hon. MICHAEL VEITCH: You also recommend in your submission that we should engage the New South Wales Law Reform Commission to review the operation of the Guardianship Act and its effects on the provision of medical treatment. What would be the benefit of engaging the Law Reform Commission in that process?

Professor STEWART: There are two things. Firstly, we need to make changes in relation to the best interest test immediately. That needs to have been done yesterday; it needs to have been done 10 years ago. That is my first request for Parliament to consider. My second request is that we then refer these issues generally to the New South Wales Law Reform Commission. That is based on two reasons: firstly, they could give us an overview of the international perspectives. They could give us an overview on what has happened in the United Kingdom with regard to the Mental Capacity Act and how it is working over there. They could also tell as how to properly integrate advanced care directives into part 5 of the Guardianship Act.

It would be a good idea to get the view of the New South Wales Law Reform Commission on that. The second reason for doing it is that they have just finished and completed their inquiry into substitute decision-making for children in medical treatment. They could quite easily build upon the work they have already done there.

The Hon. MICHAEL VEITCH: What stakeholder groups do you think should be engaged in the consultation process?

Professor STEWART: Similar to the stakeholder groups they engaged with the children groups—aged care providers, obviously the different health professions; not just the medical profession but also the nursing and allied health professions, the legal profession and also disease-related groups because we are not just talking about ageing; we are talking about particular diseases, Alzheimer's being one. We often associate Alzheimer's disease with elder care, but it is not just an age-related disease, and other disease groups like, for example, multiple sclerosis and other degenerative disease conditions—those groups.

The Hon. MICHAEL VEITCH: Your submission, which is a good submission, refers to proposals relating to substitute decision-making currently before the Australian Health Ministers Advisory Council [AHMAC].

Professor STEWART: Yes.

The Hon. MICHAEL VEITCH: Can you tell us what some of those proposals are?

Professor STEWART: I can. Some of it has been given to me in confidence as an adviser so I cannot give full details, but there is a special committee that has been convened at AHMAC to look at these issues. It comes out at the Senate report into aged care that was passed at the end of last year where they recommended that we have approaches towards uniform law of guardianship. That came out of the problem that we have that federalism makes these quite difficult. I did not have the time to go into that in my submission but there are quite disparate approaches across borders and it does not really make any sense. Because we have a mobile population and if someone's daughter is in Victoria, it raises all these difficult issues about what type of documents they have to have to make decisions for mum when she gets sick in New South Wales and so on and so forth, and the effect of documents that are recognised as legally valid in Queensland but not in New South Wales.

There are comity provisions in the guardianship legislation so that tribunals are empowered to respect the documents of other jurisdictions but it would be better if we just had a uniform approach. Coming out of that the health Ministers engaged a particular group to map out a road towards a uniform approach to guardianship legislation. At the moment they are looking at advanced care directives and laws with regards to advanced care directives and I understand that their issues paper on that is going to be released to the public relatively soon, in the next few weeks, and they will invite submissions from the public about their ideas.

The Hon. MICHAEL VEITCH: How much of a problem are the cross-jurisdictional issues with advanced care directives?

Professor STEWART: In this area we tend to talk about the daughter from Melbourne syndrome, so it is a bit of a problem. By that I mean we normally will have situations where family members are involved in care decisions and will be caring for people. Obviously there are a lot of families where children are spread across Australia or overseas and they may not have been involved in the care decisions that have been laid out by mum and by the significant carers that mum has, and when they realise that mum is dying they rush back into the jurisdiction to be with mum while she is dying, then they have these problems with the decisions that have been made.

Yes, I think it is a significant problem that is normally dealt with in a very practical and sensible way by health professionals, particularly in areas like intensive care; they are very good at dealing with them. The reason I say that is because we have not really ever tested it, as we have not had a lot of litigation. If there is one area that is ripe for litigation it would be this one. We have not had a lot of litigation at all in Australia, so that tells me that the health professionals must be relatively good as resolving disputes at that level.

The Hon. MICHAEL VEITCH: Would that be the same for foreign orders, if someone had an order for an overseas jurisdiction?

Professor STEWART: That would be difficult as well. As far as I am aware there have not been any Australian cases that have dealt with that as a problem. The only case that springs to mind is that of an Indian national who was here as a tourist who had suffered a terrible pedestrian car accident and was declared brain dead. This is a Victorian case; it is not reported. In that particular case the family wanted the treatment to be continued, even though he satisfied the definition of being dead, until their guru could contact him. It was proposed that he would be contacted astrally, that is, through some spiritual medium coming from India to contact him. The court in that case gave a stay of the order so that it could happen. That is the only case that comes to mind with regard to that and I think that was the court exercising its powers to respect different cultural values.

Dr JOHN KAYE: Professor Stewart, I want to ask you about the fact that advanced care directives are written now and may not be executed for 10 or 20 years. In that intervening period it would be reasonable to expect that there would be substantial changes in medical technology. How do we make sure that advanced care directives take into account those changes in the intervening period?

Professor STEWART: There are three things I would say about that. The first thing is that people involved in the drafting of these documents always encourage that they would be regular reviewed, like wills, but in the absence of that happening, if treatment was developed and the person had not had the chance to consider that in their decision-making, the directive most probably would not apply to it so that it could be provided.

We ask people when they are drafting these documents to provide very specific instructions about the treatments that they want and that is why generally the New South Wales Health guidelines suggest that it be done in consultation with health professionals, et cetera. So if there was new treatment suddenly developed and the person was unable to make a decision, it would not be covered by the advanced care directives so that it could be given. The final thing is that if you gave a general directive, which were something along the lines of "I refuse all life sustaining treatment", they tend to be so vague as not to be followed. At least the experience from the British jurisdictions indicates that in those situations the judges will err on the side of caution and they will order the treatment to be given.

Dr JOHN KAYE: Are you aware of the form produced by the Hunter New England Area Health Service, which is effectively an advanced care directive instruction pro forma?

Professor STEWART: I am aware of it, but I have not seen it.

Dr JOHN KAYE: From my recollection it contains effectively two business sections. One section is a set of general instructions and then there is a more detailed section that actually goes into specific treatments that you may or may not wish to reject. The second section is entirely optional and the reason for allowing it is so that people without a lot of medical expertise or knowledge can use the form meaningfully. Does not what you have just said mean that people who are just using the more general directives are not able to express their full desires?

Professor STEWART: Maybe their desire is not to be specific. I think we can forget sometimes that people do not want to go into the nitty-gritty about these things and they prefer to give a general statement of preferences and desires. That may not be binding on a decision-maker but it will help a decision-maker to bring those values into the decision they have to make, so it is still useful. It may not be a directive as such; it may be a statement of values. We can even do that in an enduring guardianship form in New South Wales. You can give a statement of values within that and that will at least give some values for the person who has to make the decision.

Dr JOHN KAYE: Do you think those values are meaningful in a legal sense and they protect medical practitioners who are going to make decisions based on those generalised statements or value statements?

Professor STEWART: Yes, I do. I think they are very useful because in any test which is to be used for substitute decision-making, whether it is best interest tests or whether it is a substituted judgement—they are the two main standards you can choose from—both of them would require some knowledge, both of them would be aided by the knowledge of what the values were of the patient. Even in the best interests test, which is primarily an objective test of what is in the best interests given our medical understanding of the patient's condition, if you also had the patient's values you could use that in the decision-making process.

Another point is that people, particularly medical professionals, have a desire for there to be a sort of protocol whereby they can come up with a direct answer. Sometimes that is possible but sometimes it is not. The best interests test is sometimes criticised for that. I think it is better if we look at processes and say, "Are we happy with this process?" rather than "Can we get a direct answer out of it?" If we can have a process whereby the interests of and the objective issues about the patient's condition, the values of the patient and the issues concerning family members and what they understand the values of the patient to be are factored in, we are more likely to come up with a better decision.

The Hon. MICHAEL VEITCH: With regard to the enduring power of attorney and advance medical directives, how would you know that someone had an advance medical directive? At the moment you rely on family or near family to advise that there is one.

Professor STEWART: Yes, and in the institutions now, such as nursing homes and in some hospitals, like John Hunter Hospital, they have processes in place whereby they will start at a very early stage talking to the patient, particularly patients with chronic conditions, about what they want to have happen. There will be regular conversations about their treatment and what the future possibilities are and what the patient wants to have done, and that is documented. They are the best types of advance care directive. In fact, we do not tend to call that a directive; that is what we call advance care planning, which is a wider concept. Advance care directives tend to be quite limited because people do not like doing them. That is my sneaking suspicion, that people do not like writing them in the same way that they do not like writing wills. They do not like having to think about that.

Advance care directives that are written on a piece of paper where what the person wants is all set out are quite rare. They are useful for two groups of patients: for religious objectors, and the Jehovah's Witness community is the best example of that, and also people with chronic conditions, such as chronic obstruction pulmonary disorder or something like that, where they know they are on a particular trend for their treatment, or motor neurone disease or anything like that where you know that this is where you are going and you have to think about these things and it is a relatively straightforward task of working out where the disease will progress, maybe not exactly as to time but you know what is going to happen. Those two groups of patients are going to find advance care directives very useful. Most of us are not going to find them as useful as a process whereby if we are in institutional care we have regular conversations about our values that are documented and we have a determined decision-maker who, when the time comes, can be called upon to be brought into the process if you are no longer competent. Those processes of advance care planning I think are probably going to be more useful.

I do not know whether the Committee has been told about the support trial in the United States in which they looked at advance care directives. It is a requirement in US hospitals under a Federal Act that everyone be told on admission to hospital that they can have an advance care directive. They studied this and found that the uptake was zero. People still did not use them and doctors still did not follow them when they were written down. The support trial in the US tells us that if you just have a piece of paper and that is the limit of your processes it is not going to work. You need a culture of advance care planning where you involve people in decision-making and in expressing their values about treatment, and you involve healthcare professionals. That is where you will get more benefit out of advance care planning. In Illinois they have a trial called "respecting patients' choices". There is a particular plan they have for doing this. The Federal Government has funded trials of this in Victoria and in New South Wales in the Hunter District.

Dr JOHN KAYE: What is it called?

Professor STEWART: It is called the Respecting Patients' Choices Program. It is from Illinois. When that was studied it was found to have a very high success rate correlation between treatment decisions and what the patient wanted, because it is about educating people and having conversations. That is far more useful than just relying on a piece of paper.

Dr JOHN KAYE: Can I get clarification: that is a program that is oriented towards people writing advance care directives or is it directed towards medical—

Professor STEWART: That can be part of it. It is a program that covers training for medical professionals, normally nursing staff, in how to have these conversations. That is one part of it, training the healthcare professionals. The second part is going into the particular institutional community, whether it is a nursing home or a ward, and being able to talk to the patients and then double-checking after the patient has died as to whether their choices have been respected. Dr Peter Saul is the main person who has been trialling that program in New South Wales. He works at John Hunter Hospital in the Hunter District.

Dr JOHN KAYE: Would you be able to provide the Committee with some papers on that?

Professor STEWART: Yes.

The Hon. MICHAEL VEITCH: The planning ahead concept you were just talking about was mentioned in previous testimony as well and there was a degree of concern about the lack of education in the broader community about the need for things such as an enduring power of attorney or an advance medical statement or directive. Is the lack of knowledge and the lack of planning ahead by society in general a real issue or do you think it is being addressed in other ways?

Professor STEWART: I think that it is a problem but that is just a general lack of information about legal matters on the part of the community and also by health professionals. If we were to educate the community I am not sure whether a broad sweep education would work. Maybe a targeted education program would. Again, a person who was involved in that sort of thing in Queensland when the legislation was brought in is Professor Colleen Cartwright, who is at Southern Cross University at Coffs Harbour. She was heavily involved in helping the drafting of the Queensland legislation and also the educational programs and when they were shopping out the advance care directives. So there is a great deal of experience coming from Queensland in particular about how you educate communities and different groups in the communities about making advance care directives. The preliminary research suggested they had a high degree of success rate in the take-up of enduring powers of attorney and advance care directives. So it can be done; there are models for doing it successfully.

The Hon. MICHAEL VEITCH: Do you think there is a need for formal registration of enduring powers of attorney and advance care directives?

Professor STEWART: The evidence we have so far is that registration does not help. Again, the focus on the form takes you away from the fact that the most important thing is having conversations. Having said that, I think the forms can be important particularly for those two groups I mentioned before—the chronically ill and people with religious objections. I think it would be a danger to make it mandatory for these things to be registered. We do not require powers of attorney to be registered unless they are in relation to land. It would disenfranchise a lot of people because of the cost and also it is not clear that the medical profession currently has the ability to call upon these centralised pieces of information. Later on when Health Connect finally works, maybe in 20 years time—that is the electronic health records system—that would be a good mechanism by which to do it. Requiring centralised registration or making it mandatory would be wrong. Having the ability to do it would be good. The only State that currently does that is South Australia, which has a centralised system for registering, but it is not mandatory there either so I am not sure whether anyone has studied how many have been registered and whether they are accessed by health professionals. Even things like the Australian Organ Donation Register are not accessed by health professionals. Even if we had a perfect system where everything had been registered, you still have to get the medicos to look at it, and that is a difficulty when they are working under pressure and time constraints, particularly in intensive care and those types of situations.

The Hon. MICHAEL VEITCH: I am trying to work through in my mind how enduring powers of attorney and advance medical directives would interact. Do you have one or the other? What happens if you have both?

Professor STEWART: You can have both and, depending on which State you are in, the State will dictate which one has supremacy. Ordinarily, if we had autonomy as the central principle, we would say the advance care directive overrides the enduring power of attorney. Currently in the Australian Capital Territory an enduring power of attorney overrides an advance care directive.

The Hon. MICHAEL VEITCH: Is that a legislated hierarchy?

Professor STEWART: It is, yes.

The Hon. MICHAEL VEITCH: Would you advocate that we move towards a legislated hierarchy?

Professor STEWART: No, not yet. I would prefer to have a good review of it by the New South Wales Law Reform Commission. We do not have anything in our Guardianship Act about advance care directives. I think that may actually be a good idea, firstly because if we have a legislative form of advance care directive that everyone has to use they tend not to be very effective because people want to express their decisions in different ways. In the United Kingdom, the Mental Capacity Act recognises advance care directives, provides for minimum content but then says nothing else about what form it has to take because they want as many people as possible to have access to making these types of decisions. They have basically codified the common law requirements. To me, that sounds like a more sensible option because it allows people to develop different forms, coming from different patient groups and from different religious groups, and you are not disenfranchising them all by saying this is the form of directive they have to have. In Victoria, they have done that. They do not have a great deal of uptake on what they call their refusal of medical treatment certificate.

Dr JOHN KAYE: Is that an advance care directive?

Professor STEWART: It is a form of advance care directive. It is very limited. The first thing it says is that it can apply only to a current condition. That is completely useless for any one who has a belief that blood transfusions will prevent them from going to heaven, because being a Jehovah's Witness is not a current medical condition, as far as I am aware. You are automatically disposing of all people who have religious objections and you are also disposing of anyone who has a general dislike of types of treatment or who might be healthy now but has a good interest as an ageing person in what is going to happen to them. They cannot fill out a refusal of treatment certificate because they do not have a current condition. Of course, we are not quite sure what "current condition" means anyway.

The Hon. MICHAEL VEITCH: Would you advocate that a legislative silence should remain for the time being?

Professor STEWART: For the time being, yes. I think now that we have had the Supreme Court decision that says you can have advance care directives and they are not destroyed by part 5 of the Guardianship

Act, why not wait a while and see what develops? I have to declare a conflict of interest because I was involved in the drafting of the policy, but there is a great policy from New South Wales Health about advance care planning, which includes advance care directives. That is a gold standard and it is being used in other States as an example of good policy and decision-making. Now that we know it is not offending any laws—we unfortunately had some difficulties with regard to some interpretations coming out of the New South Wales Administrative Decisions Tribunal; no disrespect to that tribunal but I would not have thought it was the appropriate forum to be deciding these issues anyway—

Dr JOHN KAYE: Which case was that?

Professor STEWART: There are a number of cases, which are in my submission.

The Hon. MICHAEL VEITCH: How did they finish up there?

Professor STEWART: The Guardianship Tribunal was brought within the remit of the jurisdiction of the New South Wales Administrative Decisions Tribunal. We have had people who are experts in consumer, trader and tenancy law who have had to deal with these incredibly complicated and difficult issues of end-of-life decision-making. I think Justice O'Connor has done an excellent job in trying to bring all these strands together, but initially we had some problems with an interpretation. This is the problem about whether you have best interests in the Act. They do not have best interests in the Act for the general provision about when you provide medical treatment. They have said that it has to promote and maintain health and wellbeing. One of the tribunal members thought that it could include end-of-life decision-making. It effectively took everyone who was dying out of the protection of the Guardianship Act, which effectively meant they had to be treated to death. That is the problem. Now these people who would otherwise have been allowed to make decisions for themselves or would otherwise have had the treatment withdrawn because it was no longer helping them have had to be treated to the point where the treatment kills them.

The particular case I am thinking about is WK—that was the name of the other party—where the patient was being dialysed and Professor Bruce Pussell and all the family members bar one thought that it was now time for that treatment to be withdrawn. The patient was demented, had heart disease, colon cancer and a number of other problems, and they had all made a decision in good faith to say it was time to opt for palliative care. One family member was not happy with that so a business partner, a friend of the family member, brought an application before the Administrative Decisions Tribunal and the order eventually was that they could not make a decision to withdraw treatment.

That went back to the Guardianship Tribunal for a reappointment of guardianship, but that took two or three months and in the intervening period the patient died on dialysis, having been treated to death. People do not think about these life-sustaining treatments as being harmful, but they can be. You can be ulcerated; your eyes can get ulcers on them and you can have bleeding in the oesophagus from the breathing tubes. The feeding tubes can become infected and you can get aspirational pneumonia from artificial nutrition and hydration. Oftentimes it will be the treatment that kills you. Once we realise that, we have to make a decision about the best way to allow a person to die, because they are dying. Do we do it by aggressively treating them until the treatment kills them, or can we provide them with palliative care?

Unfortunately, that decision said we had to keep treating them. Since then Justice O'Connor has reversed that position. Justice O'Connor sits as the current President of the Administrative Decisions Tribunal, but at present he has dealt only with issues where there has been an appointed guardian. According to his judgements, appointed guardians can make decisions to withdraw treatment in consultation with doctors. But where does that leave everyone who does not have a guardian? That is the problem I was trying to stress in the submission. That is great for people who have guardians, but now we are effectively taking a de facto 2000 Queensland position by requiring everyone to get a guardian before the treatment can be withdrawn. I think that is a mistake.

At present the health professionals are just relying upon their common-law powers to say, "Well, we're not providing treatment anymore." Some of them are doing that but some of them are just sort of lumbering on and they have given up on the whole process of guardianship. That is the thing that worries me. We have tried so desperately to bring in the health professionals and give them a system they can trust, but it has turned around and bitten them on the arse—pardon my French. That is so destructive. We want good relationships between the guardianship systems and the medical profession. They have to rely upon each other. Unfortunately, that is damaged by what has been happening in the past few years. So, the best thing would be to make it clear that all of the substitute decision-makers—enduring guardians, guardians, persons responsible—can make a decision that is to say no as well as yes. That is the logic of the Act but, unfortunately, it never said "best interests".

The Queensland Act says "promote and maintain health and wellbeing: or the best interests". That is what we should have. That would fix it almost straight away. I have read the submission as well by the Public Guardian. It would be sensible too in the definition that medical treatment also include a provision that medical treatment includes the non-provision or withdrawal of medical treatment. That would make it even clearer. Just two changes would fix the Act. Forgetting about advanced care directives, we could let the common law continue to develop even without referring it to the New South Wales Law Reform Commission. That would fix the problem of who can make decisions. That would get the medical profession back on side, and would allow for decision-making to be made, checks and balances; and if there are problems, you can go to the Guardianship Tribunal and the Supreme Court..

The Hon. MICHAEL VEITCH: Access other avenues?

Professor STEWART: Exactly. There is third-party decision-making and third-party dispute resolution, which is what we want. The first instance should not be to say there is a problem. The first instance should be to ask, "What are the best interests of the patient?" The Act does not allow that to happen at the moment.

The Hon. MICHAEL VEITCH: How does a living will fit into the spectre of arrangements you are talking about? I understand your support for the legislative silence in New South Wales. How does a living will fit into that?

Professor STEWART: In some of the writings I have done there is like a hierarchy of questions you ask yourself. The first question you ask yourself is: Has the patient made their own decision? Are they capable of making their own decision now? If they can talk to you or communicate with you and they can make their own decision, then that is what the decision is—absent some particular environments like the prison environment or the mental heath care setting, which are quite difficult. Put them to one side. If we had a patient who was confident, we respect their decision. If they are no longer competent, then we ask: Is there an advanced care directive? Have they made a decision in the past when they were competent? If that is the case, then we respect that decision. The next level of inquiry is, if there is no competent decision, there is no advanced care directive; is there someone else who is allowed to make the decision? That is when we go to the person responsible. That would include a guardian, an enduring guardian, a relative or close friend. We could ask them. Then we could go working together with the health professionals to determine what will promote and maintain the health and wellbeing of the patient, which is what the Act now says, or what are the best interests of the patient, which is what the Act should say. Then we could make a decision to withdraw treatment or to continue, depending on the process decided.

Finally, if no-one can agree, then you go to the Guardianship Tribunal or to the Supreme Court. They will then make a decision. The Supreme Court's power is an ancient power that overrides all of this. It is called parens patriae power. It is a Latin term. It is the ancient jurisdiction that the courts are chancery to look after infants and what they would term lunatics because of the association with mental illness and the phases of the moon. There was not a derisory term at the time. It is funny how legal terms become derisory terms, but that is another commission of inquiry.

CHAIR: It tended to have a lot to do with economics.

Professor STEWART: It did. The other term was "natural fool" or "idiot". The chancery had the power to look after those people and to take care of their estates primarily. It was mainly the rich lunatics and the rich idiots. That power came all the way to Australia with the first charter of justice in 1788. There was a jurisdiction in lunacy that came when the first civil courts were set up, which was the court of civil jurisdiction, and then later the first Supreme Court in 1814 and then in 1824. New South Wales courts have always had this superior power. The Guardianship Act actually preserves it. The Supreme Court is a circuit-breaker and we see that in cases like Northridge and the one in the Hunter Area Health Service. The court has basically come in and said, "We're not sure what the legislation says, but we don't need to worry about that. This is the answer" because they are relying on their inherent jurisdiction to make those decisions. But we do not want everyone to have to go there. That is the issue. That would be impractical. We want a good ground-based jurisdiction where people can understand it, it reflects the values of the community and people think that family members should be involved in these decisions. The medical profession by and large think that as well. Let them make decisions and then if there is a dispute, you have a clear avenue for where you go. You either go to the Guardianship Tribunal or the Supreme Court.

Dr JOHN KAYE: In an answer to Mr Veitch you talked about your hierarchy, which was very interesting, but you made exceptions for people in a mental health care environment?

Professor STEWART: Yes.

Dr JOHN KAYE: Have you developed a hierarchy or how you deal with people in a mental health care environment?

Professor STEWART: There is a new mental health care Act, which is currently in play and, unfortunately, I am not completely au fait with it. Prior to the passage of that Act it was very clear in New South Wales that if you were an involuntary patient, you had no rights to refuse treatment. Normally we would just associate that with their treatment in relation to mental illness, but the Act made it clear that you had no rights to refuse any treatment. So, if you fell over and cut your forehead and you had stitches, you were given the treatment that the mental health care provider said you had to have. Of course, people with mental illness are like everyone else; they get sick. In fact, they are more likely to get sick of other things. It is an important issue that we can also deal with and look at: What is the interface between mental health care and this respect for autonomy. The United Kingdom very clearly says that even in the mental health care setting they had to respect people's autonomy. If they are competent to make a decision about treatment, then you respect it. It does not matter that they may be an involuntary patient. It does not matter that they may be forensically insane under the old terminology.

The main common-law case is one called *Regarding C.* Mr C was in Broadmoor Asylum as a criminally insane person who thought he was a world-famous surgeon. Somehow he got gangrene in his leg. He said he did not want his leg amputated—that was the only way they were going to stop the gangrene. He said, "No, as a world-famous surgeon"—which he was not—"I understand that I could run the risk of getting septicaemia and that I could die from blood poisoning, but I would prefer to die with two legs than live with one. It is just my choice." Apart from the underlying delusion about who he was, the decision itself was a rational decision, which reflected his values. Lord Justice Thorpe was asked to intervene. The doctors went to him and said, "We don't know what to do. Is he confident to make a decision or not?" Lord Justice Thorpe said, if you can comprehend and retain the treatment information, which he could, if you can understand the treatment information, which he could, and you can reason and express a decision, communicate a decision, which he could, "then you are competent." In fact, the more accurate way to say it was that because he is an adult he is presumed to be competent and his competence was not displaced by that test. That is the more correct way of saying it. So they respected his decision.

We do not know what happened to him in the end. He may have survived, I do not know. But that is the unfortunate thing about the anonymity of these decisions: often at times you really want to know what happened in the end but you cannot find out. However, in the end I suppose it does not matter. Up until recently we did not have that in New South Wales. Until the new Act came in we would not have done that. We would have just amputated his leg. The same thing applies for the prison population. Prisoners have no right to refuse treatment. If Justice Health makes a decision to provide treatment, that is it. The Prisons Act makes it clear that you have no right to refuse treatment. The third aspect relates to children. Children can have their decisions overridden, and they have in New South Wales. In the past three years there have been two cases where 15-year-old and 16-year-old Jehovah's Witnesses who refused blood transfusions for treatment for leukaemia had their decisions overridden. The last group would be people who have an infectious disease. They can also be put under a public health order, which can require them to be given treatment. They have no right to refuse that treatment, but that is very rare for that power to be exercised. They are the four main groups of patients who have their decisions overridden.

Dr JOHN KAYE: Do you believe the capacity to override those decisions is reasonable in each case or should be moderated?

Professor STEWART: I think it needs to be moderated, particularly in the public health setting. I personally do not have a problem with that because public health is about balancing the risks to the community versus the rights of the individual. It is very utilitarian. With children, the New South Wales Law Reform Commission has stated its position that we should respect the decisions of competent children over the age of 16 to refuse treatment. I think that is probably right. It is very difficult, but I think it is probably right. I think we should respect the decisions of prisoners too. That is not a very popular cause to respect the rights of prisoners, but I think there is no reason we should not respect their decisions in that situation unless it has some detrimental effect on the maintenance of security in the prison population.

Dr JOHN KAYE: Or the health of the rest of the prison?

Professor STEWART: Or the health of the rest of the prison.

Dr JOHN KAYE: If it does not have those impacts, what would be the argument for prisoners?

Professor STEWART: That they have no rights. It is basically punitive.

Dr JOHN KAYE: Perhaps I am wandering from the terms of reference of the inquiry, but it is a matter of interest.

Professor STEWART: I have a paper I have written about those populations.

Dr JOHN KAYE: If you want to provide that to the Committee, that would be good.

CHAIR: I am happy for you to give a copy to the Committee. It clearly is not within our terms of reference. I do not think it is appropriate. If you want a copy, I will not say no.

Dr JOHN KAYE: Okay. I apologise for taking us away from our key issues.

CHAIR: Are you suggesting the Committee needs it?

Dr JOHN KAYE: No.

CHAIR: The Committee does not need it.

Dr JOHN KAYE: I understand.

The Hon. MICHAEL VEITCH: Do you think there are advantages in having more than one person equally qualified as a person responsible?

Professor STEWART: Yes, I think there are. I understand that people like the idea of going, "Right, that's the person responsible. You are the people. I'm not listening to you." However, I think that kind of goes against the spirit of getting this complicated decision-making process happening. In Queensland they say, "This is the person responsible" but if there is a dispute between possible persons responsible, automatically the Public Guardian or the equivalent of the Public Guardian, which is the Adult Guardian, steps in. That is much better because you allow for all of these people to be involved. You do not ordinarily disenfranchise them automatically, but if there is a dispute, the Adult Guardian or, in our case, the Public Guardian will step in and take over. You are allowing everyone to have their say. My suspicion is that if you give people a say, they are less likely to complain about things. If they do not agree, that is fine. They have standing to take the matter further anyway. No-one will deny them standing to go to the Guardianship Tribunal or the Supreme Court. So, bring them in and respect them and their voice, but if there is a problem and there needs to be a decision made, you have a clear access to the Public Guardian.

Let us have that provision rather than say, "We have got a list, we go through that list and we find the person who is the closest to the top." I think that is a bit artificial because why should the wife have a say when the daughter wants to have a say? What if the wife does not want to have a say? What if she says, "No, I am not going to make a decision. I would prefer my daughter to say." Rather than go through provisions that say, "In case that person does not want to have it, you then you go to this person", forget all that complexity and say, "Here is the list of people that can be persons responsible." We might want to say more about the definition of who is a relative. We do not do that in our Act but they do that in Victoria. We might define that a bit better and say—

The Hon. MICHAEL VEITCH: We were handed a copy of the Alberta legislation today and they do that too. In Alberta that articulate who the relatives are.

Professor STEWART: We have got to be careful too because they are many—they call them—blended families and non-traditional types of family structures these days. We do not want to be doing things that are going to basically carve out a section for society, which is protected, and not protect other people, even though our own values may not necessarily parallel those people. We are all going to be dying and we are all going to be going through these processes so it needs to be inclusive, but then if there is a dispute say the Public Guardian can automatically step in as the substitute decision-maker.

The Hon. MICHAEL VEITCH: Do you have a view about the collective intelligence, or the number of persons responsible, as to how big is too big?

Professor STEWART: I do not think you can say what any particular rule would be. In some families you will get a lot of cohesion and you will get people being able to say in a big group, "Yes, we are all on board. Dad has been sick for years. This is what we all decided with dad. Everyone is online." Speaking personally that certainly happened to my grandmother—that was the way she died. Unfortunately when my grandmother died I was not there but about 20 of my family members were there. There was a clear line of decision-making, the health professionals did a wonderful job of including everyone, and she died in the care of my family. Now that is a fantastic way to die and it was a beautiful way for my grandmother to go out. I would love that to happen to me when my time comes. Some families will be able to do it and some families will not. We have also got to admit that it is not going to be happy all of the time. Even within families sometimes they are cut, destroyed and rifted and we have to provide for them too. That is why you would then have the ability of the public Guardian to step in.

The Hon. MICHAEL VEITCH: What about in an instance of a medical emergency? I gave the example earlier today of my brother, where he almost passed away in a horrific traffic accident in July and he was a long way away from all family members. In that instance how many should there be? If you have three or four people listed as persons responsible with equal rights and you are the medico how do you reconcile that?

Professor STEWART: Just absent of anyone being there, the doctors already have emergency powers to make decisions in the absence of any directive from family members—that would deal with a situation where no-one was there. But if they had an emergency and they could only contact three, then they are the three different people they can contact. If they cannot get agreement between all three then they can speak to the Public Guardian. The Public Guardian already does this. So it would be a way of recognising in the statute what the Public Guardian is already doing: stepping in quickly and mediating. They do this over the phone, and the Guardianship Tribunal sometimes do hearings at besides. So the mechanisms are there for quick, clean decision-making and it is informal, in the sense there are no requirements for the rules of evidence to be dealt with. So it can be dealt with.

The Hon. MICHAEL VEITCH: You would oppose then the proposal to amend the Act so that there can only be one person?

Professor STEWART: Yes, I would.

CHAIR: This Standing Committee has a certain presumption of capacity but we still call upon numerous amounts of people to give us assistance in making a recommendation on the terms of reference. Is it prescribed anywhere in New South Wales that there is a presumption of capacity or is it not prescribed?

Professor STEWART: There is a definition of capacity in the Guardianship Act, which is basically the same definition that comes from Mr C's case that I mentioned before. Part 5 of the Guardianship Act provides for people who are not competent. So that presumption is built into the Act. It may not be exactly expressed as such, but that is the way the Act works in terms of how part 5 is triggered: it is triggered by the lack of competence in people over the age of 16.

CHAIR: But there is not a presumption that people have capacity?

Professor STEWART: There is. It is a common law presumption and it is still effective through the way the Guardianship Act works. So actually the presumption starts in the Minors (Contracts and Property) Act, would you believe, and it begins for people who are 14. So from the age of 14 up you are presumed to be competent to make decisions about medical treatment.

CHAIR: It is another layer that we need to incorporate by way of comment in our recommendations because we now have the age of 14 as to capacity and we have the age of 16 as to some other aspect—

Professor STEWART: This is the way that it works: by the time you have reached the age of 14 years you are presumed to be competent, but between the ages of 14 and 16 your parents can also make medical treatment decisions for you. Now in terms of a conflict between a 14-year-old and their mother, we do not know who would win. We do not know that because the Act is not clear and it does not specify what is to happen there. We also know that by the time you get to 16 you are completely emancipated in terms of medical decision-making.

CHAIR: Whatever that definition is?

Professor STEWART: It means the old presumption that would have been at the age of 21, then 18, is now 16, but there is also provision for that dropping down to 14. I would refer you to the report of the New South Wales Law Reform Commission, which talks about the problems in relation to I think it is section 54 of the Minors (Contracts and Property) Act. As the Act suggests, it is primarily written for children to be able to buy things or to enter into contracts of employment and things like that, but it also relates to medical treatment. It could also be improved in the recommendations of the Law Reform Commission report about how it could be made clearer. New South Wales and South Australia are the only two states that do that; everywhere else is presumed to be 18 years and above that you are competent.

CHAIR: Do you have any final comments you would like to make?

Professor STEWART: Just to impress upon the Committee how important this Act is because it will affect every single person in New South Wales. I do not know of another piece of legislation that will affect every single person in New South Wales—maybe the Road Traffic Act—but this certainly will affect everyone at some stage or other either directly, because it will be us who are dying under its provisions, or our relatives. So you cannot get a more important piece of legislation. Dying is one of most important aspects of how we live funnily enough. If the law cannot get this right then it has no place in doing anything. This is fundamental. This is fundamental to what it means to be a good person and how to live a good life. The law needs to provide an environment where those decisions can be best made and it is not doing that at the moment.

(The witnesses withdrew)

(Luncheon adjournment)

DUNCAN CHAPPELL, Adjunct Professor, Faculty of Law, University of Sydney, affirmed and examined:

CHAIR: I invite you to make some opening comments before we go to questions?

Professor CHAPPELL: Thank you, first, to the Committee for inviting me to meet with you today. I would like to make just two brief opening remarks, the first about where I think the overall direction of law reform is drifting in this area at the present time and then, second, something about what I see to be the need for psychiatric advance directives in this area of the law. First, as far as law reform is concerned, as an erstwhile law reformer myself, now retired, I am sure the Committee is very well aware there is a lively debate going on not just in this country but overseas concerning the best form that both mental health and guardianship law should take and in which direction it should go at the present time. The move goes to the fusion of both guardianship and mental health law into a generic mental capacity type of legislation.

As far as this country is concerned, in the Australian Capital Territory and in Victoria—and maybe other places as well—there are ongoing reviews of the area of mental health law and with it in the Australian Capital Territory at least guardianship law. I know that in the Australian Capital Territory fusion, as it is called, is on the agenda so far as that jurisdiction is concerned, and you may well have already heard from people involved in that process. I did appear at and speak to the Australian Capital Territory reform body on this issue some months ago now and that is how I am aware of this particular development. Also at the Australian level, Monash University has an Australian Research Council project headed by Professor Bernadette McSherry of that university, which is titled "Rethinking Mental Health Laws." I know part of that study is considering fusion as well and the nature of the direction of reform.

Of course, overseas there are many other developments which, again, I imagine you are possibly considering. In the United Kingdom there has been a lot of discussion of the need to bring together these two areas of law. In Canada and in North America generally that is so, and also in other European countries. I was not quite sure where you fitted in to this dialogue because your terms of reference seem quite broad. They might well allow this but I imagine probably taking on board the fusion at this stage is not on your agenda but I think it may well in the future be a very real matter in Australia and, equally, in this jurisdiction. Of course, I think we are all suffering a little bit of reform fatigue in the mental health area, because we have already gone through the quite elaborate process that led to the Mental Health Act of 2007. Certainly when I was president of the Mental Health Review Tribunal I was making submissions at that time on that and also on the forensic provisions which have also been changed in the form of the new Mental Health (Forensic Provisions) Act of 1990. In that debate and dialogue of reform we did not address fusion. It was not on the agenda and it was felt it was not something at that stage—only a couple of years ago—that was desirable.

I also think my personal views are moving towards a belief in fusion; that it would be preferable to have no longer as stand-alone guardianship and mental health law but fused capacity-based legislation. I also feel even more strongly that we ought in this area to have national legislation. I know that is always a pious wish of reformers, and I have experienced the frustrations of trying to bring it about in the area of sentencing law some years ago, but we obviously have national medical ethics and national medical treatment, and so on, which do not lend themselves to nuances of different approaches and different jurisdictions, and many other areas where uniformity would be of enormous benefit. Of course, we also have a very mobile population and an ageing population, where all these capacity issues become relevant, and I think it needs a national approach. So, I hope, even if you are not able to address this issue directly, that you can at least hint that this is a desirable approach.

The second thing I would like to briefly mention is that of the advanced psychiatric care directives. Again, as I am sure you are well aware, the current emphasis on guardianship law is on promoting advanced care directives, but it is one of the anomalies that in the area of psychiatric treatment at least, if a person is suffering from mental illness there is not an ability—as I understand, anyway—in this State nor across the country generally to allow for advanced care directives to be utilised. I think that is a discriminatory feature. Obviously it has a lot to do with the historical development of the mental health law and how it has reached this point, but I think a strong case could be made for allowing advanced care directives in the psychiatric arena as well as in the more traditional fields affecting other forms of medical treatment, and so on.

I am not here to explain in detail why I think that is the case. I would like to give, if I may, a copy of an article produced by Mr Bagdenovski, who is a former student of mine who did a superb paper in a course I give at Sydney University on this issue, and which I think covers all of those arguments eloquently and well. If that would be a help I can give you that reference at the end. That is all I would say at this point.

The Hon. MICHAEL VEITCH: I would like a macro perspective. We have heard a lot of the United Nations convention on the rights of people with disabilities. I want to know your views about how you see our guardianship laws in New South Wales fitting into that broad statement. Secondly, we have been advised there is like a paradigm shift taking place, and we had Professor McCallum with us yesterday who spoke at length about the new models for social policy that have been used for people with disabilities. Can I first get your views about the United Nations convention and how you see it playing out, particularly in the area of guardianship law and then the paradigm shift from incapacity to capacity?

Professor CHAPPELL: So far as the disabilities convention is concerned, I think it is a profound shift in thinking at the international level about how we deal with issues of disability and it certainly is a shift that involves moving from consideration of incapacity to capacity and stretching very much to the principles of autonomy, of decision-making by people who experience a wide range of disabilities, including mental illness. I think that is reflected in the basic clauses contained in the convention. I think it is going to stimulate, if it has not already, much of the dialogue about where we should go with this. I am afraid I do not feel qualified to say how guardianship laws specifically in this State fit into these specific provisions of the convention.

I suggest probably it is clear that neither the guardianship legislation nor the mental health legislation would infringe, at first glance, on the provisions of the convention because there is an overriding convention saying that where there is discrimination of a type that is intended to benefit those who are suffering from a particular disability than that is justified and does not render it invalid. I would have thought both the guardianship law and the mental health law are intended to be of benefit to people rather than to hinder them. If there were likely to be any challenge I would think it would more likely be in the mental health area rather than in the guardianship law. I am sure you heard very much more eloquent and detailed analysis from my colleague Ron McCallum yesterday.

The Hon. MICHAEL VEITCH: Yes, it was fantastic.

Professor CHAPPELL: It is incredible that he has been appointed to the position he has.

The Hon. MICHAEL VEITCH: He advised us yesterday he has just been elected to the chair.

Professor CHAPPELL: He has been elected to the chair of the United Nations committee, yes.

The Hon. MICHAEL VEITCH: In practice, how could decision-making arrangements be constructed to accommodate the fact that a person's capacity may vary from time to time or from situation to situation or even day to day?

Professor CHAPPELL: I think we already cope with that in the area of other types of decision-making and I think it is something we would simply have to address. Where there was doubt about capacity, I think there is a need for clearly a review mechanism which will allow for probably quite rapid decisions as to whether or not a person had the adequate capacity. That can be given already through either the Guardianship Tribunal or the Mental Health Review Tribunal, if it is a mental health question, or, always, access ultimately to the Supreme Court, which is not, I would say, a very rapid process and certainly not a cheap one. I think one of the other issues I understand you are interested in is the question of whether there should be some form of public advocacy that might take on these sorts of situations.

The Hon. MICHAEL VEITCH: That was going to be my next question.

Professor CHAPPELL: I would have thought a public advocate would be well placed to be available to take on at short notice questions in which capacity needed to be dealt with in a very quick framework and to do so in a range of areas. Equally, if there is to be fusion, there would be some review mechanism that would have to amalgamate the functions of both the Guardianship Tribunal and the Mental Health Review Tribunal. I think there is also a need, probably, to have a more flexible and accessible appeal mechanism, which I think would be to the Administrative Decisions Tribunal, rather than to the Supreme Court as exists at the present time.

The Hon. MICHAEL VEITCH: I might leave the capacity questions to someone else, but I want to focus on the public advocate role for the time being.

Professor CHAPPELL: Yes.

The Hon. MICHAEL VEITCH: We have heard almost unanimously from every witness that there needs to be a Public Advocate in New South Wales, but no-one has been able to articulate what the role of the Public Advocate would be. There seems to be general agreement that we need someone, but no-one can drill down to what the job description of this position should be and whether the position needs legislative support and frameworks around it, or whether other jurisdictions or tribunals are already doing the work that could be transferred across to the Public Advocate. I would really like to get your comments on the proposal for a Public Advocate.

Professor CHAPPELL: Yes.

The Hon. MICHAEL VEITCH: How do you personally see that playing out, particularly in the area of mental health?

Professor CHAPPELL: I felt, during the time I was at the Mental Health Review Tribunal, that there was a need for someone like an advocate because on quite a few occasions there were important issues that came up where matters of law and procedure and practice so far as patients were concerned needed to be given more attention, more detailed legal consideration, and more detailed analysis and argument, whether that would was before the tribunal, which is the Mental Health Review Tribunal, or other bodies. The Mental Health Advocacy Service, which is a very fine body, does an excellent job in the mental health area, but it is just not funded or geared towards bringing test cases or dealing with matters that are quite complex over a longer period of time. I think that is one very important role that a Public Advocate could, and should, perform.

I acknowledge that there are alternatives that perhaps might do this already. One is the Public Interest Advocacy Centre, which does excellent work as well, but it has a very targeted and focused program as to where it concentrates its activities. It is not individual orientated; it is more about broader issues. I think that the Public Advocate would be better placed as a public official to do that sort of work. Equally, really difficult cases I would think, not just in mental health but in guardianship too, could be dealt with by the Public Advocate, brought to the tribunals if necessary, or even brought to the Supreme Court. I understand that is what occurs in Victoria. I have not looked, I must admit, in depth that what we Victorian Public Advocate does, but I know him. I knew him personally for a while. I know that he was also a very powerful advocate for reform.

I think there is a role for law reform. I think today a Public Advocate would be one of the people you would want to talk to around the table about the issues, and so on. I think a pretty strong case could be made. I apologise for not having the detail of the work that the Victorian Public Advocate does, but I am sure that it would add something to this jurisdiction to have such a person.

The Hon. MICHAEL VEITCH: As you are well aware, there are different types of advocacy as well.

Professor CHAPPELL: Very much so, yes.

The Hon. MICHAEL VEITCH: Do you see that this position would have a role in systemic advocacy? I am gathering from your comments you are feeling that this position would focus more on individual case advocacy.

Professor CHAPPELL: I would see both, to be honest. I think both areas would be relevant. I think, as I said earlier, that the experience I had with the mental health tribunal was more in relation to perhaps individual cases where someone needed to be there to take up the cudgels for a particular matter, and to do so in a way that was not possible with the other resources available. But also there may well be issues that come up that are broader, and as you said, systemic. I think that the advocate could do that as well. For example, there was a great deal of concern about electroconvulsive therapy [ECT] treatment in the mental health tribunal and the question of whether or not you should allow ECT treatment for young people under the age of 18.

There were differing views, as I understood it, among the medical profession and psychiatrists about this. We had a case that came up involving something of this nature. The tribunal sought, as best it could, to find its way through and make a ruling, but it would have been very useful to have had someone like a Public

Advocate to put the arguments in the case and bring the evidence before the tribunal that would have established—I suppose, in a much more thorough way than we could—what the best interests were. That is just one example that I can think of.

CHAIR: I am trying to understand the definition of this advocate you speak of. You talk about a person. If you are trying to cover the geography.of New South Wales, if you are trying to target individual cases, or if you are trying to deal with systemic issues, I cannot visualise this superhuman person coming to grips with all of that.

Professor CHAPPELL: I think it is a title, not an individual. It will be, presumably, a Public Advocate that will have resources and, I assume, some sort of office or—

The Hon. MICHAEL VEITCH: Bureaucracy?

Professor CHAPPELL: Yes.

CHAIR: How do you see that being—

Professor CHAPPELL: Operationalised?

CHAIR: Yes, operational or resourced? It is an idea, but has anyone done any work on the size, locations and resources that are needed?

Professor CHAPPELL: I cannot, I am afraid, really be very responsive to that question. I do not know what the answer is.

CHAIR: But it is a wish list.

Professor CHAPPELL: It would have to be done, obviously, before you decided what model you wish to have. I think it would be also necessary to look around the country to see what happens at the present time in the other jurisdictions that have a Public Advocate and how it fits into the resources of the particular jurisdiction. Again I say that, not having worked in a jurisdiction that has had a Public Advocate. I cannot really say that I know enough about it. I apologise, but I just do not.

The Hon. MICHAEL VEITCH: Professor, the Public Guardian has recommended that a program of community guardians in New South Wales be established that would look at specific communities, such as ethnically based or indigenous communities. I know the mental health community has not quite the community guardian program but has a similar program. I know the Greater Southern Area Health Service has some individuals employed as community awareness people. Do you see a role for community guardians, particularly with regard to the mental health community?

Professor CHAPPELL: Yes. I thought when I read this that was a good idea. I do not know enough about how the actual guardianship process works to know whether it would be valuable there, but certainly from the mental health perspective it is very valuable. At the tribunal we would quite often have a community mental health person who would appear and who would offer comments in support of individual patients when they felt it was appropriate. I know from a patient's perspective, it was a very well-regarded aspect of the work. Also that extended to forensic patients, which is of course a separate area. But I think it is an idea that has merit. I would imagine it would work just as well in the guardianship arena as it would in the mental health arena.

The Hon. MICHAEL VEITCH: With regard to capacity, we have heard a lot about various assessment processes for determining an individual's capacity. In your experience, particularly at the tribunal, what is best environment to determine that, and who is best placed to conduct such an assessment?

Professor CHAPPELL: I guess that as far as the tribunal is concerned, we had to do it, as it were, on the run because we were in a hearing and the patient would appear and we would have to make some determination as to whether we felt the person did or did not have the capacity. Of course it is one of the ironies of the mental health area that the test does not involve, in the main, any consideration of capacities. It is the risk of harm and need for treatment that prevails. A person may have capacity in relation to certain matters, but still fit the criteria for involuntary treatment. That is especially the case when community treatment orders are being used, which is really the favoured treatment—that people should be in the least restrictive environment possible, and should be the community.

There are, with the benefits of medication, very often patients who regain capacity once they are given appropriate anti-psychotic drugs, or whatever. On one view you could say that once that happens they should no longer be involuntarily treated or subject to conditions, but because risk of harm to themselves or others also entered into the equation, as did the possibility of relapse, the issue of capacity did not prevail. It is one of those areas which is very difficult. If you were to fuse this, you would have to deal with those sorts of issues in terms of how you would deal with a situation in which someone was under a form of treatment order and on one view did have capacity to understand certain things, but probably in relation to an area and realising perhaps what the consequences were for not continuing with that treatment, they might be seen to lack the capacity. You would have to make a decision of that nature.

It is a very complex equation here. I can see very much that you would have to look at each situation, in a way, to decide what capacity test you would apply and how you would do it. The one area where we did have capacity as part of our criteria is in the ECT area whereby, if an involuntary patient is believed to benefit from ECT, the tribunal has an overriding function to decide whether that person can consent or not, and if they cannot, what is in their best interests, et cetera. That is the one area where we did have that.

CHAIR: In determining voluntary or involuntary, if I am a person with a guardian, am I considered voluntary?

Professor CHAPPELL: A guardian cannot in fact have a person or cannot make determinations on behalf of a person as far as psychiatric treatment is concerned. They could make a person a voluntary patient in a hospital, but not an involuntary patient as far as a mentally ill person is concerned.

CHAIR: The patient could not want to go there, but they could still be considered by the tribunal to be voluntary if they were there.

Professor CHAPPELL: If there is any doubt about that, they would have to go to the tribunal.

CHAIR: "They"?

Professor CHAPPELL: In that situation, the guardian might act to bring the matter before the tribunal. It is more likely that it would be an application made by the hospital to decide whether or not they could accept someone as a voluntary patient or not. I think that is another anomaly that exists. At the moment, in relation to guardianship decisions, guardians cannot make them in relation to psychiatric treatment, as I understand it. Also, as far as the predominance of legislation is concerned, where there is a conflict, the Mental Health Act prevails over the Guardianship Act.

The Hon. TREVOR KHAN: I wish to go to the advanced directives. I think you made an observation earlier that an advance care directive could be made with respect to what we could say is normal medical treatment, but cannot be made with respect to psychiatric treatment.

Professor CHAPPELL: That is my understanding.

The Hon. TREVOR KHAN: What is the basis of your understanding?

Professor CHAPPELL: It is the basis of the examination of the current legal situation. The question of the scope of these advanced directives in the psychiatric field is still one that is open and it needs clarification, let us put it that way. I think it would require legislative clarification. It would be desirable if it were clarified in that way rather than perhaps relying upon court processes, which might also result in some recognition. That is my understanding, as I say, at the present time that there is not an ability to recognise psychiatric advance care directives.

The Hon. TREVOR KHAN: You said you are going to provide us with a paper.

Professor CHAPPELL: Yes.

The Hon. TREVOR KHAN: What would you anticipate that at an advance care directive with regards to psychiatric care would contemplate?

Professor CHAPPELL: It would contemplate certainly the possibility of a person suffering at some future point from a mental illness or for that matter from a dementia or something of that nature. It would then also, I think, envisage the types of possible treatment that might be applied and whether or not that person wished to receive such treatment. ECT, I suppose, is a very good example of that. People might not want to have ECT, even if it was something that was thought to be beneficial. I think there also might be a consideration of whether or not they were prepared to be admitted to hospital and, perhaps, which hospital and which treating psychiatrist they wanted to have. I think there would be things that they would want to go through, at the very least, with their general practitioner. It would require some knowledge of mental illness to know what sorts of things you should have in that directive. I think you would also set up guidelines.

The Hon. TREVOR KHAN: One could envisage if it were to deal with psychiatric treatment that it may be prepared for a person who has already been through a series of stays and is contemplating a return at some indeterminate point in the future. That is probably the more likely circumstance in which it would rise, is it not?

Professor CHAPPELL: It is difficult to know since we have not got them to know quite how they would operate and who would want to enter into them. I think all of us ought to have advance care directives. I have to profess myself I do not have one at the present time, although my wife and I have been talking about it in light of a number of things. Most of us leave it till it is too late. Most of us, of course, do not expect that we are going to become mentally ill. Whereas the reality is that one in five of us is likely to experience some type of mental disorder, and a quite severe one in some cases. It is partly a public education matter that you would need to make people aware of the sorts of possibilities there were and what types of risk they were likely to have in a psychiatric sense, let us say. There would be some sort of guidance perhaps through your local practitioner, your GP, to decide how you might frame the actual directive. Also, as you say, you might have had one experience already perhaps of going in for psychiatric treatment and on the basis of that experience you would obviously be better informed about what might happen and say what you wish or not wish to happen to you in the future.

The Hon. TREVOR KHAN: I cannot remember the title of the decision, but you are obviously alive to the Hunter New England case?

Professor CHAPPELL: Yes.

The Hon. TREVOR KHAN: And the discussion that the justice had in relation to the decision-making process before the preparation of the advance care directive?

Professor CHAPPELL: Yes.

The Hon. TREVOR KHAN: Do I take it, as summarised, that as far as it was found in that case, essentially the test was one of capacity? It did not have to go to the wisdom of the decision as to the medical treatment that the person did not want?

Professor CHAPPELL: That is the way I read that decision, yes.

The Hon. TREVOR KHAN: If there were to be a legislative basis for advance care directives—and, I believe, the South Australian example requires a declaration by a doctor that it has been explained to the person preparing the advance care directive—do you think that legislative requirement for what is an addition of an informed consent requirement sits comfortably with the concept of autonomous decision and the rights of a person to make their own decision as to what treatment they do or do not receive?

Professor CHAPPELL: I think it does sit comfortably myself. I think it would be beneficial for anyone who is contemplating something in this area to have that level of advice. If it is mandated I do not think that is something that invades the overriding principle of autonomy. You are making the decision that you want to do this—that is autonomous. It is just that you have certain information given to you as part of the decision-making. We do it in other areas, I think, without problems. I think this would be within the principles of the disabilities convention and within the principles of autonomy generally that would apply.

The Hon. TREVOR KHAN: Do I anticipate that you would prefer to see a legislative basis for advance care directives or are you comfortable with relying on the common law in New South Wales?

Professor CHAPPELL: I would prefer to see legislation of this issue. It will clarify matters and perhaps reflect the will of the people more than relying on judicial wisdom—as much as it is to be acknowledged that judicial wisdom has moved us a very long way in the common law. But I think it is preferable in an area like this that we have legislation.

CHAIR: Are you definitively saying one or the other, not both?

Professor CHAPPELL: You will have some interpretation if you have legislation, but I think it is better to put it in as clear as terms as you can the sort of things that should go into advance care directives in a legislative formula.

CHAIR: It may not be feasible to come up with prescriptive legislative clauses that would accommodate what we are trying to achieve.

Professor CHAPPELL: There is going to be a definite need for review of any advance care directive mechanism because there will be situations where a particular directive is seen to be so unreasonable or likely to cause harm that was not foreseeable and someone will have to review it, whether it be a mental health tribunal or a guardianship tribunal or an amalgamated form of that or a court. There has to be some mechanism for that purpose.

The Hon. TREVOR KHAN: Do you see a legislative basis for advance care directives being a piece of stand-alone legislation or an addition or addendum to existing legislation?

Professor CHAPPELL: It would be best if it were inserted into a general capacity legislation, the fusion model. It should be a key part of that fusion that you have advanced decision-making or substitute decision-making, whatever it is you wish to call it. It should be included in a package of legislation. But if that fusion is not feasible, then it probably would be best to have it in stand-alone legislation relating to directive and capacity and so on. It would need to incorporate, in my view, both areas of lack of physical capacity and lack of mental capacity and should include the provision for psychiatric issues to arise and allow people with a mental illness to make those sorts of decisions as well.

The Hon. TREVOR KHAN: Would you envisage that the legislation also would provide some protection for doctors in emergency treatment circumstances?

Professor CHAPPELL: Yes. It is there now in the Mental Health Act. It is there with guardianship and so on. I think there has to be some provision for this and some protection for medical practitioners who may be faced with emergencies.

The Hon. TREVOR KHAN: I am not quite sure if I am going beyond your area. I want to ask you a couple of questions about powers of attorney because they have become an issue.

Professor CHAPPELL: I think it might be going ahead of my area.

The Hon. TREVOR KHAN: The more we have spoken to people it seems that the power of attorney as a document has morphed beyond what it was originally created under common law to do to a document that is, in a sense, a form of estate planning in advance. As a tool that deals in advance with the possible loss of capacity in terms of an enduring power of attorney, is the instrument a clumsy way of achieving what people are seeking to do?

Professor CHAPPELL: My sense is that it is a clumsy way of doing it, but I really do not know enough about the scope of powers of attorney to give you a very authoritative answer beyond that. I have had some recent experience of executing powers of attorney in relation to my own parents and things of that nature. So I know that it is a difficult and sensitive area. But I have not personally seen it as one that would allow for the sorts of advanced care planning that you are suggesting. It would be much more preferable to have separate and acknowledged enduring powers given and not trying to bolt on the power of attorney to cover this area.

The Hon. MICHAEL VEITCH: I want to follow on from Mr Khan's line of questioning. This issue has been raised also with others during testimony. Do you consider that advance psychiatric care orders would need to be registered so that people know they are in existence?

Professor CHAPPELL: It would be beneficial to have a registration system. Although in other forms of enduring power of attorney, or whatever we call them, I do not think we have that at the present time. It may be beneficial to have it generally rather than just for psychiatric ones. These documents can very easily get lost, apart from anything else. That is a problem with wills and other documents like this. They can sit in a solicitor's drawer and never be found again. We register all sorts of things. Why not this, I suppose? I cannot personally see objections to it, although it might be just another revenue-raising exercise, as far as the State is concerned.

The Hon. MICHAEL VEITCH: The Attorney General has asked the Committee to consider amending the New South Wales Trustee and Guardian Act 2009 to allow the relevant court or tribunal to exclude parts of an estate from a financial management order. The Committee notes that section 40 of chapter 4 of the Act states that "an order may be made under this chapter for the management of the whole or part of the estate of a person". What are your views as to how excluding parts of an estate would differ from making an order for part of an estate?

Professor CHAPPELL: I will have to decline to answer the question since I do not know enough about how those orders operate to make a judgement. I do not know what those situations would be where you might want to make an order in relation to part versus whole. The only financial orders I have personally been involved with have been in the mental health arena where we had jurisdiction to make financial management orders. But they were never, in my experience, made for just part. They were made for the entire estate.

The Hon. MICHAEL VEITCH: The whole estate?

Professor CHAPPELL: The whole estate. I do not remember anyone raising it as an issue in the course of any hearings that I presided over.

The Hon. MICHAEL VEITCH: My next question is a significant issue for the Mental Health Review Tribunal. The Committee has been asked to consider also whether the New South Wales Trustee and Guardian Act should be amended to allow the Supreme Court or the Mental Health Review Tribunal to vary or revoke an order even where the person remains incapable of managing their affairs on the application of a person who in the opinion of the Supreme Court or the Mental Health Review Tribunal has a genuine concern for the welfare of the protected person. What are your views on this proposed amendment?

Professor CHAPPELL: I can see some merit in that suggestion, although I was thinking about what sort of person would bring such an application. I could not, on the face of it at least, think of someone. Maybe you have someone in mind or some specific case that may have arisen.

The Hon. MICHAEL VEITCH: I am keen to hear what you consider to be the merits of such an amendment?

Professor CHAPPELL: As I recall it, the provisions relating to financial management orders were fairly loaded against the person with a mental illness that in order to get one revoked, it was necessary, in a sense, to establish that you had regained capacity to manage your own financial affairs. The proof was on you to do that. That was often a very hard test to meet. I think it would have made it easier if not only were that test to be changed—I understand there have been suggestions that it should be and it may have even occurred with the new legislation, the latest Guardianship and Trusteeship Act—but equally it would be good if there were perhaps members of the family or, for that matter I thought this was an area where the Public Advocate might also intrude who could bring a case to the tribunal to have a waiver made or to revoke an order for a particular reason. At the moment it is a pretty inflexible system, or it was certainly when I was at the tribunal. I think we would have benefited from having more flexibility and the possibility of someone intervening, but it would have to be someone with, I would have thought, neutrality and, of course, one of the problems in financial management is that neutrality often is not what lies in the intervention.

The Hon. MICHAEL VEITCH: Self-interest?

Professor CHAPPELL: Self-interest, and it would be something that would have to be closely watched for that reason. That is why the Public Advocate might be a possible person to do this.

The Hon. TREVOR KHAN: In terms of your experience on the tribunal and the like, is there a person who fulfils the role, somewhat like in the Coroner's Court, of counsel assisting?

Professor CHAPPELL: No, not really. The nearest that would come is really a mental health advocate but the advocate is there for the purposes of pushing the patient's view rather than perhaps a more neutral view. It is always a difficult matter, as I am sure the legal practitioners know, to represent people with a mental illness because, on the one hand, you need to accept their instructions and to try to present the best case on their behalf but, on the other hand, you may well recognise that they are severely compromised in terms of their own capacity and lack of ability to make proper decisions and it may well be in their interests to have involuntary treatment and so on.

It is always this sort of conflict that you have before you. But really there is no-one at the present time in the mental health context at least who sits there as a neutral person who puts a case to the tribunal. It is the tribunal itself, which obviously has the determinative powers and which has to make its own assessment of the evidence as presented to it.

The Hon. TREVOR KHAN: So the role of counsel assisting does not exist?

Professor CHAPPELL: It does not exist.

The Hon. TREVOR KHAN: But it would satisfy some of the issues that you raise in terms of the Public Advocate?

Professor CHAPPELL: It would, in the sense that there is a power under the Mental Health Act for the tribunal to seek assistance, if it wishes, and it has a range of powers to get expert evidence and so on. If it wished, it could always attain that sort of assistance but it is still not that idea of having a neutral person assisting in the sense that I think you are using it there. It might therefore require some legislative amendment if you were going to have someone like that. It could be that it would be a Public Advocate, as I say.

The Hon. MICHAEL VEITCH: An important item has come from the Public Guardian submission. They recommend that section 21A of the Guardianship Act allowing the Public Guardian to authorise members of the New South Wales Police Force to move a person under a guardianship order from one place of residence to another be amended to specify that the police may use all reasonable force. I would like your views on what I see as a pretty significant change?

Professor CHAPPELL: Is that something that the police themselves have asked for?

The Hon. MICHAEL VEITCH: No, the Public Guardian. I am not sure whether that was in consultation with the police; I have no idea.

Professor CHAPPELL: Again, under the Mental Health Act, as I am sure you know, there is widespread power for police to intervene and take people for assessment, and use of reasonable force is part of that. Equally, now ambulance officers are also authorised to do this. The police, I think, would much prefer not to have to do this or do it to the very least amount possible and only where there was a significant risk of danger or serious harm to the patient or to others, and that otherwise it should be done as a matter of a health responsibility. I have to say I share that view; it should be a health responsibility and to intrude the police into this area is to add to the stigma and discrimination against particularly mentally ill people and the association that they are somehow involved in criminal behaviour. Coming back to your particular question, I would have to say that I would want to know more about why there is a need for this.

The Hon. MICHAEL VEITCH: Why?

Professor CHAPPELL: Why. I do not know the answer to that, I am afraid.

The Hon. TREVOR KHAN: I raise this scenario. You have a person who is in a nursing home and that person increasingly suffers from dementia. It is deemed, because of their actions, inappropriate for them to remain in nursing home style accommodation but instead be moved to some form of high dependency unit, almost perhaps in the same building. I am actually envisaging a certain circumstance close to home. In those circumstances where that patient does not wish to be moved—and this could be a private institution that they are in—could you envisage a circumstance where the person has to be physically uplifted and moved?

Professor CHAPPELL: I can, but I would also envisage that there are ways of sedating people and so on, which may or may not be available to the people in the home if there is a medical intervention, and the use of restraint and so on is one of the other issues in this area. If there is a need to—and you suggest there might be—I would have thought the police ought to be protected against the possibility of liability for force and that reasonable force ought to be able to be used, but again I would want to know a lot more about how and when the police were involved in these situations. In fact, I am quite surprised to hear that they are even thinking about it in guardianship. I would have thought it was a health matter and that there would be well-trained health professionals, who could exercise restraint and, if necessary, medication to ensure that it was a peaceful transfer.

The Hon. TREVOR KHAN: Can I ask a follow-up question that flows from that? If an institution, say a nursing home, uses medication to sedate a patient to get a patient out of the institution, would that not, in a sense, constitute some form of assault in itself?

Professor CHAPPELL: Again, in the mental health area there is provision in the Act to allow this to happen and I must admit I have not thought about it in the context of the guardianship but I assume that these are people who are obviously not mentally ill as such and do not come within the mental health tribunal's perspective. I think if there is not provision allowing for reasonable measures to be taken to protect the person themselves against the possibility of risk of injury, there should be. It should be in some form of legislative framework and again why the police though? I would have thought it is something again that could be dealt with by the health professionals. As I understand it, in the nursing area trained psychiatric nurses and so on are able to use various forms of restraint and so on, and have to unfortunately, and very much in the areas of dementia and so on.

The Hon. MICHAEL VEITCH: I am a layperson, not a legal practitioner like Mr Khan. With your advanced psychiatric care orders, I am trying to work out the hierarchy with your power of attorney and enduring power of attorney. Would you see an order taking precedent over any other instrument that may have been put in place by an individual?

Professor CHAPPELL: It is probably a question of when it was executed, would be the short answer, and presumably the most recent one that applied would be the one that would have to be looked at.

CHAIR: Thank you very much for your attendance today. We may need to be in touch with you through the secretariat for some additional advice.

(The witness withdrew)

COLLEEN PEARCE, Public Advocate of Victoria, 436 Lonsdale Street, Melbourne, Victoria, 3000, sworn and examined:

CHAIR: Would you like to make any opening comments?

Ms PEARCE: I am delighted to have the opportunity to present to you today and I am looking forward to your questions, which I hope I can answer.

CHAIR: Thank you very much. We are looking forward to your contribution this afternoon because this is an area in which we need a lot of advice.

The Hon. MICHAEL VEITCH: I am really interested in the public advocacy role that is played out in Victoria so can you briefly tell us a little about yourself and your organisation, such as how many staff you have, what is your budget, the resource requirements, and how you cover Victoria?

Ms PEARCE: I can send you any supplementary information such as the exact number of staff and the exact dollars. I do not have those.

The Hon. MICHAEL VEITCH: That would be great.

Ms PEARCE: Perhaps afterwards if there are any particular questions like that we could look at them. My office in many ways does much the same work as the Office of the Public Guardian in New South Wales with regard to the provision of information and our guardianship role. We operate as a statewide service from Melbourne. In the future we would like to be regionalised but currently we operate out of 436 Lonsdale Street. We have approximately 80 staff and probably an EFT of around 65.

The key parts of our work are as defined in the Act: firstly, guardianship, and you would be familiar with that area. We also have a role in promoting community involvement. This is a bit of a legacy from the '80s when the Act was first introduced and there was a dearth of advocacy organisations or community citizen advocacy organisations in the disability area. Those roles are really now undertaken by a wider range of organisations so while we might support the development of broader advocacy groups, that is probably not within our role. It grew very much out of the philosophy that guardianship was seen as a family and community responsibility before being perceived as a responsibility of the State.

I have a role in advising the Minister, to report on any matters and make appropriate recommendations specifically in relation to any aspect of the Act. We have a general advocacy function that comes with our role as well.

The Hon. MICHAEL VEITCH: Is that systemic advocacy as well?

Ms PEARCE: Yes, it is; it is both. We are a little bit different from New South Wales. We also have a community visitor program that is attached to my office. Our community visitors visit what we call closed environments—all mental health facilities, all disability service providers and, on top of that, what we call supported residential services. They are private organisations providing supported accommodation. We make about 6,000 visits to those facilities each year and provide an annual report to Parliament. On top of that we have a small policy and research team here where we do systemic advocacy. We also have a telephone advice service providing advice to the general public and we take about 14,000 calls each year in relation to that service.

The Hon. MICHAEL VEITCH: How do you interact with the Victorian public guardian?

Ms PEARCE: There is no public guardian. I am the public guardian, if you like, as well as the Public Advocate. We do not have a public guardian specifically.

The Hon. MICHAEL VEITCH: If you table reports in Parliament, which Minister is responsible?

Ms PEARCE: As the Public Advocate I table a report in Parliament. I am appointed by Parliament for seven years so I am an independent statutory body. I give the annual report to the Attorney General and he tables it, but under my Act—I think it was just an oversight—I am not required to produce a report, but historically we always have. Our community visitors are a slightly different stream and we are funded by the Department of Human Services for our work that the community visitors undertake and the Minister tables that report.

The Hon. MICHAEL VEITCH: You said your role is much like that of the New South Wales Public Guardian, who requires a guardianship order to be made before becoming involved in the guardianship of a person. Does the Victorian Public Advocate require an order of any kind before it can become involved in guardianship?

Ms PEARCE: Yes, it does. We play a key role in the examination of matters where there is evidence of exploitation, abuse or neglect of persons with a disability. Through our community visitors program we might hear about issues of neglect. For example, we have a supported residential service in the country where there has been an allegation of sexual abuse of an elderly woman. We believe there should have been an application for guardianship for her, but I am using my powers of investigation to look at the circumstances around that to make an application for guardianship. That is rare. Generally, the court would place an order for guardianship and we would then undertake that. We have an investigating role. Generally that is undertaken within the realm of guardianship, so a matter might come before the tribunal and the tribunal may wish to have further information, so we will investigate that matter on behalf of the tribunal and the tribunal will make a determination.

The Hon. MICHAEL VEITCH: How do you manage conflicts between your role as Public Advocate and your role as public guardian?

Ms PEARCE: I think there are tensions there that are relevant, but nonetheless the guardianship jurisdiction itself is a contradiction between a person's right to safety and protection and the taking away of an individual's rights, so reducing their ability to self-determine. I think there is a contradiction there. When the Act was first considered in 1982—it came into being in 1986—the people writing the report had originally considered there would be a public guardian and a public representative—the Public Advocate. In the end they concluded after hearing evidence from the public and taking submissions that it would create greater levels of bureaucracy to have too many people and while recognising there is that contradiction they felt that was the preferable arrangement. Queensland has a Public Advocate and a Public Guardian, and my understanding is that the Queensland Parliament has moved to abolish the Office of the Public Advocate and incorporate it into the Office of the Public Guardian. Western Australia has a Public Advocate who is also the public guardian, as does South Australia.

The Hon. MICHAEL VEITCH: Some of my colleagues may have questions about that. My last question relates to the United Nations Convention on the Rights of Persons with Disabilities. It has been put to us that it is encapsulating a paradigm shift in recent years in relation to the thinking about people with disabilities, but in particular in terms of shifting the focus from incapacity to capacity and from disability to rights. Can you comment on this paradigm shift from your experience in Victoria? Can you also talk a little more about your views on the United Nations Convention in general terms?

Ms PEARCE: If we look historically at the development of the convention, it was probably one of the fastest developed conventions and one of the few that had the people concerned participating in it. The group was very mixed. Guardianship, particularly in eastern European countries, is very different and there has been a lot of concern about that guardianship model, as well as about the anti-psychiatry lobby. The convention really reflects a lot of dynamics that in Australia are not exactly the same.

We see this shift in article 12 around capacity. The most important part of that for us is the notion of supported decision-making. It is important to understand how that got to be in there and what were some of the driving forces. In my view, in order for Australia as a whole to consider how it might address the convention, we have to look at supported decision-making.

The haste with which the convention was drawn up means that no model of supported decision-making was put forward; there is no agreement as to what a supported decision-making might look like. We are all wanting to contribute to the discussion about supported decision-making without an agreed model. Notwithstanding that, I believe it is beholden on us to consider how we might implement the issue of supported decision-making. It is something we should not do hastily, but give a great deal of thought to. The Victorian Law Reform Commission currently is reviewing our Act and one of the matters it will have to consider is supported decision-making. We have a discussion paper on supported decision-making in relation to guardianship and I am happy to forward it to you. We think in Victoria there are many ways that already we are making a contribution to supported decision-making.

If we are not appointed as a guardian, we have an advocacy role. Sometimes we do go back and say, "Look, there's no need for us to be a guardian any longer" but we might stay in there as an advocate. Through that advocacy we think that we can support some people to help assist them in making decisions. But I should take a step back and say that we see supported decision-making as part of a continuum. All of us might get some support if we are making decisions. We might talk to our family about how we go on holidays moving right through to the end of the continuum where one needs substituted judgement at the far end. It is saying what is the middle ground. I do not believe you can have supported decision-making without providing adequate advocacy support.

Then the question is how does one oversee that advocacy. Any advocacy coming out of a government-funded model such as our own has a reasonable degree of oversight. But if we were implementing it with other people, what would be the mechanism to oversee that? Perhaps that might mean there is a different order of decisions in supported decision-making. I am not sure if I have answered your question entirely, but I am very happy to send you our paper on supported decision-making, which outlines our thinking in relation to it. In my view it is not something that we should do in haste because I think there are resource implications as well and to say we would do it without committing to the resources. Some people argue that with supported decision-making you will have less need for guardianship if you support people to make decisions.

In Victoria we have a very different profile of people who are under guardianship. In fact, 66 per cent of our clients are over the age of 65 and 34 per cent of our clients have dementia. That is quite different to your profile in New South Wales. No amount of support that you give them will help them make those decisions that are required. Indeed, if the trend is for an increasing number of people over the age of 65 to be under guardianship, I am not sure how that will work for everyone. But certainly for those who have mental illness where capacity might fluctuate, the same with ABI or intellectual disability, that is a particular cohort where supported decision-making may well be effective.

The Hon. MICHAEL VEITCH: The Committee would love to have a copy of your paper, if you could provide that.

Ms PEARCE: Yes.

The Hon. TREVOR KHAN: Could we return to your various roles. I am interested in how you or your office appears before what I would term the guardianship tribunal for an application. Is it the guardianship tribunal you appear before?

Ms PEARCE: Yes. Well, it is VCAT, so it is one of those super amalgamated tribunals, but it is the Guardianship List of VCAT.

The Hon. TREVOR KHAN: From what you said, your office can initiate an application before the tribunal?

Ms PEARCE: Yes.

The Hon. TREVOR KHAN: In that role would you initiate an application seeking a guardianship order in respect to a particular person?

Ms PEARCE: Yes. However, generally we do not do that. We prefer somebody else to make that application, just bearing in mind the contradictions that are inherent within the jurisdiction. It is more likely that a matter would come before the tribunal and we would then be asked to investigate to see whether or not the matter warrants guardianship and we would make a recommendation, which VCAT would act on or not.

The Hon. TREVOR KHAN: In the second circumstance you describe you are invited to play a role somewhat akin to counsel assisting in an inquest?

Ms PEARCE: Yes.

The Hon. TREVOR KHAN: You are not a party to those proceedings but more in the nature of a witness, is that the case?

Ms PEARCE: Yes, and that would be in 99.99 per cent of cases. At the moment we have the elderly woman I mentioned in rural Victoria. We are going to talk to a service provider who has concerns. We say to people, "Look, you put in an application." Wherever possible someone else puts in the application.

The Hon. TREVOR KHAN: Are the people who undertake the investigative role the same people who would post the making of the order? In other words, they undertake the work on behalf of the person the subject of an order?

Ms PEARCE: Yes, they would be.

The Hon. TREVOR KHAN: Is there potential for conflict for those people advocating for a position also being the recipients of the order once it is made?

Ms PEARCE: I think this might be hard to understand how we manage those contradictions, but I think if you talk to the current head of the Guardianship List he would say we get that balance pretty right. We have a pretty respectful relationship with the tribunal.

The Hon. TREVOR KHAN: I am sure you do.

Ms PEARCE: We work very hard to maintain that. We do not always see eye to eye on matters, but there is a contradiction that is inherent. However, I think we manage it very well. I think it is very helpful because it means that by the time something has come to guardianship we have already done an investigation—we do not do it in every case, but in a proportion of them. So, we understand the matter very well. Indeed, it may not be the same person; it may be a different person within the office, but on occasion it could be the same person. We also make recommendations to the tribunal saying that rather than this being a matter for guardianship, it may be a matter for advocacy.

The Hon. TREVOR KHAN: What, if any, is your role with regards to people suffering from a serious mental health illness?

Ms PEARCE: I think Victoria, unlike many other States, has a significant number of people on community treatment orders. They may be having involuntary treatment but residing in the community. For many of those it might be a matter around accommodation or it could be around other lifestyle matters. Any matter where there is involvement of the Mental Health Review Board is not a matter where we would get involved ourselves. Mental health issues remain with the Mental Health Review Board; ours are general guardianship matters around accommodation, broader health care or other lifestyle matters.

The Hon. TREVOR KHAN: So I am clear, you do not advocate before any tribunal on behalf of people suffering from a mental health illness?

Ms PEARCE: No.

The Hon. TREVOR KHAN: What is the youngest age for which you can seek an order before the guardianship tribunal?

Ms PEARCE: It is 18. The review is looking at changing it to 17. That is because there is a gap in our service system; people are leaving State care at 17 and guardianship does not come into effect until 18. The Law Reform Commission will be looking at whether it is appropriate for 17 year olds.

The Hon. TREVOR KHAN: What happens to the 17 year old who is no longer under the care of the equivalent of the Department of Community Services here?

Ms PEARCE: They are a group that falls through the gap. It is a gap in the service system that has been identified.

The Hon. TREVOR KHAN: Notwithstanding the age gap, is there some interagency connection that allows for people who potentially will need to flowthrough from a child-based care order to an adult-based care order?

Ms PEARCE: We do not have such a protocol. We do not see a lot of that group of people, but in talking to my colleague in Western Australia, they have a very good protocol. They have done a lot of work around that and they see more of a flowthrough. I think it is just a jurisdictional issue where we do not see many of that cohort, but Western Australia does. If you were looking for a model, I think they have a very good one.

The Hon. MICHAEL VEITCH: How many orders are there in Victoria?

Ms PEARCE: In any one year it is probably around 1,300 to 1,400.

The Hon. MICHAEL VEITCH: If I were to ask you now at 3.00 p.m. today, how many orders would there be?

Ms PEARCE: I do not know the answer to that question. I do not have it uppermost in my mind, but I certainly can get you that. If you add that to the list of questions, I could undertake and get back to you within 24 hours with that.

The Hon. MICHAEL VEITCH: Thank you. Does Victoria have provisions for responsible people to be appointed as a guardian rather than just a public guardian?

Ms PEARCE: We do. There is emphasis in the legislation on family members being made guardians.

The Hon. MICHAEL VEITCH: Is it one person who can be appointed?

Ms PEARCE: Yes.

The Hon. MICHAEL VEITCH: Or a group of people?

Ms PEARCE: One person.

The Hon. MICHAEL VEITCH: Your legislation has no provision for more than one to act equally as a guardian?

Ms PEARCE: No, just one person. Look, that is not true. We have had joint guardians on occasion, but it is a bit messy when that happens.

The Hon. MICHAEL VEITCH: In what way?

Ms PEARCE: We had an occasion where we were made joint guardians with an individual and that was really more about being a support for them in their role. But it can get a bit tricky around who is making what decision in relation to what.

The Hon. MICHAEL VEITCH: What is the criteria to be appointed a guardian in Victoria? You mentioned it could be a family member, but can anyone else be appointed?

Ms PEARCE: We have community guardians.

The Hon. MICHAEL VEITCH: How does that work?

Ms PEARCE: That works very well. We have had about 22 years now of community guardians. It really goes back to the origins of our original legislation where we talked about the promotion of family and community involvement in decision-making. We have had community guardians for about 22 years now and it works extremely well. We have a different model to Western Australia. Community guardians come under my office. We manage it as one of our volunteer programs. We provide oversight and support. Each community guardian would have only one person at any one time for whom they are responsible. Firstly, I should say that it is not a money-saving matter; it is about promoting community involvement in the lives of people who are very vulnerable.

Our community guardians have the capacity to spend a bit more time with an individual than we might as a guardian. That is particularly, perhaps, in some rural areas—they are often the more simple decisions. But it gives people some insight into the lives of people who are vulnerable and who are socially isolated, and it is a way of ensuring community involvement and community inclusion. Ours is not a very costly program. We have a half-time person who supports our community guardians. So they are there providing advice on the phone to the individual, doing the paperwork, running training sessions and making sure our community guardians manual is up-to-date. So we do that on a half-time position and we probably have about 50 community guardians, not all of them active at any one time.

The Hon. MICHAEL VEITCH: When you appoint a family member—

Ms PEARCE: We do not appoint a family member; the tribunal might do that. They would be looking at the Act and saying: Who is suitable to be a guardian? In fact, the majority of people who are appointed are family members. If we have a look at the breakdown between what we are calling the private guardians and the public guardians we are the smaller end of that.

The Hon. MICHAEL VEITCH: Do you have much involvement in financial orders?

Ms PEARCE: No, very little. That is our State Trustees—that is a completely separate organisation. We have involvement because lifestyle matters, for example, may require some finances. There are about three or four times as many people under administration than we have under guardianship, so many of our clients would have joint orders.

The Hon. MICHAEL VEITCH: As the Public Advocate in Victoria, you are not overly involved in financial orders?

Ms PEARCE: Really the only time we are involved is when the tribunal asks us to do an investigation where there might be suspected financial abuse. When I call them "investigations", that is what they are called in the Act but I really say they are more like inquiries. So we make the basic inquiries, we provide a report and if an administration order is warranted it then goes to our State Trustees who might look at that.

The Hon. MICHAEL VEITCH: Which Victorian Act of Parliament provides the framework for your position?

Ms PEARCE: It is the Guardianship and Administration Act 1986.

The Hon. MICHAEL VEITCH: That would include a definition of your roles and things like that?

Ms PEARCE: It does. I have the Act in front of me and I can tell you that, if that is of any use to you?

The Hon. MICHAEL VEITCH: It might be to help clarify your role.

Ms PEARCE: The function of the Public Advocate is to promote, facilitate and encourage provision, development and coordination of services. Now that is one of the things that I said we really do not do any more. In this day and age there are quite a lot of other services. We do not need to coordinate any of the roles. The subsets of that were promoting the development, ability and capacity of persons with a disability to act independently, minimising the restrictions on rights. Another one was to support the establishment of organisations involved with persons with a disability, relatives, guardians and friends. Now we do not do that very much any more. As I said, there are quite enough of those sorts of organisations. I do not mean enough but people are well able to develop those self-help and support organisations without us.

The next role is around arranging, coordinating and promoting informed public awareness by disseminating information. That is through our advice service, which I said takes about 14,000 calls per year, and we do community education attached to that. That is, in the provisions of the Act, the role of the tribunal but more and more we are playing a very strong educative role around enduring powers of attorney, issues related to consent and those kinds of risks and rights, so a pretty broad educational role. Then to investigate, report and make recommendations to the Minister on any aspect of the Act. So the functions have changed quite a bit and part of the review of our legislation is to review the functions of the Public Advocate.

Now my powers and duties are to act as a guardian. I can make an application to the tribunal for the appointment of a guardian. I can submit a report to the tribunal. I can seek assistance from anyone, government department or welfare organisation. I can make representations on behalf of a person with a disability—so this is the advocacy role. I can give advice. The most important one is to investigate any complaint or allegation that a person is under inappropriate guardianship, is being exploited, abused or in need of guardianship. I can make a report on that to the tribunal or just conduct an investigation. I can require a person, government department, public authority, service provider, institution or welfare organisation to provide information. So people must provide information to me. There are a number of others, but I guess they are kind of the key roles. So it outlines the advocacy, the information giving, the investigative roles that we have.

The Hon. MICHAEL VEITCH: The second last item you just read out sounds, to me, to be the most significant of the roles and that, in some context, requires investigation. What legislative investigative powers do you have?

Ms PEARCE: Sorry?

The Hon. MICHAEL VEITCH: What legislative investigative powers do you have?

Ms PEARCE: That is simply it there. It is referred to in the Act as "investigation", I really think of it more as to make inquiries into matters. Investigation seems to me to have a different level of powers but I can require people to provide me with information. That is the limit of it.

The Hon. MICHAEL VEITCH: My next question is a bit removed from that. I am keen to know who people appearing before the tribunal in Victoria can have with them? I think Mr Khan was also asking questions along that line. Who can appear with or for an individual who is before the tribunal in Victoria?

Ms PEARCE: They can have their own legal representation or family members. In my view they can take whoever is necessary, provided the tribunal finds that person acceptable.

Dr JOHN KAYE: Would you mind elaborating on that last phrase?

Ms PEARCE: The question is who has standing? I think the tribunal would have a very broad view as to who would have standing in guardianship matters. It might be that one might have to say why they had standing. Sometimes, for example, it might be a neighbour and the neighbour might have known the person all of their life and there is a very good reason why that person might have standing. On the other hand, there might be a reason why the neighbour might not be able to appear or should not appear. It is really a bit dependent on that.

Dr JOHN KAYE: So it is a question of standing—that is, the relationship between the individual before the tribunal and the person seeking to represent them?

Ms PEARCE: Yes.

Dr JOHN KAYE: Ensuring that that relationship is an appropriate relationship?

Ms PEARCE: Yes.

Dr JOHN KAYE: One of the complexities that comes out of the concept of assisted decision-making is where you have the assistant—that is, the person assisting the decision-making—understanding clearly a desire of the person who is being assisted but recognising in their opinion—that is, in the opinion of the person providing the assistance—that it is probably not in the person's best interest. If the Committee were to make a recommendation that spoke about assisted decision-making being inserted into the legislation in New South Wales, how do you think we should address that issue?

Ms PEARCE: Once again it goes back, I guess, to our model of supported decision-making as seeing it on a continuum. There might be some very simple decisions that people can make with the support of their family and friends but once we start getting to a higher order of decision-making that is when you want both the accountability of the advocate, or the person providing the support, as well as being assured that they have an understanding of what it is they are supporting a person to do.

Dr JOHN KAYE: How do we translate those ideas into legislation? What do we do with the conflict between the understanding of the person providing assistance of what is being requested and what is their understanding of the best interests of the person being assisted?

Ms PEARCE: I think therein is the difficulty in the notion of supported decision-making. It does not mean that we should in fact shy away from that in any shape or form but I think that is the difficulty. There has to be resources that are put in there but there also has to be that level of accountability. I think in Canada, it might be in Alberta, there are some models of what they are calling circles of support. So there are actual legal agreements between individuals about who might support a person when they lose capacity. You might want to put in place something akin to some of those. So it is a bit more inclusive than just the enduring power of attorney.

But once you start to get into that higher order of decision-making I keep coming back to: What is the accountability of the person supporting? How do we know that they are not just coercing them? That is why, in my view, in those higher order decisions the support needs to be provided by a publicly accountable organisation such as, in my case, the Office of the Public Advocate, where there is a level of scrutiny and oversight. But we would do that now. There would be many matters that we would advocate for rather than have a guardianship order. There are matters where we think the person can make the decision himself or herself. We still might be concerned about a person but we do not think it is appropriate to put restraints on their decision-making, so we might just keep a watchful eye for a period of time. If we had concerns we could go back to the tribunal.

Dr JOHN KAYE: Going to a slightly different area. Am I correct in saying that in Victoria there is a spectrum of capacity that is considered? That the law, and indeed your organisation, considers a spectrum of capacity, which is capable of varying in time, varying according to the situation and varying from individual to individual from fully capable to not at all capable, but lots of points in between?

Ms PEARCE: Yes.

Dr JOHN KAYE: How is that assessed or quantified in Victoria? How is that fed into the system? Who makes the assessment of what the range of capacities of an individual is and how do you write that down?

Professor CHAPPELL: We may be talking slightly at cross-purposes here but really to have a guardian appointed our Act says that the person must have a disability, must by reason of that disability be unable to make reasonable decisions and is in need of a decision to be made. So it is really very blunt in many ways. We do recognise, well certainly I recognise—and part of our submission to the Law Reform Commission will be around the need for us to have a better understanding of capacity—that a decision for an order for guardianship should be decision specific. For example, if a person needs a pacemaker put in, why should I assume total responsibility for all of their health care and dental care when that is really the one decision that is required to be made? So capacity should be decision specific and the tribunal should be very clear with us around what it is that we are being asked to make a decision about. So we should leave intact for the individual concerned as much autonomy in their decision-making as is possible.

Dr JOHN KAYE: Is that how the legislation in Victoria is written?

Ms PEARCE: No, it is not. That will be a matter that will be considered as part of the review and we will be making a submission to the review along those lines.

CHAIR: When is that review to take place?

Ms PEARCE: The review is currently under way. It is due to report to government in June 2011. We will have the first discussion paper out by Christmas and a second discussion paper out midway through the year. It is the major piece of work for the Law Reform Commission in the coming 12 months.

CHAIR: You indicated earlier that geographically you were in Melbourne?

Ms PEARCE: Yes.

CHAIR: Victoria, as I understand it, is a lot larger than that and you have something like 65 equivalent full-time staff, was it?

Ms PEARCE: Yes.

CHAIR: And you are hoping to go regional?

Ms PEARCE: Yes.

CHAIR: In terms of the rough issue of supply and demand, can you give us some indication as to how things stand?

Ms PEARCE: Yes. Look, while I say I have an EFT of 65, only 34 of those are guardians. The rest are made up by the advice service, our advocacy service and our community visitor program. So, when you are trying to break the 32 up into smaller units, it is not really big enough to support a regional office in and of itself, but if we were able to move regionally we would be looking at our next biggest regional city, being Geelong, and thereafter our other regional cities are probably Ballarat, Bendigo but possibly down the Gippsland area. If I break it up into smaller units it would be difficult, just too small.

CHAIR: So, in terms of your ability to cater for the demand, what would be your assessment?

Ms PEARCE: In terms of our capacity to cater for the demands for guardianship?

CHAIR: For the need out there for your services as the Victorian Public Advocate?

Ms PEARCE: As the Public Advocate or the Public Guardian?

CHAIR: Your role as both. As I understand it you are saying you are effectively Victorian Public Advocate and Guardian?

Ms PEARCE: Yes. All right, in terms of guardianship I think people in rural areas do not get to see their guardian as often as we would like. We are out on the road quite a bit. We are not a paper-based organisation where we review guardianship matters from here. We do an awful lot of travelling. We are on the road a lot but we do not see our clients in rural areas as often as we would like. In terms of the public advocacy function, because I look predominately at the systemic issues, that can be done from anywhere but if I do get a matter where an individual is concerned, we would investigate that matter either through our community visitor program or we would ask an advocate guardian to go up and look at it.

CHAIR: Do you have any involvement in powers of attorney?

Ms PEARCE: Too much. A large part of the work we do in our advice service is to provide information on powers of attorney and our community education service as well. Your colleagues in Victoria are conducting a parliamentary inquiry into our enduring powers of attorney. One of our key roles, and I had just discussed this with our Attorney the other day, is where an individual has no person that they can appoint to be their enduring power of attorney they often come to me. That is very difficult because the person wants to make provision for themselves when they no longer have capacity but have no-one they can call on. So, they call on me as the Public Advocate and that is something I cannot delegate. I do not do it for financial powers of attorney, only for medical powers of attorney and powers of guardianship, and I take it on personally, it is not something I can delegate. I have a filing drawer full of people who come to me and say, "I have no-one, will you do this for me?"

CHAIR: You are a statutory authority?

Ms PEARCE: Yes.

CHAIR: Do you have any capacity to raise revenue?

Ms PEARCE: No. Many of those who come to me have no-one and in order to get to me you have to tell me a story. I often feel it is humiliating for people to come to me and tell me they have no-one in their lives. One woman said to me would I sit with her, she had nobody when she died. She had terminal cancer. So, they are very onerous responsibilities for the Public Advocate and I have asked the Attorney could he assist in looking at, as he is doing, undertaking the review of enduring powers of attorney. There has to be someone who can do that. My office could do it but at the moment I cannot delegate that responsibility.

CHAIR: I assume you make representations on behalf of your statutory authority to, I assume, the Attorney General for resources on an intermittent basis?

Ms PEARCE: Yes.

CHAIR: Have you recently been making representations as to the current lack or otherwise of capacity?

Ms PEARCE: We have. We now have a waiting list for guardianship, which we all find very difficult to deal with. Advocacy, guardianship and investigations, we just cannot do it immediately. We talked that over with the Attorney General's office and they gave us two new guardian positions for two years, but we are really hopeful with a review of guardianship that we need to look very differently at how guardianship is undertaken in this State. Because, if you think in our case that 66 per cent of clients are over the age of 65 and with the onset of baby boomers and the rise in dementia, I keep saying that my office could be as large as Child Protection, and nobody wants that, least of all me. So I think we have to think about guardianship very differently. If we are looking at it in a rights-based framework, if we move towards saying, instead of a blunt instrument, appointments for guardianship should be decision specific, that we should move in and out as quickly as possible. We are very keen on orders that expire, so that we do not have to go back to the tribunal. I think compared to New South Wales we probably have a similar number of people under guardianship but ours are there for less time already and we are conscious that we are taking away an individual's right. So, as I said, we move in and out but we need to completely rethink it, otherwise you will have another child protection agency protecting the elderly and absolutely nobody wants something like that.

CHAIR: How long is the waiting list?

Ms PEARCE: It is around four to six weeks. With the additional two people we have made significant inroads into our guardianship orders.

The Hon. TREVOR KHAN: You referred to medical powers of attorney?

Ms PEARCE: Yes.

The Hon. TREVOR KHAN: Would you like to explain what they are?

Ms PEARCE: Yes. Victoria's power of attorney system is complicated. I am not sure what your regime in New South Wales is. Under our system we have three separate enduring powers of attorney. We have financial enduring powers of attorney under our Instruments Act. We have medical powers of attorney under the Medical Treatment Act and we have enduring powers of guardianship, which are under the Guardianship and Administration Act. Financial, that is clear and obvious. The difference between the medical treatment and the lifestyle ones can be very tricky. Obviously it is around accommodation and access to persons, guardianship, but also you can be appointed for health care. What is the difference between health care and medical treatment? That then becomes quite a difficult line. But under the medical treatment enduring powers of attorney, you can refuse treatment. You can sign a refusal of treatment certificate for matters, whereas under the enduring powers of guardianship you can only consent to treatment. It is a very complicated distinction and it is messy, and most of us do not understand what that difference is. For example, aside from the refusal of treatment certificate, physiotherapy is not a medical treatment, so that has to be under health care. Are pharmaceuticals health care or medical treatment? It might depend on what they are for. It is very messy.

The Hon. TREVOR KHAN: Notwithstanding that, I think I have a grip. Do I take it the power of attorney under the Medical Treatment Act is in a sense the equivalent of an advanced care directive?

Ms PEARCE: Yes, but only for a current condition. There is great reluctance to revisit the Medical Treatment Act, for a range of reasons.

The Hon. TREVOR KHAN: I could imagine. So, a limited form of advanced care directive was introduced but it only relates to pre-existing conditions?

Ms PEARCE: Yes. So you can only do it for a current condition.

The Hon. TREVOR KHAN: I take it a current known condition?

Ms PEARCE: Yes.

The Hon. TREVOR KHAN: I think you have already explained the enduring guardianship power of attorney?

Ms PEARCE: Yes.

The Hon. TREVOR KHAN: What Act was that under?

Ms PEARCE: Guardianship goes under the Guardianship Act. Financial is under the Instruments Act, and there is the Medical Treatment Act, which is where you get the enduring power of attorney.

The Hon. TREVOR KHAN: For each of these different styles of powers of attorney is there a prescribed form?

Ms PEARCE: Yes.

The Hon. TREVOR KHAN: Is it the same form or can it be included on the same form, or does one need three?

Ms PEARCE: I would not be recommending us as a model for anything to do with enduring powers, but no, because there are different requirements, different language, different signatures required.

The Hon. TREVOR KHAN: That is prescribed witnesses and the like, is that right?

Ms PEARCE: Yes. But we produce some material. We have a booklet we call "Take Control", which is a booklet people can read and get an understanding, and it has tear-out forms at the back. It is on our website, our "Take Control" booklet.

The Hon. TREVOR KHAN: If it is on your website we can pull it off. It is great that we know it is there.

Ms PEARCE: And we have produced what I think is a very good video that is on our website as well, which describes those enduring powers of attorney. It is only a 10-minute video.

The Hon. TREVOR KHAN: That would be excellent.

Ms PEARCE: Sorry, just one other thing on our website. We also have submissions there. One of our submissions this year was to the parliamentary inquiry into enduring powers of attorney. So, you might like to look at that and see what we have to say about our system in Victoria.

The Hon. TREVOR KHAN: That would be great. You have 32 guardians/advocates in Victoria?

Ms PEARCE: Yes.

The Hon. TREVOR KHAN: How many people—and I think the Hon. Michael Veitch asked you this question earlier—do you have the subject of orders? I am trying to work out how many people are each guardian/advocate—

Ms PEARCE: Each person carries up to 35 cases. It is slightly complicated because it takes a while to get it under your belt, so a new person might start off with a smaller number but we try to get up to 35 cases. That includes investigations. On top of that, guardians take time to spend time on our telephone advice service. They rotate through that. They are also required to do a certain number of community education sessions.

The Hon. TREVOR KHAN: If you have 32 guardians and they have up to 35, does that mean you only have 1,000 people under guardianship orders in Victoria?

Ms PEARCE: I would need to get back to you with a number but we do not have a large number. We turn them over pretty quickly.

The Hon. TREVOR KHAN: You would have to at that rate. I had the feeling that we had about 9,000 or 9,500 in New South Wales the subject of orders.

Ms PEARCE: Let me get back to you on that but that is certainly the caseload our people carry.

CHAIR: Thank you very much, we appreciate your help this afternoon.

Ms PEARCE: If somebody would like to get back to me if there is any question or material you would like, we can certainly do anything. But look on our website for the enduring powers of attorney submissions, video, booklet. There might be other things there that are helpful to you as well.

CHAIR: Jonathan and the secretariat have been writing things down. They will get back to you for additional assistance.

Ms PEARCE: Jonathan, I will get those numbers for you and get them back to you. But if there is anything else please just let me know.

(The witness withdrew)

(Short adjournment)

PAULINE MEREDITH BAGDONAVICIUS, Public Advocate, Western Australian Office of the Public Advocate, and

GILLIAN LAWSON, Manager—Guardianship, Western Australian Office of the Public Advocate, affirmed and examined by videoconference:

CHAIR: Hello and welcome to the hearing this afternoon. We appreciate your being with us and we are looking forward to hearing your evidence. Are you conversant with the terms of reference for this inquiry?

Ms BAGDONAVICIUS: We have the terms of reference in front of us.

Ms LAWSON: Yes, I am.

CHAIR: Because you are appearing by videoconference, you will not be able to request that your evidence be taken in camera and heard only by the Committee. Would you like to make a short statement before we go to questions?

Ms BAGDONAVICIUS: Yes. I have prepared an opening statement since you were particularly interested in hearing about the Community Guardianship Program, so please bear with me. The Community Guardianship Program in Western Australia was established in 2005 to provide a community-based alternative to the long-term appointment of the Public Advocate for people who have relatively straightforward guardianship needs. The focus of the program is to recruit and train volunteer guardians to provide guardianship services to people with decision-making disabilities in their own local communities.

Suitable volunteers are selected on the basis that they have a genuine commitment and ability to advocate for, and to protect the rights of, persons with a decision-making disability and they have clear national criminal record checks and sound referee checks. The program currently has 14 volunteers, eight of whom have been appointed guardians by the State Administrative Tribunal since 17 October 2007. The represented persons selected for inclusion in the program have the Public Advocate appointed as guardian as a last resort.

A number of criteria are used to determine a selected person's inclusion in the program. They are selected on the basis that they meet section 43 (1) (b) of the Guardianship and Administration Act 1990 in that there is no doubt about the person's incapacity to make reasoned lifestyle decisions. Represented persons have either a static or progressive diagnosis and there is no likelihood of their regaining capacity. At the point of matching, the represented person's requirement for guardianship is not complex and there is an absence of conflict. They have minimal or no carers, families or friends in their life and, as such, would greatly benefit from the appointment of a community guardian.

Represented persons selected for matching with a volunteer live in supported accommodation. This provides an important support structure and safeguard for both the represented person and the volunteer. At the point of matching, the program coordinator matches a volunteer with the represented person, taking into account the geographical proximity of where they both live. We supervise the initial contact and have regular contact with the supported accommodation provider as well as a volunteer over the following months.

The main role of the volunteer is to get to know the person with whom they are matched, with a view to eventually taking over as guardian from the Public Advocate, usually as a medical treatment decision maker. Another important part of their role is to act as advocate for the represented person. The extent to which they further become involved in the life of the person with a decision-making disability beyond the two roles of guardian and advocate is up to the individual volunteer.

The Public Advocate provides introductory training over two days and ongoing training twice a year, as well as social functions. We have developed a manual to provide guidance to appointed guardians, and regular newsletters update volunteers on developments as well as enable the coordinators to keep in touch with volunteers in between face-to-face meetings. Following the appointment of a community guardian by the tribunal, the coordinator contacts the guardian at least every three months during the term of the initial order to discuss how the order is progressing. Community guardians are encouraged to contact the coordinator at any time for one-to-one case consultation. The coordinator ensures service providers are aware they can also contact our office with any concerns about how the guardianship order is working.

The Public Advocate favoured a model where community guardians would be appointed in their own right here in Western Australia. This approach is consistent with our Act in which section 97 (1) (g) states that there Public Advocate should promote family and community responsibility for guardianship, and section 44 (5) states that the tribunal shall not appoint a Public Advocate as guardian unless there is no-one else suitable and willing to act. The appointment of a community guardian is a less restrictive alternative to the tribunal appointing a Public Advocate as guardian, which is considered the option of last resort.

The tribunal also has put in place a number of safeguards to protect the legal interest, the best interests, of the represented person. Initial appointments are usually heard by three members, and the first appointment of the community guardian is for one year. The tribunal has appointed community guardians for the maximum period of five years at the review hearing after the first year. At a hearing of an application for the appointment of a community guardian in December 2008, the tribunal included a direction that the community guardian report to the Public Advocate every three months on the progress of the order, and directed the Public Advocate to report to the tribunal at the review hearing in 12 months time on the progress of the order.

This is in effect formalising the Public Advocate's internal procedures which are to contact community guardians every three months and provide a recommendation at an initial review hearing as to whether the guardianship order is operating in the represented person's best interests. In addition, in the majority of hearings during this calendar year, 2009, the order has included a requirement that the guardian report three monthly to the Public Advocate or alternatively that the guardian inform the Public Advocate of any change in circumstances of the represented person, or any other reason why it would be in the represented person's best interests to have the order reviewed sooner.

In conclusion, the presence of a person in the represented person's life who is unpaid, independent, and able to focus solely on the person's best interests has led to improved advocacy and outcomes for the represented person and a decrease in social isolation. We feel that the best guardianship decisions are made for the represented person by someone who has an intimate understanding of the person and their needs. That concludes my opening statement.

CHAIR: Thank you very much for that. The Deputy Chair, the Hon. Trevor Khan, will commence questions.

The Hon. TREVOR KHAN: Because we have started on the issue of community guardians, could I ask how the program has been in operation?

Ms BAGDONAVICIUS: The program commenced in 2005 and that was in terms of developing the policies and procedures. It has been in operation since 2006 in terms of recruiting people to be those volunteers.

The Hon. TREVOR KHAN: How many community guardians have you recruited?

Ms BAGDONAVICIUS: Fourteen, and eight of those have been appointed now independently as guardians by the State Administrative Tribunal.

The Hon. TREVOR KHAN: Could you explain to me more clearly what that means? Does that mean that there are actually 22 community guardians, or does that mean that there are eight on the job?

Ms BAGDONAVICIUS: No. There are actually 14 on the job. It is just that eight are actually appointed so they are actually guardians now, and technically are independent of our office but still part of the program. As I explained in the opening statement, we are still having contact with them. The other six have been matched with represented persons and they are having contact with those people over a period of months. Then we will make a recommendation and provide a report to the State Administrative Tribunal when we think that person is ready to take on the role of guardian in their own right.

The Hon. TREVOR KHAN: What is the process for identifying and selecting the community guardians?

Ms BAGDONAVICIUS: We go through a recruitment process by advertising and also by circulating the same advertising through our networks in the disability sector, the mental health sector and the justice sector. We also have people who have come on board through word of mouth. We go through a process of advertising. There is a defined closing date. People put forward and address some criteria, and make an application to us. We go through a process of assessing them through a training session as well, and other assessments. If you want more detail on that, Gillian can speak to that, as she is the manager and is directly involved in the process.

The Hon. TREVOR KHAN: I would certainly invite any information we can get in terms of how it actually works.

Ms LAWSON: We are certainly looking for volunteers that have an interest in working with people with decision-making disabilities. We have been fortunate enough to recruit people who have had backgrounds one of which is as a social worker. A couple of them are physiotherapists. I think we even have a retired school principal and an ex-director of nursing. We have had people who have had professional backgrounds and who have come forward either because they are retired or because they still wish to supplement the work they do with having a volunteering role in someone's life. Our process is to select these people based on an assessment of their motivation to undertake this work, I guess it would be true to say.

We certainly have a rigorous process whereby, as part of the recruitment, we ask that they come along to a training session so they have a very clear idea of what the role is. At the end of the day these people are looking to become a legal decision maker with all the authority that is under a guardianship order. It is not just a volunteering role where you might stay involved with a person with a disability for, say, a couple of months or if you are a student for the summer holidays. We are asking people to make a long-term commitment to someone whom we would try and match in their locality.

The Hon. TREVOR KHAN: Perhaps this question falls outside your area and may move more into the area of policy, but I will ask it anyway. Why do you think it is appropriate to look for unpaid volunteers to perform this role as opposed to a private contractor performing the role?

Ms BAGDONAVICIUS: We have found this is a good way of engaging people from the community. Our Act is about us engaging the community on guardianship issues. I have to say to see the calibre of people who have come forward to take on the role is fantastic and their commitment to the people is great. I think that in the long term it will stand the represented person in better stead than a paid contractor who would see it as a job. I suspect once you move into the realm of paid contractors one may also move into expectations of perhaps higher numbers of people with whom people would be working. In terms of our appointment of our community guardians with the represented person, they take on the role of friendship to a great extent. In the vast majority of cases they are providing a greater level of contact than is possible by our office and certainly, I would think, by a paid contractor arrangement as well.

The Hon. TREVOR KHAN: How many people are the subject of guardianship orders in your jurisdiction?

Ms BAGDONAVICIUS: We currently have in the order of 500 people who are under guardianship of the Public Advocate. There are more people who are under guardianship in terms of family members and other individuals who have been appointed by the State Administrative Tribunal.

The Hon. TREVOR KHAN: How many people are employed in your office as guardian-advocates for those 500?

Ms BAGDONAVICIUS: We have a team of about a dozen guardians at the moment. They carry caseloads that vary between 35 and over 40. We have strategies around represented persons where there is less frequent contact required as well. We have a monitoring program in place in relation to those people.

The Hon. TREVOR KHAN: Do you have regional offices or are you based in Perth?

Ms BAGDONAVICIUS: We are based in Perth. We cover the country areas from Perth through country travel.

The Hon. MICHAEL VEITCH: Do community guardians have responsibility for financial matters?

Ms BAGDONAVICIUS: No. In Western Australia guardianship does not include financial matters. That is the appointment of an administrator. That would be covered by an administrative order.

The Hon. MICHAEL VEITCH: In relation to the Office of Public Advocate in Western Australia, what is the history that led to Western Australia having a Public Advocate and what is the actual role of the Public Advocate?

Ms BAGDONAVICIUS: The history of the office has come about through the Guardianship and Administration Act 1990, which came into effect in Western Australia in October 1992. At that time we had the powers of the Public Guardian. It was known as the Public Guardian initially. It was proclaimed in July 1992 to allow for administrative structures to be put in place before full proclamation took effect. In 1996 there were some amendments and that is when we became known as the Office of the Public Advocate. If you are interested in the history of this office I can draw your attention to the second reading speech provided on 6 June 1990 when the bill was in the Parliament. It gives you a good history as to the reasons why it came into being. The legislation was seen as reforming legislation and it brought Western Australia into line with Victoria, New South Wales and Tasmania at that time. It was the first time that we had a means for having a substitute decision maker in terms of guardianship and someone appointed to make decisions in the best interests of an adult who is unable to make reasoned decisions for themselves. Do you want me to give you more historical information in terms of why the Act was brought into play in Western Australia or do you want me to move on to what we do?

The Hon. MICHAEL VEITCH: Would you flesh out your role as Public Advocate and how that is different to a Public Guardian?

Ms BAGDONAVICIUS: There are some differences, as I understand New South Wales's responsibilities. Under our Act we have had as both the Public Guardian and the Public Advocate the role of investigating the circumstances of people with decision-making disabilities in the community and those for whom application for guardianship or administration may be made and we provide information to the State Administrative Tribunal. We make decisions where we are appointed as the guardian of last resort on behalf of people where they have been determined by the State Administrative Tribunal to require the appointment of a guardian. But we are the option of last resort. We also have a role in promoting an awareness of the Guardianship and Administration Act in Western Australia to ensure that people are aware of this legislation. With the 1996 amendments we were given an additional function, which was that the Public Advocate could provide advice to the Minister and through the Minister to the Parliament. That is seen as strengthening the systemic advocacy role of the office as well. Our office does provide individual advocacy as well as systemic advocacy.

The Hon. MICHAEL VEITCH: How is the individual advocacy role that you undertake initiated? How do you fulfil those obligations to the community?

Ms BAGDONAVICIUS: Our advocacy and investigation roles really go hand in hand. We have put in place awareness about our office. Of course, there is a need to increase awareness about our office. We are a small office but community providers across the disability, aged care and mental health sectors know about the functions of our office. They contact us if there are concerns that someone has a decision-making disability and may need some assistance. We also have inquiries come through to us from the public. We provide a telephone advisory service where we assist people in terms of enduring powers of guardianship—I meant enduring powers of attorney. Enduring powers of guardianship we will introduce very shortly once new legislation is proclaimed.

We take general inquiries from the public and service providers. If we determine that we need to investigate someone's circumstances as to whether or not they need a guardian or an administrator then we would follow that up and encourage either a service provider to make an application to the State Administrative Tribunal or we would look to do that. The bulk of our referrals come through the State Administrative Tribunal where people also make application to the State Administrative Tribunal indicating that someone needs a guardian or administrator. That State Administrative Tribunal may refer those cases to us to consider further and provide an independent report for when the matter comes before them.

The Hon. MICHAEL VEITCH: When a community member seeks to have an individual's circumstances investigated, is that a formal process or can it be done anonymously?

Ms BAGDONAVICIUS: We do get some anonymous inquiries to the office but it is always helpful for us, of course, to know who is making that concern known. We do not necessarily always share that with the person where we are conducting the investigation.

The Hon. MICHAEL VEITCH: In your opening comments you refer to the appointment of the guardian, particularly the Public Advocate being appointed as the guardian of last resort. I may have misheard you but I believe you said you were appointed when no-one else was prepared or available. Does that mean anyone in Western Australia can be a guardian?

Ms BAGDONAVICIUS: The State Administrative Tribunal makes the determination as to who is a guardian. They would be looking for someone who is suitable as well as available. Suitability is usually determined by how well they know the person because as the guardian one has to act in the best interests of someone and be informed as to what their wishes would be. Obviously with people with decision-making disability we look for evidence of how they have made their wishes known in the past. So a family member who knows a person well can certainly be considered suitable by the tribunal. We would hope that the tribunal would consider all options of family, friends or others who know the person before we are appointed. Most often where family are still involved in the life of the person with a decision-making disability we are appointed because the family is in a lot of conflict and cannot make decisions because of that.

The Hon. MICHAEL VEITCH: You referred to "the best interests". Is that defined within your legislation?

Ms BAGDONAVICIUS: Yes, it is. Gillian will get that for you and tell you exactly what it says in the legislation.

Ms LAWSON: In our Guardianship and Administration Act 1990 section 51 provides us guidance when we are guardians. It goes through the provisions how a guardian will act in the best interests of a represented person. In particular it talks about acting as an advocate for that person to encouraging the person to participate in the general life of the community. That is an inclusion-type concept. We also have to encourage and assist this person to become capable of caring for themselves and be able to make judgements for themselves. So at times we may have a person who perhaps has a resolving condition, like a stroke, and we would be working with them to see if they are gaining their capacity so they can start to make some of the decisions for themselves. Under "best interests" we also have to look at protecting the person from neglect, abuse or exploitation.

There are four more concepts. One is in consultation with the person take into account their wishes as expressed either at the time or previously. From time to time we may see people who have quite advanced conditions, perhaps dementia, and we may not be able to establish their wishes at the point of our appointment. But it may be by looking at their previous actions in their lives that we become informed as to what their wishes were. We also have the concept of being least restrictive of a person's rights and maintaining supportive relationships and, finally, maintaining the person's cultural, linguistic and religious environment. We find that most helpful as guardians looking how at any one time we would act on behalf of another. We would look to these provisions as a point of guidance in making best interests decisions.

The Hon. MICHAEL VEITCH: When you talk about the previous actions or decisions of an individual, does the "best interests" definition in the Act also include looking at documents such as a power of attorney, an enduring power of attorney and advance medical directives?

Ms BAGDONAVICIUS: Yes, it certainly does. At the moment we do not have advance health directives in law in Western Australia. I am working with the Department of Health because we soon will be introducing and proclaiming part 2 of the Acts Amendment (Consent to Medical Treatment) Act, which will bring into play the enduring powers of guardianship and advance health directives in Western Australia. Certainly where people have made express wishes, they will be taken into account. Those instruments through enduring powers of guardianship and advance health directives will assist any guardian in the future once that is enacted. We do have enduring powers of attorney but obviously they are in relation to people's financial affairs.

The Hon. MICHAEL VEITCH: Is it because you are the Public Advocate that you have a role to play?

Ms BAGDONAVICIUS: With the enduring powers of guardianship?

The Hon. MICHAEL VEITCH: Yes, and advance health directives.

Ms BAGDONAVICIUS: Yes. It has been an interesting history because the former Minister for Health who took the legislation through Parliament was the Minister for Health and the Attorney General. The legislation came about only because of a lot of interest in terms of the advance health directives. However, enduring powers of guardianship are to be introduced through that legislation. Health has a legal responsibility in informing health professionals around advance health directives and we have taken the lead in terms of informing the community around enduring powers of guardianship.

Dr JOHN KAYE: Welcome to New South Wales, at least vicariously. I put to both of you that we have had a lot of evidence that decision-making capacity should be regarded as a complete spectrum. On one end you have complete autonomy; on the other hand, you have the need for substitute decision-making. Is that the current way it is viewed in Western Australia?

Ms BAGDONAVICIUS: I think the Guardianship Administration Act certainly provides that spectrum of autonomy through to substitute decision-making. I think the legislation is clear in terms that the least restrictive principle within the legislation is a really important one. To come back to the presumption of competence really in terms of the application of the Act, everyone is presumed capable of looking after their own health and safety, making reasonable judgements, managing their own affairs unless they are shown to be otherwise.

Unless there is evidence before the tribunal who makes the decision that someone does not have that capacity, then someone is presumed to be competent. What the tribunal also looks at is they are making considerations as to whether or not a guardian or administrator is required is also they take into account the least restrictive principle. It is only if there is a decision that needs to be made and where there is a decision that needs to be made that someone will be appointed. As I indicated earlier, they will look to others in the community, particularly family, to take on the role in preference to the Public Advocate, who in terms of personal and lifestyle decision-making is appointed as the guardian.

Dr JOHN KAYE: With respect to financial decisions, one of our terms of reference goes directly to whether parts of the estate should be explicitly excluded from any order. Is that the situation in Western Australia?

Ms BAGDONAVICIUS: The situation in Western Australia is that financial matters are specific to administrative orders and our equivalent office is the Public Trustee, so the Public Trustee would be routinely appointed to manage administrative matters, have an administration order where there is not another way of doing that within the community.

Ms LAWSON: I might add in relation to your question about what part of an estate perhaps needs to be administered, it certainly is the case that our tribunal here in Western Australia will limit an administration order. If the problem the person is experiencing in relation to their money is, for instance, an inheritance of a will as opposed to management of their disability pension, the tribunal will seek to limit the order so it may be that the Public Trustee will just take over the management of the inheritance and leave them to keep managing their pension themselves. There is ability to separate out what should be in the authority of an administrator.

The Hon. TREVOR KHAN: You have given an indication of the introduction of what I think were described as advance care directives with regards to health care. Are those directives anticipated to deal with only existing conditions or existing conditions and unanticipated future medical care?

Ms BAGDONAVICIUS: I would probably prefer to take that question on notice. It would be, in general terms, about covering someone's wishes for if such and such happens into the future rather than just a condition they have at the moment. It may be wiser if I could have your question very specifically and then we can come back with a very specific response on that.

The Hon. TREVOR KHAN: That is not a problem. The question arose out of certain evidence given with regards to the Victorian circumstance. I have not heard of a limitation as we were told of today, so take that question on notice. With regards to advanced care directives, is it anticipated that if a guardianship order is made, that the guardianship order will supersede the advanced care directive?

Ms BAGDONAVICIUS: No. Where someone has made it clear what their medical treatment would be in terms of their wishes around their medical treatment—it is still current, still valid and you have a guardian who has the authority to make medical treatment decisions, it is very clear in terms of the new consent to medical treatment provisions that will come into operation that the advanced health directive is at the top of the tree, in terms of it takes precedence over all. After that it then becomes the enduring guardian or guardian, depending on the authority, and then it steps into a range of family members in terms of the consent hierarchy.

The Hon. TREVOR KHAN: With regards to an enduring guardian who has been appointed, I take it also under this new legislation, what will be the position of the role of the enduring guardian if a guardianship order is made or is that not anticipated to arise as an issue?

Ms BAGDONAVICIUS: Let me just be really clear: people will need to complete an advanced health directive—

CHAIR: You will have to repeat that?

Ms BAGDONAVICIUS: The advanced health directive and the enduring power of guardianship are two separate forms that someone would need to complete. If someone had completed an enduring power of guardianship form, the enduring guardian is seen as the person who is acting in the person's interests and unless there is some concern around how that person is operating, the State Administrative Tribunal would not be involved in that person's operation as an enduring guardian, but if another member of the family had a concern that the enduring guardian was not doing the right thing and thought someone else needed to be appointed as a guardian, then that matter would go through to the tribunal to consider.

The Hon. TREVOR KHAN: I suppose what I anticipated was that the power of enduring guardianship may be limited to certain specified areas such as nursing home care or the like. At least in New South Wales the power of enduring guardianship, as I understand, does not have to be entirely general; it can be specific with regards to certain matters. I suppose I anticipated there may be gaps in the power of enduring guardianship that may have to be filled by the appointment of a guardian by the tribunal?

Ms BAGDONAVICIUS: I think that could also happen here in Western Australia. Clearly the form that is proposed that is awaiting proclamation gives people a choice of appointing a plenary enduring guardian so they have all decision-making responsibility or, alternatively, specifying which areas. Also, there is the opportunity that they can appoint more than one person as the enduring guardian, so there can be joint enduring guardians. So it is possible that in due course you could have someone who might have only appointed an enduring guardian to make decisions, as you suggest, just in terms of their nursing home care, a choice of where they live, and they might need an order around another matter later. I am sure that the tribunal would look to who is also appointed as their enduring guardian to see if their function has been expanded because the tribunal would have the power to do that.

The Hon. TREVOR KHAN: And one would anticipate that the tribunal would be more comfortable to have the one person performing all roles rather than two people trying to mix and match?

Ms BAGDONAVICIUS: Absolutely, yes.

The Hon. TREVOR KHAN: With regards to both the advanced care directives and the powers of enduring guardianship, they are a consequence of legislation, as you have pointed out. Was there an inquiry or report that led to these legislative amendments?

Ms BAGDONAVICIUS: There was a discussion paper circulated back in 2004-05 prior to the bill being introduced into the Parliament in 2006. The bill took three years to get through the Parliament. There was quite a lot of contention and it was in fact determined by a conscience vote when it was passed in June 2008.

The Hon. TREVOR KHAN: It is somewhat out of your area but on the basis of general knowledge, I take it that it was not the powers of enduring guardianship that cause the necessity for a conscience vote?

Ms BAGDONAVICIUS: No, you are right. Enduring powers of guardianship, I think, gets a mention on one page, other than the second reading speech.

The Hon. TREVOR KHAN: And the rest was on the other issue?

Ms BAGDONAVICIUS: Yes, the advanced health directives, absolutely.

The Hon. TREVOR KHAN: I take it that the discussion paper would be available on the Western Australian parliamentary site?

Ms BAGDONAVICIUS: I do not think it is because I think it was released through the Health Department, if my memory is correct. In some ways it is a little overtaken by the debate that then happened in the Parliament but if you are interested in a copy, I could certainly arrange that for you through the Department of Health.

The Hon. TREVOR KHAN: That would be most appreciated. I am based in a relatively small city some five hours drive from Sydney and, as I am sure is the situation in Western Australia, the office responsible for guardianship orders is based in Sydney and it would seems that most communications are by telephone. Has consideration been given to the use of not for profits in the implementation of guardianship orders?

Ms BAGDONAVICIUS: Can I just make a comment? Obviously that is probably moving to the realm of a policy issue.

The Hon. TREVOR KHAN: It is; I accept that.

Ms BAGDONAVICIUS: I think it is probably best left at raising that at other levels rather than at this level. I have been the Public Advocate now for 18 months. It has not come up in my time as Public Advocate, but it is a policy issue for government.

The Hon. TREVOR KHAN: I was looking perhaps at your role as Public Advocate as to whether you have some initiating role with regards to changes in legislation that would initiate some review of legislation or the way in which things are done generally, or does that not fall within your role?

Ms BAGDONAVICIUS: The Act is going to be reviewed within the next three years once the new part 2 of the Acts Amendment (Consent to Medical Treatment) Act is proclaimed. The review of the Act does not fall into my ambit. That will actually fall within the Attorney General's portfolio.

The Hon. MICHAEL VEITCH: Earlier in response to a question you spoke about joint enduring guardians; having more than one appointed. When there is more than one enduring guardian appointed in Western Australia, are they appointed equally or does the order clarify a defined hierarchy for decisions?

Ms BAGDONAVICIUS: In terms of the enduring guardians where they are appointed jointly—and I need to be really clear that it is not proclaimed yet so it is not in operation—joint guardians will need to act unanimously and together. They clearly have to have a joined decision; they do not operate separately.

The Hon. MICHAEL VEITCH: I have a question about the United Nations Convention on the Rights of Persons with Disabilities. I have no doubt you are aware that Australia has signed up to that convention. There is a paradigms shift that comes from that, around a move from talking about people with incapacity to having capacity. That paradigm shift is quite significant in the way that legislation in Australia will be framed, I would suggest, in the future. Can you comment about that paradigms shift, as you see it? What is Western Australia doing as a government to give some weight to this new convention?

Ms BAGDONAVICIUS: I think probably there has been more discussion about this paradigm shift in the eastern States than there has been in this State to date. We have not been involved a lot in those discussions and I am also conscious that at the time that Australia ratified the United Nations convention, it did so on the basis that Australia was reasonably meeting the obligations as the ratification went forward as stated through the declaration.

In Western Australia the United Nations Convention was considered in a review of the Disability Services Act most recently. That report has been put forward to the Parliament and there are some recommendations about changing some of the principles to have more of a rights focus. That is probably as far as it has gone in terms of consideration in Western Australia. Certainly, in terms of our Act, I am sure consideration will be given to the implications when the Act is reviewed.

The Hon. MICHAEL VEITCH: With that paradigm shift you move towards a continuum of decision-making, from supported assisted and substituted decision-making as opposed to either having capacity or not having capacity.

Ms BAGDONAVICIUS: At this stage we have not had a lot of debate here about the implications of what assisted decision-making may mean for us. Certainly, I think our Act is already clear about the way in which we step through to substitute decision-making and, as I explained earlier, how the Public Advocate is appointed as a last resort and only where there is a need to have a guardian.

The Hon. MICHAEL VEITCH: With regard to having the capacity to make decisions, the assessment is made at a set time on a set day. Gillian spoke earlier about people coming out of a stroke and being in the rehabilitation process. Do the orders in Western Australia have set time frames? How do you accommodate people being able to make decisions on different days with different ability and different circumstances?

Ms LAWSON: Perhaps I could go back to the comment I was making about the notion of limited orders. Certainly when the Public Advocate is appointed it is most usual that we have a limited order; that is to say we do not have plenary authority. That means we cannot make all decisions of a personal welfare or medical nature. In relation to pinpointing where a person needs assistance, we are first and foremost guided by the authority we are given. By way of another example, we may be given only medical treatment and healthcare authority for, say, a young disabled person. Our role would be to confine our decision-making in consultation with that individual to their medical care. I put it to you that in every other aspect of their life they are receiving possibly assisted or supported decision-making from not only their families, loved ones and friends but perhaps from any support services they may be engaged with. In relation to your continuum of care, that probably is happening throughout people's lives in a natural way, if you like. There are the families and the service providers and we may be providing things like accommodation support in a group home, through to us having maybe only this limited function as a substitute decision-maker. So there is some continuum of decision-making in that example.

The Hon. MICHAEL VEITCH: On another matter, what is the complaints or grievance mechanism in Western Australia if people are under an order and are not happy about how the community guardian or the Public Guardian is managing their order or their affairs? What is the mechanism for raising complaints?

Ms LAWSON: In the Office of the Public Advocate we advise people that at all times if they have a concern about the involvement of a guardian they should in the first instance raise that complaint at that level. However, if people are still dissatisfied with the involvement of a guardian, I involve myself and the process will be that I will sit with the family members who may be distressed or concerned about the involvement of the guardian and try to resolve it at that level. Then if people are still most distressed further to a complaints resolution meeting they may in fact go to Pauline as our Public Advocate. There are also other options. People are informed of their rights to file a review of their guardianship order as an application to the State Administrative Tribunal, which will look at the decision when the Public Advocate was appointed above the family so they can have another opportunity to put their case before the tribunal. Ultimately people may go to our State Ombudsman if they believe there should be an inquiry as to the Public Advocate's involvement in their family member's affairs.

The Hon. MICHAEL VEITCH: Who can raise the complaint?

Ms LAWSON: Any party.

The Hon. MICHAEL VEITCH: It does not have to be a family member? It could be any interested community member?

Ms LAWSON: Yes, that is right. We sometimes have advocacy agency staff come to us on behalf of family members that may feel unempowered perhaps to approach us. I should perhaps also add that a person may make a complaint to the Attorney General because the Office of Public Advocate is a business area of the Attorney General. That is our Minister.

The Hon. MICHAEL VEITCH: What degree of representation can people have in that process? Obviously, they can have an advocate or a group of advocates, but is there a set of qualifications?

Ms LAWSON: Do you mean in relation to the party bringing their grievance to us?

The Hon. MICHAEL VEITCH: Yes.

Ms LAWSON: We would hope they would bring whoever they wished to any grievance meeting at any level. Some people bring an outside advocate from the disability agency and some people will bring a lawyer. All of those are most welcome. We would not preclude anyone's attendance.

The Hon. MICHAEL VEITCH: We cannot have lawyers getting more involved in things!

The Hon. TREVOR KHAN: Returning to the community guardian issue, at the moment essentially you have 14 of them. Are any of those community guardians currently appointed, and I accept that six are to be matched in a formal sense, looking after more than one person?

Ms BAGDONAVICIUS: No.

The Hon. TREVOR KHAN: On my maths, if we put them all into a placement that will mean that something in the order of 3 per cent of people under guardianship orders are covered by the community guardian program. Would that be about right?

Ms BAGDONAVICIUS: At this stage there are only 14 represented persons of the 500 or so people for whom I am appointed currently.

The Hon. TREVOR KHAN: Sure. What I am getting at is this: Where do you see the program going in terms of numbers?

Ms BAGDONAVICIUS: I think this program is not so much around an efficiency program but a quality of life program for the represented person. It is building here in Western Australia with slow momentum. We will go out and do another recruitment over the next year, we expect, and it would really depend on the numbers of people who come forward as to how many people are matched. At the end of the day this program is not about huge cost savings in that sense of the word. It is a program where the represented person is very isolated and does not usually have anyone else in their lives other than their service provider who is providing accommodation for them day in, day out. It makes a huge difference to these people in the sense that they have someone who is taking a direct interest in their life in the way that other people in those facilities have family and friends taking such an interest in them. I do not think our numbers are going to grow enormously because there is a lot of work involved in providing this program. There is a lot of monitoring and a lot of work in terms of preparing reports for the tribunal. The tribunal hears matters after the first 12 months and then the guardians are appointed for up to the five-year maximum period. We will be providing reports back to the tribunal and we will also be providing ongoing training. To date all of our community guardians, be they appointed by the tribunal or still in the matching, getting to know you phase, are all participating in training.

The Hon. TREVOR KHAN: I think you misconceived the purpose of my question. It is not to suggest that this was a cost-saving mechanism. It was directed towards what you said, that it is labour intensive to put a program such as this into operation. In a sense I ask again how far you see you will be capable of rolling this out, taking into account that it is demanding on your office in terms of achieving what seems self-evidently to be a very admirable and effective program?

Ms BAGDONAVICIUS: I do not think it is possible to set a target of X number of people at this point. We have one full-time position that is being job shared and it depends on their capacity. Over the last year one of our part-time coordinators has been on maternity leave and one part-time coordinator has been running with the program. From next year we anticipate we will be back to having two part-time people providing this program and that will give us greater capacity. As I say, it is very difficult to quantify exactly what our ceiling will be at this stage.

The Hon. MICHAEL VEITCH: Can I follow up the community guardian program? What level of training is provided to an individual prior to going through the matching process?

Ms LAWSON: As I think we touched upon earlier, we have had a number of people come forward who already have a great deal of expertise in the background, albeit aged care, disability or mental health, so most of our volunteers are coming to the table with a lot of the pre-requisite skills—communication skills, good interpersonal skills, understanding of the stakeholders in our areas of disability and health. The training we do is that initially, once they have got through our fairly exhaustive selection process, they come to a two-day training session. It is not optional, it is mandatory and if they do not turn up they will be off the program. In that program we go through our legislation so they get an understanding of what a statutory guardian's role is. In particular, we look at the decisions they are likely to have to make should they become at some point a legally appointed guardian. We actually work with them and use case studies to go through how one would make a medical treatment decision and the processes that are involved in that. We may take them through the fact that they should be working closely with the person they represent, first and foremost; that they should be liaising with anyone who has a close and personal relationship with them to find out their views; talk to doctors and specialists and so on.

We are giving guidance as to any aspect of the role that they will have to undertake later on as a legally appointed guardian. In that early stage they are also being exposed, in a way, to each other. We are getting the volunteers to come together as a group. They take natural support from each other as well as from our coordinator. They start to build confidence about understanding the range of disabilities. We will differentiate out, if they do not have that awareness, what a person with an intellectual disability might present like versus someone with a mental illness. We are talking around the presentation of a person who may have impaired decision-making, how to approach them, how to communicate with them and ultimately talking about all those things we mentioned earlier about best interest decision-making and what that means. There is also a lot of administration-type work in the training program, talking about issues to do with confidentiality of information, telling them about their entitlement to reimbursements, our insurance cover and things of that nature.

CHAIR: We are out of time. We very much appreciate your assistance this afternoon. Would you like to make any closing comments?

Ms BAGDONAVICIUS: Can I clarify whether you will be sending through the questions to us? I think there were two.

CHAIR: The secretariat will send any questions we have through to you in the next couple of days. There will be details of questions so you will not need to rely on any notes.

Ms BAGDONAVICIUS: Thank you.

CHAIR: Thank you very much for your help this afternoon. It is appreciated.

(The witnesses withdrew)

(The Committee adjourned at 4.43 p.m.)