Review of the *Guardianship and Administration Act 1995* (Tas)
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Information about the Tasmania Law Reform Institute

The Tasmania Law Reform Institute was established on 23 July 2001 by agreement between the Government of the State of Tasmania, the University of Tasmania and the Law Society of Tasmania. The creation of the Institute was part of a Partnership Agreement between the University and the State Government signed in 2000. The Institute is based at the Sandy Bay campus of the University of Tasmania within the Faculty of Law. The Institute undertakes law reform work and research on topics proposed by the government, the community, the University and the Institute itself.

The work of the Institute involves the review of laws with a view to:

- the modernisation of the law
- the elimination of defects in the law
- the simplification of the law
- the consolidation of any laws
- the repeal of laws that are obsolete or unnecessary
- uniformity between laws of other states and the Commonwealth.

The Institute’s Director is Associate Professor Terese Henning. The members of the Board of the Institute are Associate Professor Terese Henning (Chair), Professor Tim McCormack (Dean of the Faculty of Law at the University of Tasmania), the Honourable Justice Helen Wood (appointed by the Honourable Chief Justice of Tasmania), Ms Kristy Bourne (appointed by the Attorney-General), Dr Jeremy Prichard (appointed by the Council of the University), Mr Craig Mackie (nominated by the Tasmanian Bar Association), Ms Ann Hughes (appointed at the invitation of the Institute Board), Mr Rohan Foon (appointed by the Law Society of Tasmania), Ms Kim Baumeler (appointed at the invitation of the Institute Board) and Ms Rosie Smith (appointed at the invitation of the Institute Board as a member of the Tasmanian Aboriginal community).

The Board oversees the Institute’s research, considering each reference before it is accepted, and approving publications before their release.

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The Final Report is available at the Institute’s website at <http://www.utas.edu.au/law-reform/> or can be sent to you by mail or email.
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This study has been approved by the Tasmanian Social Sciences Human Research Ethics Committee. If you have concerns or complaints about the conduct of this study, please contact the Executive Officer of the HREC (Tasmania) Network on +61 3 6226 6254 or email human.ethics@utas.edu.au. The Executive Officer is the person nominated to receive complaints from research participants. Please quote ethics reference number [H0016752].
List of abbreviations:

ACD — advance care directive

ACTLRAC — Australian Capital Territory Law Reform Advisory Council

ADR — alternative dispute resolution

ADR Act — Alternative Dispute Resolution Act 2001 (Tas)

AGAC — Australian Guardianship and Administration Council

ALRC — Australian Law Reform Commission

CAG — Council of Attorneys-General

COTA — Council on the Ageing Tasmania

CRPD — Convention on the Rights of Persons with Disabilities

DHHS — Department of Health and Human Services

EOT — Equal Opportunity Tasmania

GAB — Guardianship and Administration Board

GBE — government business enterprise

HCPR — health care professional report

MHT — Mental Health Tribunal

MIGA — Medical Insurance Group Australia

NDIS — National Disability Insurance Scheme

NDS — National Disability Services

NSWLRC — New South Wales Law Reform Commission

OPCAT — Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

OPG — Office of the Public Guardian

OPMHS — Older Persons Mental Health Services

PCT — Palliative Care Tasmania

PRP — proposed represented person

PT — The Public Trustee

PTG — Public Trustee and Guardian

QLRC — Queensland Law Reform Commission

RFC — Roy Fagan Centre

RHH — Royal Hobart Hospital

RP — represented person

TASCAT — mooted Civil and Administrative Tribunal for Tasmania

The Act — Guardianship and Administration Act 1995 (Tas)

The Board — Guardianship and Administration Board

The Convention — Convention on the Rights of Persons with Disabilities

THS — Tasmania Health Service

VLRC — Victorian Law Reform Commission
Executive Summary

This Report evaluates the *Guardianship and Administration Act 1995 (Tas)* (the ‘Act’) against the human rights articulated in the United Nations *Convention on the Rights of Persons with Disabilities* (the ‘Convention’). The Convention enshrines the rights of people with disability, including the equal right to make one’s own decisions and for decisions about a person’s life to reflect their will, preferences and rights. Part 2 explains the relevance of international law obligations upon the operation of the Act along with other relevant developments to the legislative, policy and social landscape.

It is a testament to the creators of the Act that it has remained in force for over 20 years without substantial amendment. In fact, some of the recommendations made throughout this Report are intended as refinements to the existing legislative provisions, rather than proposing substantial reforms. Other recommendations do, however, propose more significant changes to the way that the Act provides for decisions to be made for Tasmanians requiring support with decision-making. Part 18 explains which category each recommendation fits within, and provides a suggested roadmap for legislative reform.

Part 3 of this Report recommends revision to the guiding principles of the Act to instil the principles and obligations of the Convention. Whilst the Act currently requires a person’s wishes to be carried into effect where possible, and for a least restrictive alternative to be adopted, it has been concluded that the present formulation does not give sufficient emphasis to the need for decisions to be based upon a person’s will, preferences and rights, as the Convention requires. This reflects a shift from a paternalistic ‘best interests’ approach to representative decision-making. To simplify language, and to enhance community understanding of what this means in practice, the Institute proposes that the Act incorporate a practical, step-by-step Decision-Making Process to achieve decisions based upon a person’s ‘views, wishes, and preferences.’ The Decision-Making Process, which is outlined in Part 11, permits only limited circumstances where a person’s views, wishes and preferences may not be adopted. Where this is done, however, the Decision-Making Process continues to require a person’s views, wishes and preferences to be advanced to the greatest extent possible.

Secondly, it is proposed that the scope of the Act’s jurisdiction be revised. The Act presently enables decisions to be made for individuals with disability who, because of disability, are unable to make a reasonable judgment about their personal or financial matters. This Report recommends that the Act no longer require it to be established that a person has a disability. Instead, it is proposed that the Act apply to people who are unable to understand, retain, use or weigh information relevant to a decision, or communicate a decision. Removal of the precondition for a disability promotes the equal rights of people with disability and removes the unequal treatment that people with disability are currently subject to under the Act. These reforms are discussed in Part 6.

Thirdly, the report makes a range of recommendations about how the Act can better promote access to quality, effective support with decision-making, consistent with obligations under the Convention. Whilst implicitly the Act already acknowledges the role that support can play with decision-making, including via the principle of adopting the least restrictive alternative, it has been concluded that more needs to be done. Reforms proposed aim to better acknowledge, foster and promote the use of support to make decisions to maximise a person’s autonomy and promote a will, preferences and rights approach to decision-making for people requiring support. This Report recommends that a person not be deemed unable to make their own decisions if they could make a decision with support and that a demonstrated effort to offer individuals decision-making support be required before consideration of the need for a representative decision.
As part of strengthening and advancing the use of decision-making support, Part 7 of this Report recommends that Tasmania adopt a legislative framework of supported decision-making. This approach acknowledges the reality that people often make decisions with some level of support and validates decision-making processes that utilise support. It provides another alternative before the making of a representative decision, with the aim that representatives are utilised only as a last resort. These reforms will authorise and enable the provision of support where requested, without removing the decision-making rights of the individual to make their own decision. It will require quality, accessible decision-making supports to be made available for Tasmanians on an equitable basis. This is likely to particularly benefit members of the community who do not have individuals within existing social networks from which to draw decision-making support.

One of the ways that individuals can be supported to make their own decisions is to record those decisions in advance in a form that they can have confidence will be respected. Parts 4 and 5 consider the legislative framework surrounding how individuals can record their decisions in advance, including exercising choice by deciding who they wish to act as their representative if required and any terms of those appointments. These provisions are considered fundamental to ensuring that people retain maximum control of decisions affecting their lives. As part of supporting people to make their own decisions, Part 5 recommends that Tasmania adopt a legislative framework for the creation and use of advance care directives (ACDs) to record in advance their directions about future health care and treatment. Although the role and use of ACDs is already recognised in Tasmania at common law, the Institute has concluded that codification of the common law is both necessary and desirable to better promote the preparation and use of ACDs, and to reduce or eliminate the need for a representative decision.

Where it is determined that individuals require a greater level of support via the appointment of a representative, this Report proposes a raft of reforms to provide a rights-based approach to representative decision-making so that representatives only act where needed, and only for as long as needed. This includes better articulating the duties of representatives. These reforms are discussed in Part 8 (Representative Decision-Making), Part 9 (Powers and Functions of Guardians), and Part 10 (Powers and Functions of Administrators).

This Report makes several recommendations that reflect obligations under the Convention to ensure that any interventions for people requiring decision-making support are subject to appropriate safeguards. Many of these safeguards are preventative as they aim to promote the rights and interests of people subject to the Act and prevent abuse or misuse of powers. These include recommendations to strengthen the role and functioning of the Guardianship and Administration Board (the Board) (discussed in Part 15) and Public Guardian (Part 16). One reform proposed includes an increasing role and use of alternative dispute resolution as a means of resolving issues collaboratively, efficiently and without the need for a representative decision. Part 14 also makes recommendations to enhance the Board’s accountability by ensuring that avenues to appeal Board decisions are appropriate and accessible. Other safeguarding strategies put forward include ensuring that the law is accessible and that processes are adequately responsive, as discussed in Part 18.

Safeguards for representative decision-making are explored in Part 12, with safeguards relating to consent to health care and treatment dealt with in Part 14. Whilst at first glance some of these proposals may appear insignificant, they are individually and collectively expected to provide substantial improvements to the Act’s existing safeguards. In particular, it is proposed that the Public Guardian and the Board have strengthened powers to investigate and respond to circumstances where representatives act contrary to the Act.

As part of conducting its review, the Institute has identified several matters falling outside of the scope of this project but which are suggested are of significance and ought to be investigated.
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separately. These include: the desirability of considering separately the provisions of the *Powers of Attorney Act 2000* (Tas) and the utility of the legislative framework enabling individuals to appoint attorneys and enduring guardians within a single document (Parts 4 and 17); evaluating the merits of enacting adult safeguarding legislation in Tasmania (Part 12); and the need for review of the way in which the use of restrictive practices are regulated in Tasmania (Part 17). Part 18 also explains other developments occurring at both a state and federal level under the National Disability Strategy and the State Government’s Disability Framework for Action that will likely impact the operation of the Act and result in the need for further legislative reform to the Act. This includes developments following full implementation of the National Disability Insurance Scheme (NDIS) in Tasmania in July 2019, and consequential reforms expected to the *Disability Services Act 2011* (Tas). These legislative and policy developments reflect an increasing recognition of the rights of people with disability including the right to exercise choice and control, and to participate fully in the community.
List of Recommendations

Part 3: Guiding Principles of the Act

Recommendation 3.1

That the ALRC’s National Decision-Making Principles guide reform to the Act:

(1) That all adults have an equal right to make decisions that affect their lives and to have those decisions respected.

(2) People who require support in decision-making must be provided with access to the support necessary for them to make, communicate and participate in decisions that affect their lives.

(3) Decisions that affect a person’s life must be directed by the person’s will, preferences and rights.

(4) Laws and legal frameworks must contain appropriate and effective safeguards in relation to interventions for people who may require decision-making support, including to prevent abuse and undue influence.

Recommendation 3.2

That the principles of the Convention be included in the Act. These principles are:

(a) there must be respect for the inherent dignity of persons with disability and their individual autonomy including the freedom to make one’s own choices, and their right to independence;

(b) persons with disability are not to be discriminated against;

(c) persons with disability are to be given the opportunity for full and effective participation and inclusion in society;

(d) there must be respect for difference and acceptance of persons with disability as part of human diversity and humanity;

(e) people with disability must have equality of opportunity;

(f) services are to be as physically and technologically accessible as possible to persons with disability;

(g) equality between men and women is to be promoted; and

(h) respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

Recommendation 3.3

That the guiding principles of the Act include:

- people who require support in decision-making must be provided with access to the most effective support necessary for them to make, communicate and participate in decisions that affect their lives;

- the views, wishes, preferences and rights of persons who may require decision-making support must direct decisions that affect their lives;
• the role of families, carers and other significant persons in an adult’s life to support the adult to make decisions must be acknowledged and respected; and

• a function or power conferred, or duty imposed, by this Act is to be performed so that the means that are the least restrictive of the person’s freedom of decision and action as possible in the circumstances is adopted.

Recommendation 3.4
That the guiding principles of the Act apply to any person assisting someone or making a decision for a person informally.

Recommendation 3.5
That all members of the community be encouraged to uphold and promote the Act’s guiding principles.

Part 4: Own Appointment of a Representative: Appointments of Enduring Guardians

Recommendation 4.1
That the statutory framework retain separate representatives for financial decisions and personal matters.

Recommendation 4.2
(1) That the State Government investigate community and stakeholder support for the introduction of a single enduring document in Tasmania enabling the appointment of representatives for both financial and personal matters.

(2) That if a model enduring document is agreed nationally, consideration is given to adopting the model form.

Recommendation 4.3
That a person aged 16 years and older be eligible to be appointed as an enduring guardian but that an enduring guardian not be permitted to act until they attain the age of 18 years.

Recommendation 4.4
That any person who is directly or indirectly responsible for the health care or treatment, support services or accommodation of the donor in a professional or administrative capacity also be ineligible to be the donor’s enduring guardian under s 32(4) of the Act.

Recommendation 4.5
That a donor be able to appoint the Public Guardian as an enduring guardian.

Recommendation 4.6
That s 32A(2) of the Act confirm that an alternative enduring guardian has the functions of the enduring guardian not only upon the absence or incapacity of the enduring guardian, but also upon the death or resignation of the enduring guardian.
Recommendation 4.7

(1) That the Act enable a third party to execute an instrument or revocation of instrument on behalf of the donor, at the donor’s direction. The third party should be an adult and not an enduring guardian or witness to the instrument.

(2) That the Act require interpreters to certify on an instrument or revocation of instrument that they are not aware of anything that causes them to believe that the donor does not understand the nature and effect of the instrument or revocation of instrument.

Recommendation 4.8

That the standard form instrument (form 1) and revocation of instrument (form 2) require witnesses to certify that:

(a) they are not aware of anything that causes them to believe that the donor did not sign freely or did not understand the instrument or revocation of instrument;

(b) the donor signed in their presence; and

(c) the donor is who they purport to be.

Recommendation 4.9

(1) That ss 32(2)(c) and 33(2)(b) of the Act be revised to provide that a party and ‘close relative of a party’ are ineligible to act as a witness to an instrument or revocation of instrument.

(2) That the phrase ‘close relative’ be defined consistently with s 3(1) of the Powers of Attorney Act 2000 (Tas).

(3) That witnesses to instruments and revocations of instruments be required to declare that they are not a party to the instrument or a close relative of a party and that the term ‘close relative’ be explained on the standard form instrument (form 1) and revocation of instrument (form 2).

(4) That the Act provide an equivalent fine to that contained in s 9(7) of the Powers of Attorney Act 2000 (Tas) for a person who is a party to an instrument or who knows he or she is a close relative of a party to an instrument acting as a witness to the signature of the donor, or initialling by the donor of an alteration of an instrument.

(5) That any alteration of an instrument need to be initialled by the donor and the enduring guardian, with the donor’s initialling of the alteration to be witnessed by two adult witnesses who are not a party to the instrument or close relative of a party, with those witnesses able to be the same, or different, to the witnesses to the instrument.

Recommendation 4.10

That, when signing an instrument to accept the role of enduring guardian, an enduring guardian be required to declare that they:

- are eligible to act;
- understand their obligations;
- understand the consequences of failing to comply with their obligations;
- undertake to act in accordance with the Act; and
- have read and understood any advance care directive of the donor.
Recommendation 4.11

(1) That comparative powers be given to the Registrar of the Board in relation to the registration of instruments as are provided to the Recorder of Titles under s 11 of the Powers of Attorney Act 2000 (Tas), with the exception that the Registrar not be permitted to retain any portion of the registration fee upon refusing to register an instrument.

(2) That the Board be able to declare an instrument valid despite it not complying with the formal requirements of the Act.

Recommendation 4.12

(1) That a donor be able to revoke an instrument using a form ‘to similar effect’ to the standard form revocation of instrument (form 2) included in the Act.

(2) That an equivalent provision to s 32AE(1) of the Powers of Attorney Act 2000 (Tas) be included in the Act, enabling a donor to revoke an instrument by giving notice to the enduring guardian(s).

(3) That donors be required to take reasonable steps to give notice to their enduring guardian(s) of the revocation of their appointment. Failure to give notice should not invalidate the revocation.

Recommendation 4.13

(1) That the Act confirm that an instrument is revoked on the death of the donor.

(2) That the Act provide that the authority of an enduring guardian is suspended at any time that the enduring guardian does not have decision-making ability to act as the enduring guardian.

Recommendation 4.14

That, if s 32AE(3) of the Powers of Attorney Act 2000 (Tas) remains, it be revised to:

(a) enable a donor to negate the automatic revocation of their enduring power of attorney upon the ending of their marriage or registered personal relationship in their enduring power of attorney; and

(b) provide that only the appointment of the attorney who was party to a marriage or registered personal relationship with the donor is revoked upon the ending of their marriage or personal relationship without revoking the entire document, to the extent that it appoints a substitute or joint attorney (where their appointment was expressed to be joint and several).

Recommendation 4.15

That an enduring guardian be able to resign by completing and registering a standard form to be included in the Act, or by using a form to similar effect. The enduring guardian should then be required to take reasonable steps to advise the donor and any other appointed enduring guardian of that resignation.

Recommendation 4.16

(1) That there not be a registration fee payable on the registration of an instrument, but that the Registrar have discretion to impose a registration fee where more than one instrument is registered for a person in a calendar year.

(2) That there not be a fee for the registration of a revocation of instrument.
**Recommendation 4.17**

(1) That the Board be properly resourced to develop an online search function to search the register of instruments.

(2) That there be no search fee payable to search the register of instruments.

(3) That consideration be given to establishing a single repository for the registration of enduring powers of attorney, instruments and advance care directives.

**Recommendation 4.18**

That the Act state that the authority of a Board-appointed guardian takes priority over the authority of an enduring guardian to the extent that the same functions are conferred upon both.

**Part 5: Making Decisions in Advance – Advance Care Directives**

**Recommendation 5.1**

(1) That Tasmania adopt a legislative framework for advance care directives.

(2) That the legislative framework for advance care directives be included in the Act.

**Recommendation 5.2**

That the Act not preclude children with decision-making ability making an advance care directive.

**Recommendation 5.3**

(1) That the Act confirm that an advance care directive is not invalid merely because it does not possess certain formal characteristics.

(2) That legislation contemplate a person making a valid advance care directive orally.

**Recommendation 5.4**

(1) That witnessing requirements for a written advance care directive be consistent with requirements for instruments.

(2) That the Board be able to declare an advance care directive valid despite any non-compliance with formal requirements.

**Recommendation 5.5**

(1) That a form advance care directive be included in a Schedule to the Act but that use of this form not be mandatory.

(2) That there is strong community and stakeholder engagement and consultation in relation to the development of the form advance care directive including consumer, medical and legal input.

**Recommendation 5.6**

(1) That an advance care directive or instrument not be permitted to contain directions that:

- are unlawful;
- would require an unlawful act to be performed;
• would result in a health practitioner breaching a professional standard or code of conduct; or
• relate to mandatory treatment, for example under the Mental Health Act 2013 (Tas).

Any directions of this type should be void and of no effect.

(2) That legislation clarify that a direction in an advance care directive or instrument cannot compel a health practitioner to perform a particular form of health care and treatment other than the withdrawal or withholding of health care and treatment.

(3) That legislation confirm that a direction amounting to a refusal of health care and treatment is binding if:
• it was made voluntarily by a person with decision-making ability to make the directive;
• it is clear and unambiguous; and
• it extends to the situation at hand.

(4) That the Act confirm that a directive in these circumstances has the same effect as if the person made the decision whilst they had the decision-making ability to do so.

(5) That health practitioners be able to refuse to comply with a binding direction in an advance care directive if they believe on reasonable grounds that it does not reflect the current wishes of the person.

Recommendation 5.7

(1) That the Public Guardian have power to mediate matters and attempt to resolve disputes in relation to advance care directives and instruments, broadly consistent with ss 45(1)–(4) of the Advance Care Directives Act 2013 (SA).

(2) That if the Public Guardian is not able to resolve a matter, or it considers it more appropriate that the matter is determined by the Board, that the Public Guardian be able to refer a matter to the Board for determination.

(3) That the Board have power to give advice and directions and make declarations to resolve disputes relating to advance care directives.

Recommendation 5.8

That there be an express duty upon enduring guardians, guardians and health practitioners to give as much effect as possible to the advance care directive of a person without decision-making ability to consent to a particular health care and treatment decision.

Recommendation 5.9

(1) That the Act provide that, except in relation to urgent health care and treatment, before administering health care and treatment to a person who does not have decision-making ability to give consent to that health care or treatment, health professionals must make reasonable efforts in the circumstances to ascertain whether that patient has either or both an advance care directive or instrument.

(2) That the Act provide a duty upon prescribed health facilities (to be defined in the Regulations) to make reasonable enquiries to ascertain whether a patient in their facility has either or both an
advance care directive or instrument and, if so, ensure a copy is placed with the patient’s clinical records.

(3) That guardians have a duty to make reasonable enquiries to ascertain whether a represented person has an advance care directive.

**Recommendation 5.10**

(1) That the Act provide for the registration of advance care directives.

(2) That failure to register an advance care directive not affect the validity of the document.

(3) That there not be a registration fee payable on the registration of an advance care directive, but that the Registrar be given a discretion to impose a registration fee where more than one advance care directive is registered for a person in a calendar year.

(4) That there not be a fee for the registration of a revocation of advance care directive.

(5) That an online search function be developed to search the register of advance care directives.

(6) That there not be a search fee to search the register of advance care directives.

(7) That the State Government work with other state and territory governments to develop a national repository for advance care directives.

**Part 6: Decision-Making Ability**

**Recommendation 6.1**

That the test that assesses a person’s ability to make decisions for the purposes of the Act not require the person to have a disability.

**Recommendation 6.2**

That, where necessary, the Convention definition of ‘disability’ be used in the Act.

**Recommendation 6.3**

(1) That the Act adopt the term ‘decision-making ability’ when referring to a person’s ability to make decisions or give consent.

(2) That the definition of ‘decision-making ability’ be consistent with the definition of ‘decision-making capacity’ contained in s 7(1)(b) of the *Mental Health Act 2013* (Tas) which provides that an adult is taken to have the ability to make a decision unless a person or body considering that capacity is satisfied that they are unable to understand information relevant to the decision, retain information relevant to the decision, use or weigh information relevant to the decision, or communicate the decision (whether by speech, gesture or other means).

(3) That ‘information relevant to a decision’ be defined consistently with s 7(1)(d) of the *Mental Health Act 2013* (Tas) to include information on the consequences of:

- making the decision one way or the other; and
- deferring the making of the decision; and
- failing to make the decision.

(4) That the Act refer to a person’s decision-making ‘ability’ rather than ‘capacity.’
Recommendation 6.4

(1) That the definition of decision-making ability provide that a person has decision-making ability if they are able to make a decision with practicable and appropriate support.

(2) That the Act provide that it may not be determined that a person does not have decision-making ability unless all practicable steps have been taken to provide the person with appropriate support to make and communicate a decision.

Recommendation 6.5

That the definition of ‘decision-making ability’ in the Act adopt equivalent provisions to s 7(3) of the Mental Health Act 2013 (Tas), which confirm that:

(a) a person may be taken to understand information relevant to a decision if it reasonably appears that he or she is able to understand an explanation of the nature and consequences of the decision given in a way that is appropriate to his or her circumstances (whether by words, signs or other means); and

(b) a person may be taken to be able to retain information relevant to a decision even if he or she may only be able to retain the information briefly.

Recommendation 6.6

(1) That the Act require a donor to have decision-making ability to make and revoke an instrument.

(2) That the Act outline what ‘information relevant to a decision’ includes in relation to a donor’s decision-making ability to make or revoke an instrument.

Recommendation 6.7

(1) That any person with decision-making ability to make an advance care directive be able to make an advance care directive.

(2) That the Act acknowledge that a person’s decision-making ability should be assessed in relation to each directive or statement in an advance care directive.

Recommendation 6.8

That the Act list factors that must not, by themselves, result in an assumption that a person does not have decision-making ability. These should include:

- where a person makes a decision that is, in the opinion of others, unwise;
- where a decision results, or may result, in an adverse outcome for the person;
- where a person does not have a particular level of literacy or education;
- where a person engages in particular cultural, political or religious practices; and
- assumptions because of a person’s age.

Recommendation 6.9

That the Act require a person assessing a person’s decision-making ability to take reasonable steps to conduct the assessment at a time, and in an environment in which, the person’s ability can be most accurately assessed.
Recommendation 6.10
That the Regulations exclude health practitioners submitting a report that deals with the decision-making ability of a close relative (defined in accordance with Recommendation 4.9(2)) for the purposes of regs 4 and 8.

Recommendation 6.11
That the Act create an offence where a person intentionally or recklessly obstructs another person undergoing an assessment of their decision-making ability for the purpose of the Act, without reasonable excuse.

Part 7: Supported Decision-Making

Recommendation 7.1
That an adequately funded public education program be developed and delivered to ensure that Tasmanians understand the rights of people with disability articulated in the Convention on the Rights of Persons with Disabilities, including the need to provide adults requiring support with decision-making with access to the support they may require to make and implement decisions about matters affecting their lives and the duties of individuals who provide that support.

Recommendation 7.2
That adequately funded decision-making support programs be developed, ensuring equity of access.

Recommendation 7.3
That the standard Board application forms ask specifically about the informal decision-making supports that have been offered to a proposed represented person and/or attempted prior to the making of the application.

Recommendation 7.4
(1) That the Act provide that a donor may specify in an instrument a time from which, a circumstance in which or an occasion on which the authority for all matters or the authority for a specified matter under the instrument is exercisable, which may be:
   • immediately on the making of the instrument; or
   • when the donor ceases to have decision-making ability for the matters or matter; or
   • any other time, circumstance or occasion.
(2) That the standard form instrument provide guidance to donors about their options to nominate when the authority of their enduring guardian is to commence.

Recommendation 7.5
(1) That a legislated supported decision-making scheme be introduced in Tasmania.
(2) That, as part of introducing legislative reforms to establish a supported decision-making scheme, the Act be renamed to reflect the new framework.
(3) That legislative reform to establish a formal supported decision-making scheme be supported by an appropriate lead-time incorporating a comprehensive public education campaign explaining the reforms, emphasising that the scheme is intended to complement not replace existing informal support arrangements.

Recommendation 7.6
That a legislated supported decision-making scheme be available for personal matters, including consent to health care and treatment.

Recommendation 7.7
(1) That legislation enable an individual to appoint their own supporter for personal matters including consent to health care and treatment.

(2) That, to appoint a supporter, an individual needs ‘decision-making ability’ to appoint a supporter.

Recommendation 7.8
(1) That legislation enable the Board to appoint supporters for personal matters, including consent to health care and treatment.

(2) That the Board not be permitted to appoint a supporter where the proposed supported person objects to that appointment.

Recommendation 7.9
That legislation contain the following safeguarding provisions in relation to supporters:

(a) that there be a clear description of a supporter’s role. Subject to the terms of their appointment, and the directions of a supported person or the Board, a supporter’s role should include:

- to obtain and disclose personal and other information on behalf of the supported person relevant to a decision;
- to assist the supported person to understand information relevant to a decision;
- to provide advice to the supported person about a decision;
- to assist the supported person to communicate their decision; and
- to endeavour to ensure the decisions of the supported person are given effect.

(b) That legislation state explicitly that a supporter cannot make decisions on behalf of a supported person.

(c) That supporters only be permitted to act during periods in which the supported person has decision-making ability for the relevant matter.

(d) That supporters be required to comply with the duties outlined in Recommendation 8.3(2).

(e) That a supported person be able to direct their supporter to report to a person or body when they are acting as supporter.

(f) That a person be able to revoke their own appointment of a supporter.
(g) That the Board be able to revoke the appointment of a supporter in defined circumstances, broadly consistent with the test to revoke a representative.

(h) That supporters have a duty to notify the Board if they consider that the test for the appointment of a representative may be satisfied.

**Recommendation 7.10**

That Recommendation 5.7 (providing a mediation role for the Public Guardian) be extended to supporters.

**Part 8: Representative Decision-Making**

**Recommendation 8.1**

(1) That the test to appoint a representative require the Board to be satisfied that:

- (a) the proposed represented person does not have decision-making ability in relation to one or more personal matters (in the case of a guardianship order) or financial matters (in the case of an administration order);
- (b) the proposed represented person is in need of a guardian or administrator; and
- (c) the guardianship order or administration order will promote the proposed represented person’s personal and social wellbeing.

(2) That, when considering whether there is a need for a representative, the Board be required to consider:

- (a) the values, wishes and preferences of the proposed represented person;
- (b) whether the needs of the proposed represented person could be met by other means less restrictive of that person’s freedom of decision and action, including whether the need could be met by informal means, through negotiation, mediation or similar means, or in the case of a guardianship order, through the appointment of a supporter;
- (c) the wishes of any primary carer or close relative of the proposed represented person or other person with a direct interest in the application; and
- (d) the desirability of preserving existing relationships that are important to the proposed represented person.

**Recommendation 8.2**

That, when conferring authority upon a representative, the Board need to be satisfied that the test for the appointment of a representative is satisfied in relation to each function conferred.

**Recommendation 8.3**

(1) That the duties of representatives be outlined in a separate section of the Act.

(2) That the duties of representatives include the following:

- (a) to uphold the guiding principles of the Act;
- (b) to act honestly, diligently and in good faith;
- (c) to treat the represented person (the ‘person’) with respect and dignity;
(d) to communicate with the person by any means that they consider the person will be best able to understand;

(e) to keep the person informed about decisions made and steps taken by the representative as appropriate in the circumstances;

(f) to regularly consult with any other appointed representative of the person and them keep informed about substantial decisions or actions, subject to the terms of their appointment;

(g) to act as an advocate for the person;

(h) to encourage and support the person to develop their decision-making abilities where possible;

(i) to act in such a way so as to protect the person from violence, neglect, abuse or exploitation; and

(j) to respect the person’s right to privacy.

Recommendation 8.4

That the Act require Board-appointed representatives to apply to the Board for the review of an order if they consider that the test for the appointment of a representative would no longer be met.

Recommendation 8.5

That the rights of enduring guardians to access information in s 32B(1) of the Act also be included for Board-appointed guardians and administrators.

Part 9: Functions and Powers of Guardians

Recommendation 9.1

That the Act describe the scope of a guardian’s role as relating to ‘personal matters’.

Recommendation 9.2

That the description in the Act that a guardian has a role akin to that of a parent in relation to a child be removed.

Recommendation 9.3

(1) That ‘personal matters’ be defined to include:

- deciding where and with whom a represented person lives whether permanently or temporarily;
- restricting visits on behalf of a represented person where it promotes their personal and social wellbeing, and prohibiting visits where the guardian reasonably believes that it would have an adverse effect on the person;
- consenting to, or refusing or withdrawing consent to health care and treatment other than special treatment;
- deciding upon education, training, and work arrangements of a represented person; and
- legal matters that relate to personal matters.
That ‘legal matter’ be defined to include:

- the use of legal services for a represented person’s benefit; or
- bringing or defending a legal proceeding or hearing in a court, tribunal or other body on behalf of the person.

**Recommendation 9.4**

1. That the terms ‘medical treatment’ and ‘health care’ as used in the Act be replaced with the single term ‘health care and treatment’.
2. That ‘health care and treatment’ be defined to include ‘health care’ of any kind, including:
   
   a. anything that is part of a health service within the meaning of the Health Practitioner Regulation National Law;
   
   b. an intimate forensic procedure and a non-intimate forensic procedure normally carried out by a person authorised to carry out the procedure under s 40 of the *Forensic Procedures Act 2000* (Tas); and
   
   c. any other act declared by the Regulations to be health care and treatment for the purposes of the Act.
3. That the term ‘health care and treatment’ exclude the assessment and treatment of mental illness given to a patient under the *Mental Health Act 2013* (Tas) and any other matter that is declared by the Regulations to not be health care and treatment.
4. That the term ‘health practitioner’ be defined to mean a health practitioner within the meaning of the Health Practitioner Regulation National Law, and any other profession prescribed in the Act’s Regulations.

**Recommendation 9.5**

That the Act provide a non-exhaustive list of matters that fall outside the authority of a guardian, including:

- those matters within the scope of an administrator’s authority;
- consenting to, or refusing or withdrawing consent to special treatment (unless giving consent to the continuation of special treatment is approved by the Board);
- consenting to assessment and treatment for mental illness covered by the *Mental Health Act 2013* (Tas);
- making, revoking, or amending a represented person’s Will, enduring power of attorney, instrument, or advance care directive;
- voting on behalf of a represented person;
- consenting to marriage or the dissolution of marriage or significant relationship, or a sexual relationship of the represented person;
- making decisions about the care and wellbeing of a represented person’s child;
- consenting to the adoption of children, surrogacy arrangements and parenting orders;
- acting after the death of the represented person;
• disciplining, chastising or punishing the represented person; or
• consenting to an unlawful act.

**Part 10: Functions and Powers of Administrators**

**Recommendation 10.1**

That the authority of administrators be described in the Act as relating to ‘financial and property matters’.

**Recommendation 10.2**

1. That the existing non-exhaustive lists of powers of administrators in s 56(2) of the Act and powers of attorneys in s 31(2A) of the *Powers of Attorney Act 2000* (Tas) be made consistent.

2. That both the Act and the *Powers of Attorney Act 2000* (Tas) clarify that administrators and attorneys’ powers extend to legal matters relating to financial and property matters.

3. That the lists of matters falling within the scope of an attorney’s and administrator’s authority be revised to avoid use of legalistic terms and to include:
   - description of more day-to-day financial transactions for example, insuring a person’s property, withdrawing money from, or depositing money into a represented person’s account with a financial institution;
   - power to apply for and hold a license or permit;
   - obtaining or surrendering insurance for the represented person;
   - as exceptions to the power to invest money in any manner in which a trustee may invest, power to:
     - retain any of the represented person’s existing investments that are not authorised trustee investments, including taking up rights to issues of new shares or options for new shares to which the person becomes entitled by their existing shareholding; and
     - retain property owned by the represented person as a joint tenant or tenant in common;
   - lodging and removing caveats over land; and
   - lodging and removing caveats against the issue of a grant of probate or administration in an estate.

**Recommendation 10.3**

That the State Government review pending recommendations of the NSWLRC dealing with the rights and powers of representatives in relation to a person’s digital estate and consider any need for legislative reform.

**Recommendation 10.4**

That the Act provide a non-exhaustive list of matters that fall outside the authority of an administrator, including:
• personal matters included within the scope of a guardian’s authority;
• making, revoking or amending a represented person’s Will, enduring power of attorney, instrument or advance care directive;
• voting on behalf of a represented person;
• consenting to marriage or the dissolution of marriage or significant relationship, or a sexual relationship of the represented person;
• making decisions about the care and wellbeing of a represented person’s child;
• consenting to the adoption of children, surrogacy arrangements and parenting orders;
• acting after the death of the represented person;
• disciplining, chastising or punishing the represented person; and
• consenting to an unlawful act.

Recommendation 10.5

That protections for representatives who enter into or participate in court proceedings on behalf of a represented person be reviewed.

Part 11: Decision-Making Process

Recommendation 11.1

That the Act contain a separate section headed ‘the Decision-Making Process’ that outlines when and how representatives and the Board are to make decisions for a person.

Recommendation 11.2

That the Decision-Making Process require the Board and representatives (the decision-maker) to adopt the following process when making any decision on behalf of a person who does not have decision-making ability to make their own decision about the matter:

1. First, the decision-maker must consider whether there is a need for a decision. There is no need for them to make a decision where the person has made a binding direction in advance that applies to the circumstances, including in a valid advance care directive.

2. Second, the decision-maker must consider whether the person is likely to become able to make their own decision, and if so, when. If the decision-maker considers that a decision can be delayed until the person gains the ability to make the decision, without that delay causing harm, then the decision should be delayed.

3. If the decision-maker considers that a decision needs to be made, then the person’s views, wishes and preferences must be given all practical and appropriate effect. A person may communicate their views, wishes and preferences by any means.

4. Where the person’s views, wishes, and preferences cannot be determined, the decision-maker must give all practical and appropriate effect to what the decision-maker reasonably believes the person’s likely views, wishes and preferences are, based on all the information available, including by consulting with family, carers and other significant people in the person’s life that the decision-maker reasonably believes the person would want to be consulted.
5. A decision-maker may not give all practical and appropriate effect to the person’s views, wishes and preferences only where:

   (a) it is necessary to prevent unacceptable harm to the person or another person; or
   (b) it would be unlawful.

In any of these cases, a representative must adopt Step 6 whilst continuing to give as much effect as possible to the person’s views, wishes and preference.

6. If it is not possible to determine or apply the person’s views, wishes and preferences, a decision-maker must act to promote and uphold the person’s personal and social wellbeing and act in a way least restrictive of their human rights.

**Part 12: Safeguards for Representative Decision-Making**

**Recommendation 12.1**

(1) That the Act provide the ability to apply to the Board for an internal review of its original decisions by a division of the Board not comprising members who were involved in the original decision.

(2) That the Supreme Court of Tasmania rules, practices and procedures be reviewed to facilitate accessible pathways to appeal Board decisions to the Supreme Court.

(3) That there be publicly available, accessible information produced explaining the appeal process and which is provided to parties following a determination of the Board.

(4) That legislation provide that no order for costs may be made against an applicant in an appeal if he or she is the person in respect of whom the decision appealed against relates.

**Recommendation 12.2**

That the Act limit those who are eligible to request a statement of reasons of the Board’s determination to:

(a) those classes of individuals who are entitled to appeal a determination of the Board; and

(b) any other person that the Board considers has a proper interest in the matter.

**Recommendation 12.3**

(1) That the Act give the Board power to refer a matter for mediation.

(2) That the Board have mediation services available.

(3) That the use of mediation not be compulsory.

(4) That the Board be added as a prescribed tribunal under the *Alternative Dispute Resolution Act 2001* (Tas).

**Recommendation 12.4**

That the Public Guardian have power to attempt to resolve disputes involving representatives, consistent with Recommendation 5.7.
**Recommendation 12.5**

That the Board have power to review an instrument of its own motion.

**Recommendation 12.6**

That the Act confirm that the Board’s powers to revoke instruments extend equally to revocations of instruments.

**Recommendation 12.7**

1. That the wording of s 34(1)(b) of the Act be revised to confirm that the Board may only revoke or amend an instrument where the donor does not have decision-making ability to revoke or amend the instrument.

2. That the Board have power to appoint a substitute enduring guardian after revoking an enduring guardian’s appointment where the instrument does not already provide a substitute.

3. That the Board have power to suspend an instrument.

**Recommendation 12.8**

That, to revoke the appointment of a representative, the Board need to be satisfied that:

(a) in relation to all representatives (enduring guardians and Board-appointed representatives):
   - the representative is not willing or able to act in that capacity; or
   - the representative has acted in an incompetent or negligent manner or contrary to the Act; or

(b) in relation to enduring guardians only, that there has been a major change in circumstances since the appointment was made and:
   - the amendment is the only practicable way to address this circumstance; and
   - if the donor had decision-making ability, he or she would agree to the amendment; and

(c) in relation to Board-appointed representatives only, that the representative no longer meets the eligibility requirements that apply to be appointed as a representative.

**Recommendation 12.9**

1. That the Act provide that an order of the Board appointing a representative is suspended if the representative does not have decision-making ability to act in that capacity.

2. That an order appointing an administrator be suspended upon the administrator becoming bankrupt or insolvent.

3. That if the appointment of an administrator is suspended because of bankruptcy or insolvency, that administrator be required to advise the Board of that circumstance.

**Recommendation 12.10**

That the Act require former representatives to facilitate the handover of authority upon termination of their appointment. Handover should occur as follows:

(a) if a new representative is appointed, then to the new representative;
(b) if an order appointing a representative is terminated, then to the person who was formerly a represented person; and

(c) if terminated because of the death of the represented person, then to their legal personal representative.

Recommendation 12.11

(1) That reports from representatives require representatives to:

(a) describe attempts to encourage and support the represented person to develop their decision-making skills; and

(b) articulate any future opportunities identified to build the represented person’s decision-making skills.

(2) That the Board’s processes when receiving reports from representatives provide opportunity for a represented person to speak directly with the Board’s registry staff as part of the reporting process wherever possible.

Recommendation 12.12

(1) That the Act confirm a donor’s ability to nominate in their instrument a person or body that their enduring guardian must take reasonable steps to notify upon them commencing to act in the role for the first time.

(2) That the standard form instrument provide a space for a donor to nominate a person or body that their enduring guardian must take reasonable steps to notify upon them commencing to act in the role for the first time.

Recommendation 12.13

That the standard form instrument provide a space for a donor to nominate a person or body who their enduring guardian must report to whilst acting in the role.

Recommendation 12.14

That an equivalent provision to s 32D(1) of the Act be included in relation to Board-appointed administrators and guardians, confirming that administrators and guardians must keep accurate records of all dealings and transactions that they make as representatives.

Recommendation 12.15

(1) That the Board be required to consider the following matters when determining the duration of an order appointing a representative:

• the likelihood of improvements to the represented person’s decision-making ability;

• the prospect that likely changes to circumstances including short term interventions to establish supported arrangements will mitigate the need for a representative; and

• that the order is the least restrictive of the person’s freedom of decision and action as is possible in the circumstances.
(2) That any continuation of an order appointing a representative be permitted to last for a maximum of three years, after which time the order lapses unless it is continued in accordance with the Act.

Recommendation 12.16

That, to continue an order appointing a representative, the Board need to be satisfied that the test for the appointment of a representative continues to be met.

Recommendation 12.17

That the standard form instrument explain what conflicts of interest are and how they may be managed.

Recommendation 12.18

That the Act deal with conflicts of interests involving guardians and administrators as follows:

(a) that the existing definition of ‘conflict of interest’ in s 32C(2) of the Act be moved to the definition section (s 3) so that it applies to all uses of that term throughout the Act;

(b) that the test for appointment as a representative require the Board to consider:
   (i) the extent to which the interests of the proposed represented person and proposed representative are likely to conflict; and
   (ii) whether the proposed representative is likely to comply with the Act;

(c) that the Act state that being a relative or beneficiary of a represented person’s Will does not of itself amount to a conflict of interest;

(d) that the Act state that, just because the proposed representative is in conflict with a close relative of the proposed represented person, does not, of itself, mean that they are not suitable to act as a representative; and

(e) that representatives have a duty to report conflicts of interest, or potential conflicts of interest, that arise during the course of their appointment to the Board.

Recommendation 12.19

(1) That administrators be authorised to make certain gifts and donations without Board approval equivalent to s 31 of the Powers of Attorney Act 2000 (Tas), subject to any contrary orders of the Board.

(2) That administrators be required to include an account of any gifts made when submitting accounts to the Board, subject to any contrary orders of the Board.

Recommendation 12.20

That the assessment of the eligibility of administrators and guardians under the Act be revised as follows:

(a) to provide a single section in the Act setting out what factors the Board must consider when assessing the suitability of proposed representatives (both administrators and guardians);

(b) to require the Board to be satisfied that the proposed representative understands their obligations and duties and will act in accordance with those obligations and duties;
(c) to take into account ‘the views, wishes and preferences’ of the proposed represented person, instead of ‘wishes’;

(d) instead of considering the importance of preserving ‘existing family relationships’, the assessment be of ‘existing relationships that are important to the person’;

(e) instead of there being an assessment of the ‘sufficient expertise’ of a proposed representative, the Board evaluate whether the proposed representative has the requisite skills or access to appropriate support to competently perform the role; and

(f) that whether a representative be required obtain a Registration to Work with Vulnerable Adults Check be considered as part of future reform to the Registration to Work with Vulnerable People Act 2013 (Tas).

Recommendation 12.21

That when deciding upon who to appoint as a representative, the Board be required to consider the desirability of appointing a person who has a personal relationship with the proposed represented person, rather than a person without a personal relationship.

Recommendation 12.22

That s 11(11) of the Act be revised as follows:

(a) to confirm that the powers in this section extend to the Registrar;

(b) to require provision of a document in addition to a report or information, with ‘document’ being defined in accordance with r 381 of the Supreme Court Rules 2000 (Tas);

(c) to extend the group or entity this section relates to, to include health practitioners and for the term ‘service provider’ to be better articulated including providing examples;

(d) to provide that the cost of providing a document, report or information is to be borne by the person, group or entity providing the document, report or information; and

(e) to require individuals to comply with a request for a document, report or information unless the person has a reasonable excuse, with a reasonable excuse including that compliance with the request may tend to incriminate the person.

Recommendation 12.23

(a) That the Act enable a person to apply to the Board for an order that any document, information or report lodged with the Board not be disclosed to specified person or class of persons.

(b) That s 86(2) of the Act be revised to provide that sub-s (1) ‘does not prevent the disclosure of information as required or permitted by any law [or] if, in the case of information relating to the personal affairs of another person, that other person has given consent in writing.’

Recommendation 12.24

That only those with a legitimate interest be able to search the register(s) of instruments and advance care directives and that it be an offence to search the register(s) without a legitimate interest.

Recommendation 12.25

(1) That s 88 of the Act be revised to confirm that the powers granted to the Board may be exercised by the Registrar.
(2) That representatives only have a power to obtain, read and copy a represented person’s Will with an order from the Board.

(3) That the Act define ‘Will’ to include a Will, alleged Will, part of a Will, or a revoked Will or other testamentary document, including Codicil.

Recommendation 12.26
That providing the Board with the ability to award remedies where a represented person suffers financial loss because of the actions of a representative be considered as part of instituting the Tasmanian Civil and Administrative Tribunal.

Recommendation 12.27
That upon appointment, Board-appointed representatives be required to declare that they:

- understand their obligations;
- understand the consequences of failing to comply with their obligations; and
- undertake to act in accordance with the Act.

Recommendation 12.28
That the merits of introducing adult safeguarding legislation in Tasmania be reviewed.

Part 13: Consent to Health Care and Treatment

Recommendation 13.1
(1) That whether the Act should govern consent to health care and treatment for children be the subject of separate review.

(2) That, if the Act continues to apply to the giving of substitute consent to health care and treatment for children with disability:

(a) the Act contain a similar section to s 219 of the Mental Health Act 2013 (Tas), confirming that the Act does not affect the jurisdiction of the Supreme Court and Family Court to give or refuse consent to health care and treatment; and

(b) confirming the effect of valid consent or refusal to consent under the jurisdictions of either the Supreme Court and Family Court upon the operation of the Act.

Recommendation 13.2
That, if the Act continues to apply to children with disability, it provide that the best interests of the child must be the paramount consideration in relation to any exercise of function or power under the Act.

Recommendation 13.3
(1) That Part 6 of the Act apply to any person who does not have decision-making ability to give consent to the carrying out of health care and treatment, whether or not they are a represented person.
(2) That, if the Act continues to apply to children with disability, the test of decision-making ability provide that a child is taken to have the ability to make a decision about his or her own health care and treatment (‘decision-making ability’) only if a person or body considering that ability under this Act is satisfied that:

(a) the child is sufficiently mature to make the decision; and

(b) the child is able to:

(i) understand information relevant to the decision; and

(ii) retain information relevant to the decision; and

(iii) use or weigh information relevant to the decision; and

(iv) communicate the decision (whether by speech, gesture or other means).

Recommendation 13.4

That the Act confirm that health care and treatment is not be able to be performed without consent where the health practitioner is aware that the patient has refused that health care and treatment in a valid advance care directive.

Recommendation 13.5

(1) That the Act define the following treatments as ‘minor health care and treatment’:

- non-intrusive examinations made for diagnostic purposes (such as visual examination of the mouth, nasal cavity, eyes or ears);
- first-aid; and
- administration of pharmaceutical drug for which a prescription is not required and which is normally self-administered, if it is being used for its recommended purpose and dosage level.

(2) That the Act confirm that consent to minor health care and treatment is not required where the person does not have decision-making ability to give consent and the minor health care and treatment is to be carried out to promote or maintain the person’s health and wellbeing.

Recommendation 13.6

That s 41 of the Act remain but it be revised to also provide that, to perform health care and treatment without consent:

(a) before the health practitioner administers the health care and treatment, they must make reasonable efforts in the circumstances to ascertain whether the patient has a person responsible; and

(b) the health practitioner who carries out or supervises the health care and treatment must document in the clinical records relating to the health care and treatment the reasonable efforts taken in the circumstances to locate an advance care directive and person responsible for the patient.
Recommendation 13.7
That the Act confirm that a person can indicate an objection to health care and treatment by whatever means, including:

- having indicated on a previous but similar occasion that they did not want the health care and treatment; or
- having previously communicated their objection to the health care and treatment, including in an advance care directive,

and they have not subsequently indicated to the contrary.

Recommendation 13.8
(1) That the Public Guardian be able to give consent to health care and treatment as a person responsible of last resort where consent is required and there is no valid advance care directive that applies to the decision and no one falling within the definition of person responsible.

(2) That the Act provide that the Board may consent to health care and treatment:

- classified as special treatment; or
- where consent to health care and treatment is required and there is no valid advance care directive that applies to the decision and no one falling within the definition of person responsible.

(3) That guidelines be developed to outline circumstances where it may be appropriate to request the Public Guardian to consent as the person responsible of last resort, or instead apply to the Board for either it to give consent or appoint a guardian with power to consent to some or all health care and treatment.

(4) That s 46A of the Act be deleted and that, in its place:

(i) the Act provide that the Board may treat an application for it to consent to the carrying out of health care and treatment on a person as an application for a guardianship order; and

(ii) the Board be permitted to make a guardianship order at a hearing of an application for consent to health care and treatment if the Board is satisfied that the test to appoint a representative is met.

Recommendation 13.9
(1) That the Act confirm that a person responsible and the Board may only give consent to health care and treatment where the person does not have the decision-making ability to make a decision about that health care or treatment.

(2) That the Act contain a separate section outlining the test for both persons responsible and the Board (decision-makers) to apply to make decisions about consent to health care and treatment.

(3) That the Act require decision-makers, when making decisions about consent to health care and treatment, to:

   (i) adopt the Decision-Making Process outlined in Recommendation 11.2; and

   (ii) consider the following:

   - the consequences if the health care and treatment is not carried out;
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• any alternative health care and treatment available;
• the nature and degree of any significant risks associated with the proposed health care and treatment, or any alternative health care and treatment;
• whether the proposed health care and treatment can be postponed on the basis that a better health care and treatment may become available; and
• that the health care and treatment is to be carried out only to promote and maintain the person’s health and wellbeing.

Recommendation 13.10
That the Act contain special provisions dealing with the substitute consent to the participation in research for adults who do not have the decision-making ability to provide their own consent.

Recommendation 13.11

(1) That non-intrusive examinations, observing a person’s activities and collecting information be excluded from the definition of medical research.

(2) That the Act confirm that a person can give advance consent or refusal to consent to participation in research including in a valid advance care directive.

(3) That a donor of an instrument be able to confer authority upon their enduring guardian to make decisions about consent to participation in research where the donor does not have decision-making ability to give their own consent.

(4) That the Board be able to confer authority upon guardians to make decisions about consent to a represented person’s participation in research where a represented person does not have decision-making ability to give consent.

(5) That the Board have authority to make decisions about consent to participation in research for a person who does not have decision-making ability to give consent.

(6) That, if any research decisions are reserved as matters for the Board only, there be clear distinction between the role of the Board and the relevant Human Research Ethics Committee, avoiding duplication of functions.

(7) That the Act provide that, where a person’s decision-making ability fluctuates, an attempt should be made to seek their consent to their participation in research at a time when the person has decision-making ability to consent.

(8) That the Act provide that, for a decision-maker to give consent to a person’s participation in research, that research must have the approval of a Human Research Ethics Committee.

(9) That the Act enable decision-makers to give consent to a person without decision-making ability participating in research that is not intended to treat a condition that the person has.

(10) That a person’s objection to participate in research be respected.

(11) That there be an ability to apply to the Board for the review of a decision to consent or refusal to consent to participation in research.
Recommendation 13.12
That ‘health care and treatment’ be defined to include the withdrawal or withholding of health care and treatment, including life sustaining measures.

Part 14: Safeguards for Consent to Health Care and Treatment

Recommendation 14.1
That Recommendation 5.7 be extended to enable the Public Guardian to attempt to resolve disputes involving persons responsible and consent to health care and treatment.

Recommendation 14.2
(1) That a person responsible be able to apply to the Board for advice or direction on any matter relating to the scope of their role or the exercise of any power.

(2) That the Board be empowered to:
   (i) approve or disapprove of any act proposed to be done by a person responsible;
   (ii) give such advice to a person responsible as it considers appropriate; and
   (iii) direct or offer advice to a person responsible of its own motion.

Recommendation 14.3
That the definition of ‘person responsible’ in the Act provide that a person’s guardian is their person responsible only if the order or instrument appointing the guardian authorises the guardian to make a decision about that particular health care and treatment or all health care and treatment matters.

Recommendation 14.4
That the definitions of ‘person responsible’ in s 4 of the Act be revised as follows:
- to provide that, where there is more than one person falling within the definition of ‘spouse’ then it is the most recent person to qualify as the spouse who is the ‘spouse’ for the purposes of this section; and
- for the term ‘relative’ to include any person who is related to the person in accordance with customary law or tradition (including Aboriginal customary law or tradition).

Recommendation 14.5
(1) That the definition of ‘person responsible’ in s 4 of the Act require a person to:
   - be reasonably available;
   - have decision-making ability in relation to the particular matter;
   - be willing to act; and
   - be in a close and continuing relationship with the person.

(2) That the Act provide a simple, non-mandatory form for individuals to complete and register with the Board to indicate their refusal to act as person responsible.
Recommendation 14.6
That the Board be able to make a declaration about the authority of a person to act as another person’s person responsible upon application from an interested party, or of its own motion.

Recommendation 14.7
(1) That the Act contain a separate section dealing with the consent to the admission and, if necessary, detention of a patient within a secure unit where the patient does not have decision-making ability to give their own consent where the provisions of the Mental Health Act 2013 (Tas) do not apply.

(2) That the term ‘secure unit’ be defined to:

(i) exclude places of detention covered by the Corrections Act 1997 (Tas) and any approved secure health units governed by the Mental Health Act 2013 (Tas); and

(ii) include facilities as listed in the Regulations.

That the Regulations include the Roy Fagan Centre as a secure unit.

(3) That consent to the admission and, if necessary, detention of a patient without decision-making ability within a secure unit fall outside of the scope of a person responsible’s authority.

(4) That the section contain the following elements:

- that only the Board or a guardian with specific authority be permitted to consent to the admission or detention of a patient within a secure unit;
- enabling the Board to appoint a guardian with authority to consent to the admission or detention of a patient within a secure unit, including the temporary appointment of the Public Guardian in urgent circumstances;
- requiring guardians’ decisions to consent to the admission or detention of a patient within a secure unit to be subject to periodic review by the Board;
- confirming that an application can be made to the Board for the review of a decision to consent to the admission or detention of a patient within a secure unit;
- enabling the Board to conduct ‘own motion’ reviews of the substitute consent to the admission or detention of a patient within a secure unit;
- confirming a patient’s rights, consistent with s 63 of the Mental Health Act 2013 (Tas). Key components include (but are not limited to):
  - the right to have contact with, and to correspond privately with, his or her guardian, supporter, lawyer, or any other person nominated by the patient to represent their interests; and
  - the right to have contact with, and to correspond privately with, Official Visitors; and
- requiring secure units to provide patients with a statement of rights, consistent with s 129 of the Mental Health Act 2013 (Tas).

(5) That the Mental Health Act 2013 (Tas) Official Visitors Scheme be extended to the Act subject to any specific adjustments required to meet the needs of the Act.
Part 15: Functions, Powers and Duties of the Board

Recommendation 15.1
(1) That the Board not be required to conduct a hearing to revoke an order appointing a representative where the representative applies for the revocation of the order.
(2) That applications by a representative for the revocation of an emergency order not require a Health Care Professional Report.

Recommendation 15.2
That the Act enable the Board to make an emergency guardianship order despite the proposed represented person being the donor of an instrument, equivalent to s 65(4)(c) of the Act dealing with emergency administration orders.

Recommendation 15.3
That, to make any order or give any direction under s 65 of the Act, instead of referring to ‘reason of urgency’, the Board be required to be satisfied on reasonable grounds that there is an immediate risk of harm to the person’s health, welfare, or property if an order or direction were not made, including because of a risk of abuse, exploitation, neglect or self-neglect.

Recommendation 15.4
(1) That there is no change to the notice of hearing provisions of the Act.
(2) That, if there is change to the notice of hearing provisions, the Board have discretion to shorten the notice period if it considers it proper to dispense with notice of the hearing by reason of urgency but that, if it does, it be required to provide reasonable notice.

Recommendation 15.5
(1) That the Act contain a section outlining who the parties to a hearing are.
(2) That the section adopt Table 1 of the Board's Practice Direction ‘Who is a “party” to an application before the Board?’ which provides that the parties to an application are:
   • in relation to applications involving guardianship (including reviews and advice and direction), the proposed represented person, the applicant(s), the proposed guardian, and the Public Guardian;
   • in relation to applications involving administration (including reviews and advice and direction), the proposed represented person, the applicant(s), the proposed administrator, the Public Guardian, and the Public Trustee;
   • in relation to applications for consent to health care and treatment (including advice and direction), the person who is the subject of the application, the applicant(s), the health practitioner who will carry out the health care or treatment, any person responsible for the person who is the subject of the application and the Public Guardian; and
   • in relation to applications to review an instrument (and advice and directions to enduring guardians), the donor or purported donor of the instrument, any guardian or purported guardian, the applicant(s), and the Public Guardian.
(3) That, if Recommendation 7.8 is adopted, then, in relation to applications for support orders, the Act provide that the parties to an application are the proposed supported person, the applicant(s), the proposed supporter, and the Public Guardian.

(4) That the Board have discretion to join anyone as a party not otherwise specified, if it considers they should be a party.

**Recommendation 15.6**

(1) That the Act contain an equivalent provision to cl 7(4) of sch 4, pt 2 of the Mental Health Act 2013 (Tas), requiring the Board to make arrangements for the representation of a person in respect of whom a hearing is being held if it considers that the person is, or may not be, receiving useful assistance elsewhere and that they are, or may be, personally incapable of making those arrangements.

(2) That the Board be required to make arrangements for the views and interests of a person in respect of whom a hearing is being held to be independently represented where the person in respect of whom the hearing is being held does not wish to, or is unable to, attend the hearing.

(3) That the Board not be required to make arrangements for separate representation of a person in respect of whom a hearing is being held where it is satisfied that it is inconsistent with the person’s views, wishes and preferences.

**Recommendation 15.7**

That a review be conducted in relation to the merits of utilising intermediaries in the guardianship jurisdiction.

**Recommendation 15.8**

(1) That an equivalent power to that granted to the Public Guardian in s 15(2) of the Act be conferred upon the Board, providing it with power to do all things necessary or convenient to be done in connection with the performance of its functions.

(2) That the need for legislative reform to deal with the appointment of an administrator for the estate of a missing person be reviewed.

**Part 16: Functions, Powers and Duties of the Public Guardian**

**Recommendation 16.1**

That the descriptions of the functions of the Public Guardian in s 15(1) of the Act be reviewed for clarity and to eliminate duplication.

**Recommendation 16.2**

That one of the functions of the Public Guardian be to support and educate representatives, supporters and informal supporters, including by giving advice on the functions and powers that may be exercised under the Act, the operation of the Act generally and on appropriate alternatives to taking action under the Act.

**Recommendation 16.3**

That the Public Guardian have the following additional functions and powers:
• to investigate complaints and allegations against supporters and representatives including persons responsible;
• to investigate matters of its own motion; and
• to investigate circumstances where a person with a disability is suspected to be subject to or at risk of harm, abuse, exploitation or neglect.

Recommendation 16.4
That strategies be developed to improve the delivery of systemic advocacy for people with disability.

Recommendation 16.5
That the Public Guardian have adequate powers to conduct investigations. These provisions should:
• provide the Public Guardian with equivalent powers to the powers of the Board to require the provision of reports, documents and information;
• require individuals and bodies to assist the Public Guardian with its investigations, including answering questions and attending conferences;
• give the Public Guardian power to access premises either with a warrant or on an order of the Board; and
• permit a person to decline to provide information or answer a question in exceptional circumstances, for example, where it might tend to incriminate the person.

Recommendation 16.6
That the application of s 85 of the Act be extended to cover provision of information to the Public Guardian.

Part 17: Interrelationship with other Legislation

Recommendation 17.1
That the recommendations made in this Report be considered as part of the review of the Disability Services Act 2011 (Tas) to take place following full implementation of the NDIS in Tasmania in July 2019.

Recommendation 17.2
That there be comprehensive consideration of how the use of restrictive practices should be monitored and regulated in Tasmania.

Recommendation 17.3
(1) That substitute consent to the use of chemical restraint be included within the comprehensive review of the legislative framework governing regulation of the use of restrictive practices, proposed in Recommendation 17.2.

(2) That, pending the outcome of that review:
(i) the Act include a definition of chemical restraint as meaning ‘medication given primarily to control a person’s behaviour, not to treat a mental illness or physical condition’;
(ii) the Act enable interested parties to apply to the Board for the review of any substitute decision to consent to the use of chemical restraint pursuant to the Act; and

(iii) the Board and Public Guardian be able to conduct ‘own motion’ investigations and reviews of any substitute consent to the use of chemical restraint pursuant to the Act.

Recommendation 17.4

(1) That the Powers of Attorney Act 2000 (Tas) be reviewed in light of the obligations and principles articulated in the Convention on the Rights of Persons with Disabilities and recommendations contained in this Report, noting in particular:

- Part 3 of this Report which deals with the guiding principles of the Act, including Recommendation 3.3;
- Parts 4 and 12 of this Report in relation to the appointment, removal and supervision of enduring guardians;
- Recommendations in Part 6 of this Report in relation to the test and assessment of a person’s decision-making ability; and
- Recommendations in Part 7 of this Report proposing introduction of a legislated supported decision-making scheme for personal matters.

(2) That as far as possible there be consistency between the structure and provisions of the Act and the Powers of Attorney Act 2000 (Tas).

Recommendation 17.5

(1) That consideration is given to the need to continue operation of the Alcohol and Drug Dependency Act 1968 (Tas).

(2) That if the Alcohol and Drug Dependency Act 1968 (Tas) continues in operation, the Act confirm that it does not apply to the treatment and control of persons suffering from alcohol dependency or drug dependency dealt with under the Alcohol and Drug Dependency Act 1968 (Tas).

Recommendation 17.6

(1) That the Act mandate a statutory review of the Act.

(2) That the statutory review period be every three years.

Part 18 – Enablers and Subsequent Matters

Recommendation 18.1

That there be adequately funded robust and accessible public education about the Act and any reforms. Educational materials should be produced in a variety of formats and include both print and web-based information.

Recommendation 18.2

That the Act be as accessible as possible, including:

- a logical structure;
• use of plain English;
• clearly defined terms;
• avoiding internal referencing to other sections of the Act; and
• brevity.

Recommendation 18.3
That the State Government review and monitor the adequacy of resources allocated to groups directly involved in administering the Act, notably the Board, OPG, Public Trustee and Legal Aid Commission of Tasmania, to ensure that those bodies are able to perform their functions, duties and powers effectively.

Recommendation 18.4
(1) That the need for reform to the Act be further reviewed upon any amendments being made to the Disability Services Act 2011 (Tas), Mental Health Act 2013 (Tas) or Aged Care Act 1997 (Cth) to ensure consistency wherever possible.

(2) That the State Government work with the other state and territory governments, and the federal government, with a view to developing nationally consistent guardianship laws, including substitute consent to health care and treatment.

(3) That if agreement is reached nationally about the enactment of uniform guardianship laws, the State Government work to enact uniform legislation.

(4) That there be clear and streamlined pathways for instruments, enduring powers of attorney and advance care directives made or registered in another jurisdiction to be recognised, registered and used in Tasmania.

Recommendation 18.5
That reforms proposed in this Report are progressed in accordance with the implementation strategy outlined in Table 18.1 of this Report.
Part 1

Introduction

1.1 Background to the Reference

1.1.1 The Guardianship and Administration Act 1995 (Tas) (the Act) came into force on 1 September 1997. The Act sets out how decisions may be made for people with disability who are unable to make their own decisions. The Act covers decisions about:

- ‘personal matters’ — for example, where a person lives;
- a person’s ‘estate’ — their financial and property affairs; and
- medical and dental treatment.

It also governs how an adult may appoint an enduring guardian to make decisions about their personal affairs in the future.

1.1.2 Amendments have been made to the Act, but it has not had a substantive review since it was enacted 20 years ago. Since that time, there has been a shift in community expectations with an emphasis on human rights. In 2008, Australia ratified the United Nations Convention on the Rights of Persons with Disabilities (the ‘Convention’). The Convention requires equality for people with disability. It has significant impact on the operation of guardianship laws and other domestic laws and has resulted in a number of law reform commissions reviewing legislation across Australia. The Australian Law Reform Commission (ALRC) has stated that reform to state guardianship laws is critical in order to implement the Convention.

1.2 Terms of Reference

1.2.1 The former Attorney-General of Tasmania, the Hon Vanessa Goodwin, requested the Institute to review the Act to ensure that it is responsive to the needs of the community, and that it advances, promotes and protects the rights of people with impaired decision-making capacity.

The Terms of Reference are as follows:

The Tasmania Law Reform Institute is to review and report on the need for or desirability of changes to the Tasmanian Guardianship and Administration Act 1995, having regard to the following:

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1 Guardianship and Administration Amendment Act 2015 (Tas); Guardianship and Administration Amendment Act 2013 (Tas); Justice and Related Legislation (Miscellaneous Amendments) Act 2009 (Tas); Justice and Related Legislation (Further Miscellaneous Amendments) Act 2006 (Tas).


A. The general principles established by the United Nations *Convention on the Rights of Persons with Disabilities* and other international human rights instruments;

B. Developments in policy, law and practice in Tasmania and other jurisdictions that may impact on persons with impaired decision-making capacity since the Act commenced; and

C. Whether the current guardianship and administration framework will be sustainable and responsive to the needs of Tasmanians, in particular demographic changes.

In particular, the Institute is to have regard to:

a) the role of guardians, administrators and ‘persons responsible’ in advancing the interests of persons with impaired capacity when making substitute decisions in line with national and international trends;

b) the need to ensure that the powers and duties of guardians, administrators and ‘persons responsible’ are effective, appropriate, and advance the interest of persons with impaired capacity;

c) the functions, powers and duties of the Guardianship and Administration Board and Office of the Public Guardian;

d) the appropriateness of current mechanisms to address poor conduct of guardians, administrators and ‘persons responsible’ not acting in the best interests of a person with impaired capacity;

e) provisions in relation to consenting to medical and dental treatment and how to address long term or indefinite medical treatment in institutional and non-institutional settings;

f) how both informal and formal assisted or supported decision-making frameworks are working for persons with impaired capacity in Tasmania, including consideration of national and international trends;

g) the interrelationship between the *Guardianship and Administration Act 1995* and other relevant Tasmanian legislation, in particular the *Mental Health Act 2013, Disability Services Act 2011* and associated regulations, the *Powers of Attorney Act 2000, Alcohol and Drug Dependency Act 1968, Public Trustee Act 1930*, and the *Trustee Act 1898*, and how these Acts should interact if legislative amendments are proposed; and

h) other matters the Tasmania Law Reform Institute consider relevant to the Terms of Reference.

### 1.3 Conduct of this review

1.3.1 During the pre-consultation phase of this project, the Institute met with several stakeholders whose valuable feedback assisted to scope the issues raised in the Institute’s Issues Paper. During the drafting of the Issues Paper, the Institute was involved in co-convening an Elder Abuse Symposium in partnership with Council on the Ageing Tasmania (COTA), Equal Opportunity Tasmania (EOT) and the University of Tasmania. The Symposium brought together over 60 representatives from the aged care sector, the legal profession, police, unions, clinicians, policy makers and academic researchers to examine the social, legal, and clinical dimensions of elder abuse.
and neglect in Tasmania. This forum also highlighted matters relevant to this project, noting that the Act’s operation extends to Tasmanians with dementia who may be at risk of elder abuse and neglect.

1.3.2 The Institute released its Issues Paper in December 2017. This was followed by a period of community consultation which closed on 19 March 2018.

1.3.3 In addition to publishing an Easy Read version of the Issues Paper, the Institute produced a video advising community members about the Act and this review, with the video link published on the Institute’s website and social media pages. The Institute thanks those stakeholders who shared this video and information about the review amongst their networks. The Institute would particularly like to acknowledge the contributions of Kim Barker, the Public Guardian, Julie Butler, Advocacy Practise Leader at the Speak Out Association of Tasmania (Speak Out), and Dr Matthew Fasnacht, Senior Psychiatrist at the Older Person Mental Health Service (OPMHS) South for contributing to the filming of this video and to the University of Tasmania for providing funding. The Institute also developed a flyer advising about the review which several stakeholder organisations agreed to display. The Institute was also invited to attend briefing sessions with staff of the Board, the Office of the Commissioner for Children and Young People and Speak Out, as well as members of the Elder Law and Succession Committee of the Law Society.

1.3.4 Fifty formal submissions were received, either in writing, by completing the submission template, or by contacting the Institute to make a verbal submission. In addition to the formal responses received, the Institute was also invited to attend community consultation sessions convened by external stakeholders. The Institute takes this opportunity to acknowledge and thank the following organisations who facilitated meetings with the Institute’s researcher:

- Carers Tasmania, which arranged meetings with its members in Hobart, Launceston and Devonport;
- National Disability Services (NDS), arranging meetings in Hobart, Launceston and Burnie;
- COTA and Dementia Australia (Tasmania), convening a joint meeting of members in Hobart; and
- The Menzies Institute for Medical Research.

1.3.5 The Institute consulted with a further 57 individuals who attended these meetings. Combined with the formal submissions received, this project therefore incorporates feedback from a total of 107 organisations and individuals. Submissions received have deeply enriched this Report, and the Institute thanks all those who have contributed to the review.

1.3.6 The Institute also wishes to acknowledge the significant contribution of the members of its Reference Group for this project, Philippa Shirley, Jennifer Dunbabin and John Blackwood.

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1.4 Structure of this Report

1.4.1 This Report is divided into several parts:

- Part 2 provides an overview of the policy environment in which this review was conducted. Part 3 then considers, in light of this policy framework, the desirability of reform to the guiding principles governing the Act.

- Parts 4 and 5 review how a person may exercise autonomy by appointing an enduring guardian and making an advance care directive.

- Part 6 evaluates when the Act’s jurisdiction is invoked based on an assessment of a person’s ability to make decisions.

- Part 7 considers how people requiring support with decision-making may be offered support and evaluates how the Act presently recognises the use of support with decision-making. This Part considers the needs and merits of reform to the legislative framework to provide a formal system of supported decision-making as a middle ground between the making of an autonomous decision and a representative decision.

- Parts 8 to 12 consider the appointment, role, duties and powers of guardians and administrators (collectively referred to as representatives). Part 8 reviews when a representative may be appointed. Parts 9 and 10 consider reform to the functions and powers of guardians and administrators. Part 11 outlines recommendations about when and how representatives should make decisions for a represented person. Part 12 then reviews safeguards for representative decision-making.

- Parts 13 and 14 analyse the medical treatment decision-making scheme. Part 13 deals with when and how substitute consent to medical treatment may be given and Part 14 reviews safeguarding provisions.

- Parts 15 and 16 consider the role, powers and duties of the Board and Public Guardian.

- Part 17 considers the need for or desirability of reform to related legislation, notably the Powers of Attorney Act 2000 (Tas) (‘Powers of Attorney Act’), Disability Services Act 2011 (Tas) (‘Disability Services Act’), and Mental Health Act 2013 (Tas) (‘Mental Health Act’).

- Part 18 concludes by making recommendations to improve the effectiveness of the Act’s operation, along with considering future developments and reforms that may become necessary or desirable.
Part 2
Legal and Policy Framework

2.1 Introduction

2.1.1 The Act came into force on 1 September 1997. Much has changed since this time. In 2008, Australia ratified the United Nations Convention on the Rights of Persons with Disabilities. In response, there have been a number of changes to Australia’s legal and policy framework, reflecting a greater rights-based approach to laws and policy impacting people with disability.

2.1.2 The Institute’s Terms of Reference asked for the need for, or desirability of, changes to the Act having regard to developments in policy, law and practice in Tasmania and other jurisdictions that may impact upon persons with impaired decision-making capacity since the Act commenced. This Part discusses key changes in Australia’s legal and policy framework impacting the rights of people with disability which have influenced recommendations made in this Report.

2.2 UN Convention on the Rights of Persons with Disabilities

2.2.1 The Convention does not declare any new or different rights for people with disability. Rather, it explains how human rights apply specifically to people with disability. Other relevant international instruments include the Universal Declaration on Human Rights; the International Covenant on Civil and Political Rights; the International Covenant on Economic, Social and Cultural Rights; and the Convention against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment. Other international laws deal specifically with certain groups, including women and children.

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8 International Covenant on Civil and Political Rights, opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976) (‘International Covenant on Civil and Political Rights’).


2.2.2 The Convention was adopted on 13 December 2006 and opened for signature on 30 March 2007. Australia formally ratified the Convention on 17 July 2008 and Optional Protocol on 21 August 2009. The Optional Protocol, amongst other things, deals with the role of the Committee of the Rights of Persons with Disabilities (the ‘Convention Committee’).

2.2.3 The Convention records the rights of people with disability to equality, dignity and autonomy. When passing the Disability Services Act, the Tasmanian Parliament reflected on the rights of people with disability under the Convention, noting that it:

makes a shift from a world where people with disability were viewed as ‘objects’ of charity, medical treatment and social protection to a world where they are viewed as ‘subjects’ with rights, who are capable of claiming those rights and making decisions for their lives based on their free and informed consent, as well as being active members of the society.

2.2.4 Article 12 of the Convention is key to the operation of guardianship laws. It provides:

**Article 12 – Equal recognition before the law**

1. States Parties reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law.

2. States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.

3. States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.

4. States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests.

5. Subject to the provisions of this article, States Parties shall take all appropriate and effective measures to ensure the equal right of persons with disabilities to own or inherit property, to control their own financial affairs and to have equal access to bank

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loans, mortgages and other forms of financial credit, and shall ensure that persons with disabilities are not arbitrarily deprived of their property.\textsuperscript{16}

2.2.5 Ratification requires Australia to proceed in good faith to give effect to the Convention.\textsuperscript{17} Article 4 of the Convention provides that State parties must ensure the human rights and fundamental freedoms for all persons with disabilities, including by adopting all appropriate legislative measures to implement the rights recognised in the Convention and modifying or abolishing laws that constitute discrimination against persons with disabilities.\textsuperscript{18} The ALRC has stated that reform to state guardianship laws is critical in order to implement the Convention.\textsuperscript{19} Arstein-Kerslake has commented that ‘Article 12 exists due to an outcry from the disability community. This alone should be enough for us to re-examine law and practice.’\textsuperscript{20}

2.2.6 There is debate about whether the Convention permits any circumstances in which decisions for people with disability can be made by others, for example, by representatives. The Convention Committee has issued a General Comment on the effect of Article 12 of the Convention, stating that its effect is to require the abolition of guardianship laws in place of supported decision-making arrangements.\textsuperscript{21} The Australian Government has issued interpretive declarations of its understanding of the effect of Article 12 of the Convention, stating that it understands that the Convention permits substitute decision-making regimes like guardianship laws where they are time-limited, used as a last resort and subject to appropriate safeguards.\textsuperscript{22} The Convention Committee challenges this interpretation and has recommended that the Australian Government withdraw its declaration and work towards abolition of guardianship laws.\textsuperscript{23} To the Institute’s knowledge, all Australian and overseas jurisdictions have retained some form of guardianship legislation enabling substitute decision-making in defined circumstances.

2.2.7 Australian law reform bodies\textsuperscript{24} have adopted the Australian Government’s interpretation. All contemplate substitute decision-making as part of a continuum of decision-making support which may be permissive where it is time limited, used as a last resort and subject to appropriate safeguards. In 2010, the Queensland Law Reform Commission (QLRC) reviewed guardianship laws in Queensland, recommending that the principles of the Convention be adopted within their
guardianship legislation. In 2012, the Victorian Law Reform Commission (VLRC) delivered its Final Report on Guardianship. It recommended a raft of reforms in response to the principles and obligations of the Convention. In July 2016, the ACT Law Reform Council (ACTLRAC) released its Final Report into guardianship law in the ACT. It too made a number of recommendations to guardianship legislation intended to promote the human rights of people with disability. In April 2017, the Guardianship of Adults Act 2016 came into force in the Northern Territory. It, along with the Advance Personal Planning Act 2016 (NT), contain a number of contemporary provisions reflecting the decision-making rights of people with disability. Since the Tasmania Law Reform Institute (TLRI) released its Issues Paper in December 2017, there have been two new guardianship Bills put forward in Victoria and Queensland, with those Bills incorporating many of the recommendations previously made by the respective law reform commissions in those states. Most recently, the NSW Law Reform Commission (NSWLRC) has reviewed guardianship legislation in New South Wales, delivering its Final Report in May 2018.

2.2.8 The VLRC, ACTLRAC and the NSWLRC have all recommended reform to guardianship legislation to incorporate a formal supported decision-making scheme in light of the Convention. Legislated supported decision-making regimes provide formal acknowledgment of and legitimise decision-making made with support. They provide a further, formal alternative to the appointment of a representative and the making of a representative decision for those requiring support with decision-making. Supported decision-making frameworks are discussed in more detail in Part 7.

2.2.9 Whilst the QLRC did not recommend a legislated supported decision-making scheme, it recommended a range of reforms aimed at acknowledging and promoting the use of informal decision-making within the community, along with suggesting ways in which legislation could better safeguard the interests of those receiving informal decision-making support. Theirs was the first comprehensive review of guardianship legislation in Australia following ratification of the Convention, with Australia’s legal and policy environment now eight years more advanced. During that period, legislative schemes have been in operation in a number of jurisdictions overseas.

2.2.10 A legislated supported decision-making scheme has been operating in Victoria since 2014. Under reforms made to the Powers of Attorney Act 2014 (Vic), individuals may appoint a ‘supportive attorney’ to provide them with decision-making support. Legislative reforms under the Guardianship and Administration Bill 2018 (Vic) would also enable the tribunal to appoint a supporter for an individual who requires support with decision-making.

2.2.11 Recent revisions to the Queensland Act have not included a legislated supported decision-making model. The Northern Territory also has not introduced a legislated supported decision-making scheme. Both jurisdictions have, however, made several reforms to their guardianship Acts to better reflect the rights of people with disability.

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26 VLRC, above n 24.
27 Guardianship of Adults Act 2016 (NT).
28 Guardianship and Administration Bill 2018 (Vic); Guardianship and Administration and Other Legislation Amendment Bill 2018 (Qld).
29 NSWLRC, above n 24.
30 See ibid Recs 7.1–7.21.
31 Under the new Guardianship and Administration Bill 2018 (Vic).
2.2.12 There are several elements to achieving full compliance with obligations under the Convention. It would be inappropriate, perhaps reckless, to abolish guardianship laws in the absence of ensuring an effective replacement scheme. The use of supported decision-making as an alternative to guardianship requires more than legislative reform — it necessitates the development of accessible and effective decision-making supports within the community, and policies and procedures that recognise, encourage, and support such a model. It also requires robust and effective safeguards. Ultimately, ratification of the Convention requires a demonstrated commitment to taking action in good faith to work towards compliance with the Convention. Legislative reform that fosters and strengthens these broader developments is one component of this.

2.2.13 It is timely that the State Government has referred this review to the Institute, providing the opportunity to reflect on the suitability of Tasmania’s guardianship laws within this context.

2.3 Subsequent developments in policy, practice, and other laws

2.3.1 The Terms of Reference asked the Institute to consider developments in policy, law and practice since the Act commenced that may impact persons with impaired decision-making capacity. As noted earlier in this Part, a key driver of changes to law, policy and procedure at a national level has been Australia’s ratification of the Convention. This next Part explores notable developments.

The ‘Shut Out’ Report

2.3.2 The 2009 ‘Shut Out’ Report shone a light upon how people with disability experience disadvantage and social isolation, not because of their disability, but as a consequence of external factors. It highlighted the barriers that exist which prevent people with disability participating fully and equally in the community. Thirty-one per cent of respondents who lodged a submission to that review stated that comprehensive legislative and policy review was needed to eliminate conflicts with the Convention. The findings of this report informed the development of the National Disability Strategy.

National Disability Strategy 2010–2020

2.3.3 The National Disability Strategy is an agreement between the federal and all state and territory governments. The National Disability Strategy aims to provide national leadership towards better inclusion for people with disability and progress Australia’s obligations under the Convention. The goal of the National Disability Strategy is to create an inclusive and enabling

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32 See Arstein-Kerslake, above n 6, 33.
34 Ibid 17.
society that maximises opportunities for people and their participation in social, economic and cultural life. It aims to ensure equality for people with disability.

**Tasmania’s Disability Framework for Action**

2.3.4 In January 2018, the State Government released its third Disability Framework for Action, *Accessible Island: Tasmania’s Disability Framework for Action 2018–2021*.\(^{37}\) It comprises the State Government’s implementation plan for the National Disability Strategy, providing ‘a whole-of-government approach to ensure that all government departments implement socially just policies and practices for Tasmanians with disability.’\(^{38}\) As the name suggests, *Accessible Island* outlines a range of activities aimed at making Tasmania a more inclusive and accessible place so that people with disability can participate fully within the community.

2.3.5 One of the action items of *Accessible Island* is to consider the recommendations of the ALRC in relation to powers of attorney and to continue to educate the public about guardianship matters.\(^{39}\) These matters are considered in this Report.\(^{40}\)

**Department of Justice Action Plan**

2.3.6 The Department of Justice’s Disability Action Plan\(^{41}\) outlines the Department’s plan to deliver on activities under *Accessible Island*. Amongst a range of action items intended to ensure that the Department of Justice achieves accessibility for people with disability, relevant action items include to:

- support people with disability, their families and carers to build and strengthen supportive networks within the community;\(^{42}\)
- consult with people with disability on the design and implementation of Tasmanian Government policy and legislation;\(^{43}\)
- maintain and strengthen protections and supports for people with disability who experience, or are at risk of experiencing, violence, sexual assault, abuse and neglect;\(^{44}\)
- support independent advocacy to protect the rights of people with disability;\(^{45}\) and
- consider recommendations from the ALRC in relation to powers of attorney, and continue to educate people about guardianship and power of attorney issues.\(^{46}\)

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39 Communities, Sport and Recreation, above n 37, Action Item 3.12.
40 See Parts 4 and 17.
42 Ibid Action Item 1.19.
43 Ibid Action Item 1.24.
44 Ibid Action Item 2.5.
Tasmania’s Disability Justice Plan

2.3.7 The Disability Justice Plan for Tasmania 2017–2020\(^{47}\) comprises the State Government’s plan to implement the National Disability Strategy in relation to equal access to justice for people with disability. The Plan observes the barriers that people with disability face in accessing services and recognises the need for modifications or support to ensure that people with disability can participate equally within the justice system. Its objective is to ensure that the Tasmanian justice system is responsive to the needs of people with disability, to provide equality before the law and equal access to justice for all. The Plan reflects the State Government’s commitment to developing targeted strategies to remove unnecessary roadblocks that people with disability can face. The Plan’s supporting Action Items include ensuring that people’s need for support is identified at an early opportunity and that supports are made available to ensure that people can participate equally in the justice system.\(^{48}\) Relevantly, Action Item 11 requires support for people with disability to make decisions that affect their lives to enable them to exercise their legal rights and participate in legal processes. The Plan acknowledges that people with disability can be supported in all but the most extreme cases to exercise their legal capacity.

Enquiry into Delivery of Outcomes under the National Disability Strategy

2.3.8 The Senate Community Affairs Reference Committee was recently asked to conduct an enquiry into implementation of the National Disability Strategy. It issued its report in November 2017.\(^{49}\)

2.3.9 The enquiry observed significant issues with implementation of the National Disability Strategy. The report states that:

Since the introduction of the Disability Strategy, Australian governments, industry bodies, community groups and individuals have been involved in myriad activities to improve the accessibility and inclusivity of communities. However, despite some positive instances indicating some progress there continue to be major problems in accessibility and inclusive for people with disability and the Disability Strategy has failed to live up to expectation for many.\(^{50}\)

2.3.10 The Committee reinforced that:

Accessibility, or the lack of it, is not created by a person’s disability. It is created when the environment in which they live is being designed for other people’s skills and needs. Accessibility is not about creating a ‘special’ solution to meet the needs of people with disability. It is about reducing the inherent discrimination of the way our communities have previously been designed, built and organised, to ensure that all abilities are catered for.\(^{51}\)

\(^{46}\) Ibid Action Item 3.12.


\(^{48}\) Ibid Action Items 1, 8, 10, 11, 12.

\(^{49}\) Senate Community Affairs References Committee, above n 35.

\(^{50}\) Ibid [3.109].

\(^{51}\) Ibid [4.41].
2.3.11 It noted that:

The Disability Strategy is viewed as essential to deliver better outcomes for those participating in the NDIS and particularly for people with disability not eligible for the NDIS. However, the implementation of the Disability Strategy in the seven years since its introduction has left much to be desired. Many people think it has been sidelined while the NDIS rollout has been happening.\(^{52}\)

### The National Disability Insurance Scheme

2.3.12 The *National Disability Insurance Scheme Act 2013* (Cth) (‘NDIS Act’) is one way that the federal government has acted to give effect to the Convention.\(^{53}\) The objectives of the client-centred model include supporting people with disability to be independent, to have the same opportunity to participate socially and economically in the community, and to have choice and control so that, as much as possible, a person makes decisions for themselves.\(^{54}\) The *NDIS Act* requires that support be provided to people in dealing with the Agency,\(^{55}\) and to participate in, and contribute to, social and economic life.\(^{56}\) The Act recognises the importance of informal supported decision-making and requires that informal supported decision-making options be explored before a substitute decision-maker is appointed.\(^{57}\) The NDIS comprises an existing framework in which people with disability exercise freedom of choice over their health and personal circumstances, along with the use of individuals or networks of people to provide decision-making support. The ALRC has suggested that ‘[t]his new approach to individual decision-making at the Commonwealth level can also be used to guide law reform at the state and territory level.’\(^{58}\)

2.3.13 The full rollout of the NDIS in Tasmania in July 2019 will see broad reform to the disability space in Tasmania. The recent National Disability Insurance Scheme Amendment (Quality and Safeguards Commission and Other Measures) Bill 2017, passed on 4 December 2017, includes establishment of the NDIS Quality and Safeguards Commission, an independent Commonwealth body tasked with overseeing implementation of the NDIS Quality and Safeguarding Framework. These reforms impact the division of functions between the states and Commonwealth and will require amendments to be made to the *Disability Services Act*. The Australian Human Rights Commission comments that it is currently uncertain which state oversight and safeguarding mechanisms will continue to operate once the NDIS rollout is complete,\(^{59}\) with negotiations between the federal and state governments ongoing.\(^{60}\)

2.3.14 It must be recognised that not all people with disability will be NDIS participants. The Australian Human Rights Commission has recently estimated that only about 10 per cent of

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\(^{52}\) Ibid [4.42].

\(^{53}\) *National Disability Insurance Scheme Act 2013* (Cth) s 3(1)(a).

\(^{54}\) Ibid s 3(1)(c). See also ss 4–5.

\(^{55}\) Ibid s 17A(2).

\(^{56}\) Ibid s 17A(3)(c).

\(^{57}\) Ibid ch 3.

\(^{58}\) ALRC, above n 3, [1.29].


Australians living with disability will be participants of the Scheme.\textsuperscript{61} It is important to ensure that non-NDIS participants have equal rights and protections to those falling under the Scheme. There may be a continuing role for state legislation, including the Act, to play in providing these safeguards.

\textsuperscript{61} Australian Human Rights Commission, above n 59, 4.
3.1 Introduction

The Institute’s Terms of Reference ask for advice about the need for, or desirability of, changes to the Act in light of the general principles established in the Convention.

The guiding principles of the Act in s 6 provide the basis upon which decisions are made and actions are taken under the Act. They are fundamental to the Act’s operation. This Part analyses how these guiding principles align with the Convention and makes recommendations for reform. Reforms proposed reflect a shift from a ‘best interests’ approach to decision-making to adopting a ‘will, preferences and rights’ model that recognises the importance of offering support to people who require support to make decisions affecting their lives. The recommendations outlined in this Part anchor proposals outlined in later parts of this Report.

3.2 The Convention and a will, preferences and rights approach to decision-making

As explained in Part 2, the Convention requires decisions about a person’s life to be directed by their ‘will, preference and rights.’ Rationales for basing decisions on a person’s will and preferences include that:

- every person should have the ability to make decisions that affect his or her life;
- people without disability are not required to establish that a decision is rational, or in their best interests; and
- decisions based on a person’s perceived best interests tend to overemphasise safety. All people have the right to take risks and make mistakes.

3.3 The ALRC’s National Decision-Making Principles

In 2014, the ALRC reviewed the effect of the Convention on Commonwealth laws. Through a consultative process, it developed four National Decision-Making Principles, intended as a way to implement the principles of the Convention within Australia’s legal framework. It recommended that state guardianship laws be made consistent with four National Decision-Making Principles:

63 Convention Committee, above n 21, [22].
64 ALRC, above n 3.
3.3.2 The ALRC reinforced these Principles in its recent report on elder abuse, released in 2017.\footnote{ALRC, *Elder Abuse – A National Legal Response*, Final Report 131 (2017) [2.109].} The Decision-Making Principles have also been supported by the Senate Community Affairs Reference Committee\footnote{Senate Community Affairs References Committee, Parliament of Australia, *Report into Violence, abuse and neglect against people with disability in institutional and residential settings, including the gender and age related dimensions, and the particular situation of Aboriginal and Torres Strait Islander People with disability* (2015) Recommendation 6.} and the ACTLRAC.\footnote{ACTLRAC, above n 24, Recommendation 3.}

3.3.3 The Issues Paper asked whether the ALRC’s National Decision-Making Principles should form the basis of reform to the Act.

### Should reform to the Act be founded upon the ALRC’s National Decision-Making Principles?

The principles are:

- That all adults have an equal right to make decisions that affect their lives and to have those decisions respected.
- People who require support in decision-making must be provided with access to the support necessary for them to make, communicate and participate in decisions that affect their lives.
- Decisions that affect a person’s life must be directed by the person’s will, preferences and rights.
- Laws and legal frameworks must contain appropriate and effective safeguards in relation to interventions for persons who may require decision-making support, including to prevent abuse and undue influence.\footnote{Ibid Recommendation 3-1.}

3.3.4 There was broad support for the ALRC’s National Decision-Making Principles. Of the 19 written responses to this question, 10 agreed that the ALRC’s Decision-Making Principles would provide a strong basis for considering reforms to the Act. The other responses were not explicit in either supporting or rejecting the Principles. For example, the Board expressed neither support nor opposition to the Decision-Making Principles, but commented that it supported principles that would provide for guardianship approaches that are fully compatible with Australia’s international obligations under the Convention. Speak Out Advocacy also stated that the Act should fit the...
Convention. The Public Trustee acknowledged the National Decision-Making Principles but commented that it is content to work within the current framework.

3.3.5 Of the verbal submissions received, most comments indicated support for the Principles. Some commented that a represented person should have the ability to be spontaneous and spend their money as they wish. Others commented about the importance of ensuring that people with disability are acknowledged and heard, and certainly not ignored. Some perceived that guardianship laws are sometimes used improperly to exert power over individuals and families, with applications to the Board being made too readily where third parties (for example, health professionals, service providers or family members) disagree with the decisions that a person with disability is making.

3.3.6 National Disability Services (‘NDS’) submission observed that the NDIS Act is one example of Commonwealth legislation that provides for people having choice and control in relation to decisions that affect their lives. It endorsed the ALRC’s Decision-Making Principles being used to achieve national consistency. Some family members and carers of NDIS participants, however, expressed concerns about the primacy given to a participant’s wishes under the Scheme. It was observed that decision-making based solely on a participant’s wishes or values can lead to harm to the person and have negative repercussions for those around them. Some perceived that a participant’s choice about the supports they receive, or do not receive, can create a burden upon those around them. Family members and carers felt that they had sometimes needed to help to resolve matters where problems or difficulties had arisen. It was commented that decisions that focus exclusively upon an individual’s wishes or values may only be workable where the person has the support of others around them who are able to act as a ‘buffer’ to mitigate adverse consequences. Concerns were raised about whether and how this form of person-centred decision-making works where an individual does not have a support network available to assist them.

3.3.7 Concerns that respondents raised in response to the ALRC’s Decision-Making Principles typically fell into one of two broad themes:

• firstly, that this does not amount to any broad variation to the Act’s current approach; and
• secondly, that the approach fails to adequately address the potential for harm.

These are discussed below.

Is this model any different to the Act at present?

3.3.8 Whilst a number of respondents commented that this approach will require a shift in focus and emphasis, others observed otherwise. The Board, for example, commented that the Convention ‘does not focus in any novel way upon the rights of and obligations to those without or with impaired decision making capacity.’ It commented that the Convention requires appropriate safeguards, but that:

the ‘safeguards’ mandated are precisely those measures and considerations with are set out in the current legislative framework and which underpin the current decision making process of the Board.

3.3.9 The Board stated that it already interprets the Act in light of the Convention. It noted that both s 27 and s 57 of the Act set out what ‘best interests’ means for guardians and administrators, and that this includes consideration of the wishes of the person and the desirability of preserving existing relationships. Some stakeholders noted that the Act already:
Part 3: Guiding Principles of the Act

- requires a ‘least restrictive’ approach to be adopted where available;\(^{70}\)
- requires consideration of a person’s wishes, and for those wishes to be carried out wherever possible.\(^{71}\) The term ‘wishes’ aligns with a person’s ‘will and preferences’ using the language of the Convention; and
- involves taking into account a person’s ‘best interests.’\(^{72}\) Some observed that a person’s best interests and their wishes are so intrinsically linked that determining what is in a person’s ‘best interests’ cannot be ascertained without considering their wishes.

**Least restrictive alternative**

3.3.10 The Institute agrees that the guiding principle of adopting a least restrictive alternative is consistent with a human rights approach to decision-making for people requiring decision-making support.

**Relevance of a person’s wishes**

3.3.11 Presently all decisions under the Act must carry into effect a person’s wishes as much as possible.\(^{73}\) It is one of the Act’s three guiding principles.

3.3.12 One situation where it would not be possible to carry out a person’s wishes is when those wishes are inconsistent with what is determined to be in their best interests, because representatives have a duty to act at all times in a person’s best interests.\(^{74}\) The effect is that the Act only permits decisions that carry out a person’s wishes where those wishes are consistent with their best interests.\(^{75}\)

**Best interests**

3.3.13 The Convention Committee has stated that ‘the “best interests” principle is not a safeguard which complies with article 12 [of the Convention] in relation to adults.’\(^{76}\) The ALRC has interpreted the Convention to mean that a person’s will and preferences must form the basis of a decision and are only able to be overridden to prevent harm.\(^{77}\) Only where a person’s will and preferences cannot be reasonably determined should decisions be based upon promoting a person’s human rights.\(^{78}\) This approach is discussed further in Part 11.

\(^{70}\) *Guardianship and Administration Act 1995* (Tas) s 6(a).

\(^{71}\) Ibid s 6(c).

\(^{72}\) Ibid s 6(b).

\(^{73}\) Ibid s 6.

\(^{74}\) Ibid ss 27(1), 57(1).

\(^{75}\) The *Powers of Attorney Act*, on the other hand, allows an attorney to make decisions that are consistent with a donor’s wishes, or likely wishes, even where those wishes are not in the donor’s best interests. It provides that an attorney has not failed to protect a donor’s interests if it is ‘an exercise of a power that the donor would have been likely to make if he or she were not subject to a mental incapacity’: *Powers of Attorney Act 2000* (Tas) s 32(1B).

\(^{76}\) Convention Committee, above n 21, [21].

\(^{77}\) ALRC, above n 3, Recommendation 3-3(2).

\(^{78}\) See this approach endorsed by the ALRC and ACTLRAC: ALRC, above n 66, Part 3 Principle 3; ACTLRAC, above n 24, Recommendation 3; VLRC, above n 24, see Recommendation 21, for example.
3.3.14 Taking into account a person’s ‘best interests’ can involve consideration of their human rights. But it can also result in a person’s will and preferences being overridden where their will and preferences are assessed to not be in their best interests. The Act’s requirement that representatives uphold a person’s best interests at all times does not give sufficient authority to representatives who may want to act consistently with a person’s wishes, despite those wishes not necessarily being consistent with their ‘best interests.’ The ‘best interests’ approach requires decisions that are deemed best for a person. Under a will, preferences and rights approach, the focus is upon a person’s wishes, whilst considering harm.

<table>
<thead>
<tr>
<th>The Act</th>
<th>The Convention</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Try to adopt a person’s wishes but do what is best for them.</em></td>
<td><em>A person’s wishes prevail and may only be departed from if it affects their other rights.</em></td>
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3.3.15 This can be demonstrated using the following example:

Jane adores her three cats. She wants to convert her spare room into a giant custom-built cat run, estimated to cost thousands of dollars to build.

Following the current approach under the Act, Jane’s administrator is only permitted to use Jane’s financial resources in her best interests, even if this is what Jane really wants. Her administrator does not consider this use of money to be in Jane’s best interests.

Under a will, preferences and rights approach, Jane’s administrator would be required to act in accordance with Jane’s wishes, unless it would result in unacceptable harm. Unacceptable harm in this example could, for example, include where this would leave Jane without any money to buy food.

3.3.16 Some decision-makers might view a person’s ‘best interests’ as effectively amounting to the sum of the other parts — in other words, that it is the end result of adopting the least restrictive alternative and carrying into effect a person’s wishes. Other decision-makers may interpret s 6 to mean that ‘best interests’ is something separate to what is the least restrictive alternative and consistent with a person’s wishes, noting that it is listed as a distinct factor to consider. Some representatives may not appreciate the rights confirmed under the Convention and how they affect interpretation of the Act.

3.3.17 The three existing guiding principles of the Act are not expressed to be in any particular order of priority, and there is nothing to indicate any particular weighting that should be given to each consideration — a matter that the Office of the Public Guardian (OPG) raised in its submission. The only words that give any guidance are the limiting words of ‘if possible’ which are only used in relation to consideration of the least restrictive alternative and a person’s wishes.

**Other ways to achieve a will, preferences and rights approach to decision-making**

3.3.18 It is acknowledged that the ALRC’s National Decision-Making Principles and accompanying Guidelines are only one way to achieve greater compliance with the Convention. It is not necessarily the only way. One alternative could be to continue to adopt the term ‘best interests’, but with the phrase ‘best interests’ defined to provide a greater rights-based focus. The Issues Paper noted that some jurisdictions continue to adopt the term ‘best interests’ within their guardianship
laws. The Northern Territory, for example, adopts the language of ‘best interests’, but with the term defined to promote a rights-based perspective.

3.3.19 The Institute called for submissions about whether there is support for retaining ‘best interests’ as part of the Act and, if so, whether it would be useful to define the term.

(i) Should the term ‘best interests’ remain part of the Act?

(ii) If so, what should ‘best interests’ be explained?

3.3.20 There were 22 written submissions addressing this question, in addition to a number of verbal submissions and comments. Not all respondents expressly answered in the affirmative or negative, with a number making observations indicating a preference one way or another. Ten written submissions expressed support for retaining a requirement to consider a person’s ‘best interests’ as part of the Act. Of these, the substantial majority supported the phrase being defined or explained.

3.3.21 Some respondents that supported continuation of a ‘best interests’ approach suggested that it may be appropriate where it is not possible to make a decision consistent with a person’s will and preference. The Medical Insurance Group Australia (MIGA), for example, commented in relation to medical treatment decisions that there may at times be good reason to depart from a person’s will and preference. Specifically, it wished to ensure that medical professionals were not compelled to act in accordance with a patient’s will and preference without exception. Appropriate exceptions given included where a decision would be impractical or impossible. In those circumstances, it supported continuation of decisions being based upon a patient’s best interests. Another submission also commented that ‘best interests’ may be an alternative default test where the person’s wishes are totally impracticable. These comments and concerns are addressed in Part 11 via the Decision-Making Process that it is proposed representatives and the Board be required to follow.

3.3.22 One submission suggested that the phrase ‘best interests’ be defined to mean that no detriment arises from the decision. Similarly, the Board commented that:

Given the complexities of financial management and the realities of financial elder abuse, there is some reluctance to entirely abandon the ‘best interests’ model that currently operates in these circumstances. The legislation must require the person appointed to a decision making role to identify and follow the person’s wishes wherever possible, but not in situations where to do so would cause undue harm or risk of abuse. This concern is overcome if a similar provision to section 9(1)(d) of the decision-making principles of the Victorian Guardianship and Administration Bill 2018 is included in the Act.

79 See TLRI, above n 69, [2.6.2]. See for example Mental Capacity Act 2005 (UK) s 4.
80 Advance Personal Planning Act 2016 (NT) ss 22(6A), (7).
81 TLRI, above n 69, Question 2.3.
82 MIGA is a medical defence organisation and medical indemnity insurer advising, assisting and educating medical practitioners, medical students, health care organisations and privately practising midwives throughout Australia.
83 See Recommendation 11.2.
84 Dr Elizabeth Pickup, General Practitioner.
85 This section provides that ‘the represented person’s will and preferences should only be overridden if it is necessary to do so to prevent serious harm to the represented person.’ This is incorporated into the Decision-Making Process: refer to Recommendation 11.2.
3.3.23 The Interim Commissioner for Children and Young Persons expressed support for continuation of the ‘best interests’ principle in relation to children, noting that Article 7 of the Convention requires that ‘in all actions concerning children with disabilities, the best interests of the child shall be a primary consideration.’ The Institute acknowledges and agrees with this reasoning and addresses this matter in Part 13.

3.3.24 Dr Lisa Eckstein supported retention of decision-making based on a person’s best interests. Dr Eckstein noted that ascertaining a person’s will and preference can be particularly difficult in the context of dementia, where a person’s will and preference might change over time. Dr Eckstein referred the Institute to a journal article demonstrating that, in relation to one individual, two people can reach different conclusions about what ‘will and preference’ should be adopted — the person’s will and preference before onset of dementia, or their will and preference with dementia. Similar observations were made about the challenges of identifying the will and preference of a person with anorexia nervosa:

Another situation where respecting a person’s wills and preferences may prove insufficient as a decision-making device is in the context of conditions like anorexia nervosa (AN) where the condition itself may impede persons from developing and expressing an authentic choice when it comes to receiving treatment. How should a decision-maker, for example, weigh a statement by an AN patient such as ‘I wasn’t really bothered about dying, as long as I died thin’ Should this overriding desire for thinness be taken as the person’s will and therefore the basis for medical decision-making? Determining a person’s wills and preferences is especially challenging when a person has suffered from a condition such as AN from the time that they were a minor and therefore they have never had the opportunity to express an authentic view.

3.3.25 Dr Eckstein therefore challenged a person’s will and preference as the primary tool for decision-making, concluding by commenting upon the comparative benefits of retaining a ‘best interests’ approach:

Best interests provides some objective criteria for reconciling these challenges, especially when recognised that the best interests standard needs to be informed by the person’s will and preferences, to the extent that these can be ascertained.

Retaining a best interests standard also recognises the practical challenges that decision-makers face in ascertaining a person’s will and preferences, and the stress that can be experienced by those faced with making such determinations. Notably, in a review of hypothetical treatment scenarios, surrogates only predicted a patient’s treatment choices...
68% of the time. Since most of the scenarios were binary choices, random guessing would have been correct about 50% of the time.\textsuperscript{92}

3.3.26 Seven written responses did not support retaining ‘best interests’ as part of the Act. A number of comments made during public consultation meetings also expressed concern with the way in which a ‘best interests’ approach is applied. Criticisms typically fell within one of two interrelated categories:

1. that what one person might think of as being in a person’s ‘best interests’ might be different to another’s perspective; and
2. because of this subjectivity, it can lead to decisions that are overly risk-averse.

3.3.27 The OPMHS observed that interpretation of best interests ‘can vary significantly between different decision makers with different focus.’ It commented that, if the term were retained, it should not be seen as a general standard, but should be ‘from the person’s perspective, taking into account their current and previous preferences, culture, lifestyle etc.’ In other words, what is important is what a person would themselves likely consider to be in their ‘best interests’, taking into account their values, rather than an objective standard based on a ‘reasonable person’, for example.

3.3.28 Respondents indicated concern that decision-makers may have a tendency to make decisions that are overly protectionist, or risk-averse when seeking to promote a person’s ‘best interest’. The Institute heard several examples from participants in community consultation sessions where family members or carers perceived that decision-makers had taken an overly protectionist approach. They commented that they had experienced situations where a represented person or loved one had been called upon to provide extensive details to satisfactorily demonstrate that a particular course of action would be in a person’s ‘best interests’. This was said to have occurred in relation to what they considered to be seemingly incidental, everyday financial and lifestyle matters.\textsuperscript{93}

3.3.29 Advocacy Tasmania observed:

While it may be possible to reform this language to reflect a more contemporary and rights-based understanding, this language really reflects a long history of people’s rights and choices being taken away and substituted with what someone else thinks is best for them. Being able to determine what is in our own interests is an essential part of being human and having the support to consider and make these decisions is where the focus of the Act needs to be.

3.3.30 It was generally accepted that guardianship law should move away from paternalistic notions. The Board, for example, endorsed legislative guidance about what the term ‘best interests’ means to assist in moving away from paternalistic notions of ‘best interests’.

\textit{Conclusion}

3.3.31 The Institute appreciates that the difference in approach and outcome might depend upon how individual decision-makers weigh the sometimes competing considerations in s 6 of the Act. It


\textsuperscript{93} Examples provided included, for example, where a person seeks to access money for a new pair of shoes, or wants a chocolate bar after dinner.
has concluded, however, that a will, preferences and rights approach is fundamentally different to the Act’s present formulation, necessitating legislative reform. A change in language is necessary to emphasise the rights of the individual and to move away from paternalistic notions of guardianship. The term ‘best interests’ is not included within recent legislative reforms in Victoria and Queensland. It has also been omitted in recent recommendations for reform made in New South Wales.

Consideration of harm

3.3.32 The second concern expressed in relation to the ALRC’s National Decision-Making Principles related to Principle 3 — that ‘Decisions that affect a person’s life must be directed by the person’s will, preferences and rights.’ Comments made related to how this Principle takes into account the risk of harm to a person.

3.3.33 The Board commented in its submission that, by virtue of Australia’s ratification of the Convention, the emphasis should be upon prioritising the ‘rights, will and preferences’ of a person ‘where this will not cause harm’ (emphasis added). The OPMHS submitted that it supported the ALRC’s Decision-Making Principles, but also commented that there should be consideration of harm. Clinical Associate Professor Robyn Wallace also raised the issue of harm in her submission. Associate Professor Wallace commented that, whilst the equal right to make decisions and to have those decisions respected is fundamental, it can also be problematic if decisions are not informed. For example, what if a person’s decision would result in adverse consequences but they are not capable of understanding those consequences? These concerns appear primarily based on the need to ensure that reforms that require focus upon a person’s ‘will, preferences and rights’ do not result in a person’s other human rights being denied.

3.3.34 It is acknowledged and agreed that it is important that any decision-making framework consider and adequately resolve issues of harm in order to safeguard a person’s rights and interests. However, the Institute makes the following observations:

3.3.35 Individuals have a range of tolerance to risk. What is an unacceptable level of harm or risk for one person might be an acceptable level to another. In other words, assessment of risk, and tolerance to it, is subjective. A representative or the Board might have a different level of risk tolerance to a represented person.

3.3.36 The Institute also observes the importance of allowing individuals to take risks (the ‘dignity of risk’), a matter highlighted by COTA in its submission. The ability to take risks is said to be fundamental to personhood. The freedom to make mistakes and learn from them is part of building

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94 Which uses the phrase ‘personal and social wellbeing’, which is defined in Guardianship and Administration Bill 2018 (Vic) cl 4.
95 Which focuses on promoting and safeguarding an adult’s rights, interests and opportunities: see for example, cl 8 Guardianship and Administration Bill 2018 (Qld).
96 See for example, NSWLRC, above 24, Recommendation 5.4.
97 Chair of the Royal Australia College of Physicians Tasmanian Regional Committee.
Part 3: Guiding Principles of the Act

3.3.37 Under a risk analysis framework, consideration needs to be given to the likelihood of harm. There is only the potential for harm where a person’s will and preference are at the forefront of decision-making. On the other hand, there is certain denial of a person’s rights if a will, preference and rights approach is not adopted. Giving preference to avoiding the risk of harm or abuse over a certain denial of a person’s rights implies that the rights outlined in Article 12 of the Convention are of lesser importance than other human rights.

3.3.38 It must also be recognised that there is the potential for harm under the current model. There is the risk that representatives might abuse or exploit a represented person, act incompetently, contrary to the principles of the Act, or give priority to their own personal interests over the interests of a represented person.

3.3.39 The Convention requires decision-making based on a person’s will, preferences, and rights (emphasis added). This explicitly requires consideration of a person’s human rights. The ALRC interprets this to mean that it may be appropriate, in extreme circumstances, that a person’s will and preference not be adopted where it would result in a denial of the person’s other human rights. The Institute considers that the ALRC’s resulting Rights, Will and Preference Guidelines address the relevance of the risk of harm in these circumstances. These Guidelines are discussed further in Part 11 and are incorporated into the proposed Decision-Making Process for the Board and representatives to follow when providing a person with decision-making support.

The Institute’s view

3.3.40 Reform to the Act should be aimed towards achieving the ultimate goal of compliance with the Convention. Advocacy Tasmania’s submission is noted, which commented in response to the ALRC’s National Decision-Making Principles that:

The first three principles are essential to shift the focus from being on a person’s disability and best interests to their rights, choices and the support they need to exercise those rights on an equal basis with other people. This focus shift is a fundamental aspect of the UN Convention and contemporary understanding and recognition of the inherent rights, dignity and autonomy of people with disability.

3.3.41 It is acknowledged that the ALRC’s Decision-Making Principles are only one method to achieve greater compliance with the Convention. However, one benefit to adopting the Principles is that they provide a framework from which to develop nationally consistent laws.

Achieving National Consistency

3.3.42 One criticism made frequently during the Institute’s public consultation was the lack of consistency amongst guardianship laws across Australia. The Institute heard numerous examples where difficulties had arisen where enduring documents or orders were made outside of Tasmania but needed to be used within the state. The practical steps involved in having arrangements made in one jurisdiction recognised in another were described as cumbersome. Similarly, community members expressed concerns about the validity of documents created under the Act when they may
need to be used in another jurisdiction where different laws apply. This might occur, for example, when someone travels interstate for leisure or for medical treatment or moves interstate.

3.3.43 A further benefit to developing nationally consistent guardianship laws would likely be to dispel or reduce community misunderstanding of the Act. ‘Folklore’ can often arise because people mistakenly assume that the Act is consistent with laws in other jurisdictions, which may in fact be materially different.

3.3.44 The Institute was told frequently during its public consultations that greater uniformity amongst guardianship laws across Australia is critical to ensuring that the law is responsive to the needs of the community. Whilst the ALRC’s Principles are only one way that uniformity could be achieved, they provide a useful framework that can be progressed at a state level, pending progress towards uniform legislation at a national level. The ACTLRAC has recommended that the ALRC’s Decision-Making Principles be adopted in the ACT. It could be expected that legislative reforms at a national level will also consider, if not adopt, the National Decision-Making Principles as a framework. The NDIS is one example. It is therefore anticipated that, not only will adopting the Decision-Making Principles achieve greater compliance with the Convention, but it will also assist in achieving greater consistency amongst laws across Australia.

3.3.45 Given public support for the approach, that it aligns with the Convention, and that it may assist to achieve greater consistency amongst legislation and policy across Australia, the Institute recommends that reforms be founded upon the ALRC’s Decision-Making Principles.

Recommendation 3.1

That the ALRC’s National Decision-Making Principles guide reform to the Act:

(1) That all adults have an equal right to make decisions that affect their lives and to have those decisions respected.

(2) People who require support in decision-making must be provided with access to the support necessary for them to make, communicate and participate in decisions that affect their lives.

(3) Decisions that affect a person’s life must be directed by the person’s will, preferences and rights.

(4) Laws and legal frameworks must contain appropriate and effective safeguards in relation to interventions for people who may require decision-making support, including to prevent abuse and undue influence.

3.4 Guiding principles of the Act

3.4.1 As explained earlier in this Part, the Act contains overarching principles that govern the operation of the Act. These principles require all functions and powers to be performed so that:

- the means which is the least restrictive of a person’s freedom of decision and action as is possible in the circumstances is adopted;
- the best interests of a person are promoted; and

101 ACTLRAC, above n 24, Recommendation 3.
Part 3: Guiding Principles of the Act

- the wishes of a person with a disability or in respect of whom an application is made under the Act are, if possible, carried into effect.\(^{102}\)

3.4.2 The Issues Paper provided examples of principles governing guardianship laws in other jurisdictions and asked for stakeholder’s views about what principles should guide the operation of the Act.

<table>
<thead>
<tr>
<th>What principles should guide the operation of the Act?(^{103})</th>
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3.4.3 There were 16 written and verbal submissions addressing this question.

3.4.4 The Board, EOT, and Advocacy Tasmania supported the principles of the Convention forming the guiding principles of the Act. TasCOSS also supported the Convention being used to guide the operation of the Act:

Where a decision cannot be made by the person, even with support, for example if a person is in a coma or otherwise unable to communicate, Article 12 makes it clear that a decision be made that is “the best interpretation of will and preferences”. This should replace “best interest” interpretations which are highly subjective—and often based on gendered and class- and race-based notions of what makes “a good life”—and may be in conflict with the person's will and preferences. The ACT Spectrum of Support report argues that what is required is “decision support … provided to people to enable their will and preference to be heard in substitute decisions that are being made by others.

3.4.5 The OPG gave examples of ways that s 6 of the Act could be reformed:

The OPG considers the principles underpinning the Act should be reviewed in line with contemporary thinking about the priority to putting into effect the person’s will and preferences; allowing the dignity of risk; the right to support for decision-making and the promotion of autonomy in decision-making; the promotion of personal, emotional and social well-being; the right to full participation in civil and social life; the right to live free from abuse, neglect and exploitation; the recognition of informal support, family, friends and carers; and the adoption of the least restrictive alternative.

3.4.6 Palliative Care Tasmania (PCT) also gave suggestions of principles that could be adopted to guide operation of the Act, including:

- a person’s right to be involved in decision making, even if they lack capacity;
- the right to consent to treatment and care; and
- the right to be listened to.

3.4.7 The Mental Health Tribunal (MHT) referred the Institute to the New South Wales’ Disability Inclusion Act 2014 as providing a useful example of legislation supporting the objectives of the NDIS.\(^{104}\)

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\(^{102}\) Guardianship and Administration Act 1995 (Tas) s 6.

\(^{103}\) TLRI, above n 69, Question 2.1.

\(^{104}\) Disability Inclusion Act 2014 (NSW) s 4. The general principles are as follows:

(1) For the purposes of this Act, the disability principles relating to people with disability are the general principles set out in this section.

(2) People with disability have an inherent right to respect for their worth and dignity as individuals.
Adopting the principles of the Convention

3.4.8 The Institute agrees that reform to the Act should align with the Convention. The best way to achieve this is to enshrine the principles of the Convention\(^\text{105}\) directly in the Act. Doing so would require those applying the Act to consider and uphold the principles of the Convention. It may also serve a broader educative purpose as it is expected that a substantial proportion of the community are unaware of the Convention or its governing principles. It is unlikely that those who come into contact with the Act would have the inclination to review the Convention. They may, however, review key parts of the Act, or be guided by educational resources which would likely highlight key elements of the Act.

3.4.9 The principles of the Convention have been incorporated into the *Disability Services Act*\(^\text{106}\). Similar provisions are also contained in the *Mental Health Act*\(^\text{107}\). Tasmania’s *Disability Framework for Action 2018–2021* also adopts the principles of the Convention.\(^\text{108}\) The Act already adopts a variation of one of the principles by providing that people must be encouraged and supported to participate in the life of the community as much as possible.\(^\text{109}\)

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3 People with disability have the right to participate in and contribute to social and economic life and should be supported to develop and enhance their skills and experience.

4 People with disability have the right to realise their physical, social, sexual, reproductive, emotional and intellectual capacities.

5 People with disability have the same rights as other members of the community to make decisions that affect their lives (including decisions involving risk) to the full extent of their capacity to do so and to be supported in making those decisions if they want or require support.

6 People with disability have the right to respect for their cultural or linguistic diversity, age, gender, sexual orientation and religious beliefs.

7 The right to privacy and confidentiality for people with disability is to be respected.

8 People with disability have the right to live free from neglect, abuse and exploitation.

9 People with disability have the right to access information in a way that is appropriate for their disability and cultural background, and enables them to make informed choices.

10 People with disability have the same right as other members of the community to pursue complaints.

11 The crucial role of families, carers and other significant persons in the lives of people with disability, and the importance of preserving relationships with families, carers and other significant persons, is to be acknowledged and respected.

12 The needs of children with disability as they mature, and their rights as equal members of the community, are to be respected.

13 The changing abilities, strengths, goals and needs of people with disability as they age are to be respected.

\(^{105}\) *Convention on the Rights of Persons with Disabilities* art 3.

\(^{106}\) *Disability Services Act 2011* (Tas) s 5(2)(c)-(j). The Institute notes, however, that the recent report into the review of the *Disability Services Act* comments that the Commissioner for Children submitted that ‘Principles in the Act are high level, “directional” statements that may not be specific enough to deliver safe, quality services to people with disability.’ It thus concludes that ‘There is no overarching human rights framework in Tasmania therefore the CRPD needs to be incorporated more transparently into the Principles, particularly those pertaining to children and young people in Article 7.’ The report recommends that this be achieved by way of adoption of s 4 of the *NDIS Act* (general principles guiding actions under this Act): *Review of the Disability Services Act 2011*, Report of the Review Committee (29 June 2018) 25–26, Recommendation 1. The Institute has not recommended a similar approach on the basis that s 4 of the *NDIS Act* is directed towards access to support services.

\(^{107}\) *Mental Health Act 2013* (Tas) sch 1(ª).

\(^{108}\) Communities, Sport and Recreation, above n 37.

\(^{109}\) *Guardianship and Administration Act 1995* (Tas) ss 27(2), 58(2)(b).
Recommendation 3.2

That the principles of the Convention be included in the Act. These principles are:

(a) there must be respect for the inherent dignity of persons with disability and their individual autonomy including the freedom to make one’s own choices, and their right to independence;
(b) persons with disability are not to be discriminated against;
(c) persons with disability are to be given the opportunity for full and effective participation and inclusion in society;
(d) there must be respect for difference and acceptance of persons with disability as part of human diversity and humanity;
(e) people with disability must have equality of opportunity;
(f) services are to be as physically and technologically accessible as possible to persons with disability;
(g) equality between men and women is to be promoted; and
(h) respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

Revised guiding principles

3.4.10 Based on feedback received, there are several principles that the Institute considers should be adopted as guiding principles of the Act. These are explained below.

That people who require support in decision-making must be provided with access to the most effective support necessary for them to make, communicate and participate in decisions that affect their lives

3.4.11 This adopts Principle 2 of the ALRC’s National Decision-Making Process. The Institute recommends a minor variation by requiring ‘effective’ supports to be made available. This ensures that supports are of a high quality and tailored to the individual to best enable a person to make decisions affecting their lives. An equivalent requirement is contained in Saskatchewan in Canada.\footnote{Adult Guardianship and Co-Decision-Making Act 2000 (Sask) s 3.} A variation also appears in the new Victorian legislation, requiring provision of ‘practicable and appropriate’ support.\footnote{Guardianship and Administration Bill 2018 (Vic) cl 8(1).}

That the views, wishes, preferences and rights of people who may require decision-making support must direct decisions that affect their lives

3.4.12 This adopts Principle 3 of the endorsed ALRC’s National Decision-Making Process.

The role of families, carers and other significant persons in an adult’s life to support the adult to make decisions must be acknowledged and respected

3.4.13 This recommendation adopts one of the guiding principles of guardianship legislation in Queensland.\footnote{Guardianship and Administration and other Legislation Amendment Bill 2018 (Queensland) cl 8.} It is intended to reinforce the critical role that informal supporters, carers and others
close to a person play in supporting a person and advancing their rights and interests. A number of respondents identified this as a gap in the current legislation, causing support networks to feel excluded.\(^{113}\) This reform complements the *Tasmania Carer Policy*, with one of its key objectives being an increased recognition of carers.\(^{114}\)

*A function or power conferred, or duty imposed, by this Act is to be performed so that the means that are the least restrictive of the person’s freedom of decision and action as possible in the circumstances is adopted*

3.4.14 This principle is consistent with one of the existing guiding principles.\(^{115}\) What is least restrictive of a person’s freedom of decision and action is consistent with the Convention and the ALRC Decision-Making Principles because it focuses on people’s human rights and autonomy. It implicitly endorses use of informal support for decision-making and is aimed at ensuring that people do not have a representative appointed on their behalf if their needs could be met in less restrictive ways. It has also remained one of the guiding principles in proposed revisions to the legislation in Victoria.\(^{116}\)

### Recommendation 3.3

That the guiding principles of the Act include:

- people who require support in decision-making must be provided with access to the most effective support necessary for them to make, communicate and participate in decisions that affect their lives;
- the views, wishes, preferences and rights of persons who may require decision-making support must direct decisions that affect their lives;
- the role of families, carers and other significant persons in an adult’s life to support the adult to make decisions must be acknowledged and respected; and
- a function or power conferred, or duty imposed, by this Act is to be performed so that the means that are the least restrictive of the person’s freedom of decision and action as possible in the circumstances is adopted.

### Requiring informal supporters to apply the general principles

3.4.15 One of the gaps within the existing legal framework is a lack of clarity about the role and duties of informal supporters who are not formally appointed as representatives and thus not subject to the Board’s oversight. This gap creates a risk of informal supporters failing to act in accordance with the rights and interests of the person that they are supporting informally. The Board’s submission estimates that about 1.83% of the population living in Tasmania with a ‘mental or behavioural disorder’ disability had an application to the Board made about them. Further, only about 0.89% of the population living with a ‘mental or behavioural disorder’ disability in Tasmania is subject to an order of the Board. This means that by far the greatest number of people who may be in need of decision-making support fall outside of the Board’s oversight.

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\(^{113}\) Primarily Carers Tasmania, and carers attending consultation meetings, but along with other individual respondents.


\(^{115}\) *Guardianship and Administration Act 1995* (Tas) s 6(a).

\(^{116}\) Guardianship and Administration Bill 2018 (Vic) cl 8(1)(e).
Part 3: Guiding Principles of the Act

3.4.16 The Institute endorses Queensland’s approach where legislation confirms that informal supporters must uphold and apply the general principles of guardianship legislation.\(^\text{117}\) This reform was introduced in Queensland in accordance with the QLRC’s recommendations.\(^\text{118}\)

3.4.17 It is not suggested that a penalty be included in the Act where an informal supporter breaches their duties. Depending upon the conduct, it could, however, have implications under other laws.

<table>
<thead>
<tr>
<th>Recommendation 3.4</th>
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<tbody>
<tr>
<td>That the guiding principles of the Act apply to any person assisting someone or making a decision for a person informally.</td>
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</table>

**Encouraging the community to uphold the general principles**

3.4.18 The Act can and should play a role in reinforcing the rights of people requiring decision-making support. Similar to Recommendation 3.4, it is suggested that all members of the community be encouraged to uphold and promote the general principles of the Act. This proposal reinforces the role that everyone has in ensuring that the rights of people requiring decision-making support are upheld. In this way, it serves an educative function aimed at influencing community behaviour.

3.4.19 As commented in relation to Recommendation 3.4, it is not suggested that the Act impose sanctions where members of the community breach the Act’s guiding principles. It is instead intended to serve a proactive, educative function.

<table>
<thead>
<tr>
<th>Recommendation 3.5</th>
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<tr>
<td>That all members of the community be encouraged to uphold and promote the Act’s guiding principles.</td>
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</tbody>
</table>

**3.5 Process for representative decision-making**

3.5.1 This Part has outlined revised guiding principles of the Act. The Institute makes further recommendations about when and how decision-maker’s ought to make decisions in Part 11.\(^\text{119}\)

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\(^{117}\) *Guardianship and Administration Act 2000* (Qld) s 11(3).

\(^{118}\) QLRC, above n 25, Recommendation 4-2.

\(^{119}\) See Recommendation 11.2.
Part 4

Appointing your own Representative

4.1 Introduction

4.1.1 This Part considers how the Act governs the way in which a person can appoint their own representative. The legislative framework in Tasmania provides for the separate appointments of enduring representatives for financial matters (called attorneys) and representatives for personal matters (called enduring guardians). The Powers of Attorney Act deals with the appointment, removal and supervision of attorneys. The Act governs the appointment, removal and supervision of enduring guardians. The scope of this review is to evaluate the need for reform to the Act rather than the Powers of Attorney Act although there is broad alignment between the Acts and the desirability for consistency in approach.

4.1.2 The appointment of one’s own decision-maker is a key element of the decision-making continuum. It provides one method for individuals to exercise choice and control in deciding who they wish to act as their representative in the future, if the need were to arise. Advance care directives are another document that enable a person to retain control of decisions affecting their lives, and these are considered in the following Part. Other parts are also relevant to the role of enduring guardians: Parts 6 and 8 consider when the powers of an enduring guardian should become operative, Part 9 reviews the powers and functions of guardians, and Part 12 considers safeguards for representative decision-making.

4.1.3 Whilst the Terms of Reference did not specifically call for a review of the appointment of an enduring guardian or use of advance care directives, the Institute considers that these two documents are fundamental to the operation of the Act because they provide a means to support people to make their own decision.

4.2 The representative decision-making scheme

4.2.1 Tasmania has separate appointments of decision-makers for financial matters and personal matters. A representative appointed by a person to make financial decisions is called an ‘attorney’. Statutory provisions dealing with the role and powers of attorneys are contained in the Powers of Attorney Act. A representative appointed by a person to make personal decisions is called an ‘enduring guardian’. Statutory provisions dealing with the role and powers of enduring guardians are contained in the Act. Also contained in the Act are provisions dealing with the appointment and powers of administrators and guardians. An ‘administrator’ is a person appointed by the Board to make financial decisions. A ‘guardian’ is a person appointed by the Board to make personal decisions. Table 4.1 explains the framework.

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120 Or the Public Trustee or Public Guardian.
121 Or the Public Guardian.
Table 4.1: Tasmanian representative decision-making framework

<table>
<thead>
<tr>
<th>Financial Representatives</th>
<th>Title given to representative</th>
<th>Governing legislation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appointed by a person for themselves</td>
<td>‘Attorney’</td>
<td>Powers of Attorney Act</td>
</tr>
<tr>
<td>Appointed by the Board</td>
<td>‘Administrator’</td>
<td>The Act</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Personal Representatives</th>
<th>Title given to representative</th>
<th>Governing legislation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appointed by the person for themselves</td>
<td>‘Enduring guardian’</td>
<td>The Act</td>
</tr>
<tr>
<td>Appointed by the Board</td>
<td>‘Guardian’</td>
<td>The Act</td>
</tr>
</tbody>
</table>

4.2.2 If a person wishes to appoint a representative for both personal and financial matters, then an instrument appointing an enduring guardian (an instrument) and enduring power of attorney are required. If the Board is satisfied that it needs to appoint a representative, then it must make separate orders appointing an administrator and guardian. There is no overlap between the roles and each serves a separate and distinct function to the other.

**Potential reform to the framework**

4.2.3 The House of Assembly Standing Committee on Community Development (the ‘Standing Committee’), in its recent Inquiry into Palliative Care, reported that they observed significant confusion amongst Tasmanians including some health care workers about the differences between an enduring power of attorney and an instrument.\(^\text{122}\) This observation raises the question of whether there should remain distinct roles of attorneys/administrators for financial decisions and enduring guardians/guardians for personal matters. In some jurisdictions a person may appoint one decision-maker for both financial and personal matters,\(^\text{123}\) and/or the relevant court or tribunal may appoint a single decision-maker with power to make both personal and financial decisions.\(^\text{124}\)

4.2.4 The Issues Paper outlined a range of potential advantages and disadvantages to each option. The question was posed whether the roles of representatives for personal and financial matters should remain separate or be consolidated.

<table>
<thead>
<tr>
<th>Should one representative be able to make both personal and financial decisions, or should the roles remain separate?(^\text{125})</th>
</tr>
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</table>

4.2.5 The substantial majority of respondents supported retention of separate representatives for personal and financial matters. It was observed that there may be occasions where one person could fulfil both functions, but it was considered that the role and titles should remain distinct. Only two submissions supported combining the roles, although both commented that they were also content with the current framework.


\(^\text{123}\) In Queensland, the ACT, Victoria, South Australia and the Northern Territory. The NSWLRC has recently made the same recommendation: see for example, NSWLRC, above n 24, Recommendation 4.3(3).

\(^\text{124}\) *Guardianship of Adults Act 2016* (NT) s 16; *Mental Capacity Act 2005* (UK) s 16; *Assisted Decision-Making (Capacity) Act 2015* (Ireland) s 38(2)(b).

\(^\text{125}\) TLRI, above n 69, Question 4.6.
4.2.6 Arguments supporting retention of separate roles included:

- the different skill sets and personal attributes needed for financial and personal decisions;\(^\text{126}\)
- the importance of avoiding ‘role creep’ where a representative is only required for, say, financial matters, but the representative attempts to expand their role into decisions about personal matters;
- it provides accountability where separate individuals are appointed and are thus able to monitor each other’s activities, acting as a safeguard;\(^\text{127}\)
- this approach still enables the appointment of the same individual(s) to make both financial and personal decisions if considered appropriate or desirable; and
- it provides an opportunity for a represented person to extend their networks.\(^\text{128}\)

4.2.7 The Institute observes that, fundamentally, retaining separate roles enables a person and the Board to easily and clearly designate personal and financial functions between different people where appropriate. Having a single role encompassing both personal and financial matters would make appointing different individuals for each function cumbersome.

4.2.8 Consistent with responses received, the Institute recommends that separate roles of representatives for financial and personal matters remain.

**Recommendation 4.1**

That the statutory framework retain separate representatives for financial decisions and personal matters.

**One enduring appointment**

4.2.9 Five responses to this question raised the possibility of reforming the legislative framework to enable a person to appoint both an attorney and an enduring guardian within the single enduring document. It was submitted that this would resolve confusion about the role and purpose of enduring powers of attorney and instruments and simplify the scheme. This approach is consistent with the ALRC’s proposal which recommends a single model document be created that enables the appointment of all decision-makers for financial, medical and personal matters.\(^\text{129}\) In proposing this approach, the ALRC noted that:

> A single agreement, while permitting the principal to appoint different individuals for different types of decisions, may reduce confusion as to what enduring documents have been signed, clarify the roles of attorneys and guardians, and reduce confusion as to who needs to be contacted with respect to a particular decision.\(^\text{130}\)

\(^{126}\) The Board commented: ‘This is recognised by some differences in the eligibility criteria set out in the Act for guardians and administrators.’

\(^{127}\) Speak Out submitted that separation of the roles means that ‘people don’t overstep the mark. Someone can be too much in charge of your life.’

\(^{128}\) Speak Out advocates.

\(^{129}\) ALRC, above n 66, Recommendation 5-3.

Part 4: Appointing your own Representative

4.2.10 The Institute understands that, anecdotally, there are occasions where individuals choose not to create an instrument at the time of making an enduring power of attorney. This can be for a range of reasons, including the desire to avoid legal costs and the registrations fee payable for two documents.\(^{131}\) The OPMHS’s submission commented that:

Currently, enduring guardian is often neglected and only a POA appointed. This leaves people vulnerable when treatment/lifestyle decisions are required and can lead to prolonged hospital stays, which are neither in the interest of the person concerned nor the wider community.

4.2.11 It is of concern to the Institute that some individuals may feel that they must choose between the appointment of an attorney and an enduring guardian because of the additional steps and cost required. This imposes a barrier to people nominating who they want to promote their rights and interests if the need for a representative arises. A person’s own appointment of their representative is a fundamental way in which they can exercise choice and control by deciding who they want to act, and the circumstances in which the representative may act. It also enables the donor to express their will and preference, by either making directions or expressing values and wishes to assist their representative in the role. This assists to achieve the fundamental principle of the Convention; that it is a person’s will and preference that must direct decisions affecting their life.

4.2.12 Another benefit of better facilitating individuals appointing their own representatives is a decreased need for applications to the Board for the appointment of a representative where an enduring appointment has not been made. It also reduces the guess work in ascertaining a person’s likely wishes in relation to their choice of representative in these circumstances.

4.2.13 The Institute has conducted this review taking into account overwhelming feedback received during the Institute’s community consultations and the House of Assembly Palliative Care Inquiry commenting that the law in this area is overly complex and confusing. It is desirable that the legislative framework be simplified. One of the ways that this could be achieved is by enabling a person to appoint representatives for financial and personal matters within the single enduring document.\(^{132}\)

4.2.14 It is outside of the Institute’s Terms of Reference to consider and make recommendations about the consolidation of the legislative framework regulating enduring appointments. Further consultation with stakeholders is necessary, along with consideration of a range of consequential reforms needed — including, amongst other matters, the registrations of any newly proposed single enduring document. For this reason, the Institute has not made recommendations as part of this review proposing reform to enable a person to appoint an attorney and enduring guardian within the one document. It is recommended, however, that this be further evaluated. It is also recommended that, if there is progress nationally to develop a model enduring document, as proposed by the ALRC, that any agreed approach is considered for introduction in Tasmania.

\(^{131}\) See [4.7] in relation to the registration of instruments.

\(^{132}\) See for example the NSWLRC’s recent recommendations: NSWLRC, above n 24, Recommendation 8.1.
**Recommendation 4.2**

(1) That the State Government investigate community and stakeholder support for the introduction of a single enduring document in Tasmania enabling the appointment of representatives for both financial and personal matters.

(2) That if a model enduring document is agreed nationally, consideration is given to adopting the model form.

### 4.3 Appointing an enduring guardian

#### 4.3.1 The following paragraphs review how a person appoints an enduring guardian.

#### 4.3.2 The ALRC made specific recommendations about enduring documents as part of its inquiry into Elder Abuse. It recommended that:

Safeguards against the misuse of an enduring document in state and territory legislation should:

- (a) recognise the ability of the principal to create enduring documents that give full powers, powers that are limited or restricted, and powers that are subject to conditions or circumstances;
- (b) require the appointed decision-maker to support and represent the will, preferences and rights of the principal;
- (c) enhance witnessing requirements;
- (d) restrict conflict transactions;
- (f) set out in simple terms the types of decisions that are outside the power of a person acting under an enduring document; and
- (g) mandate basic requirements for record keeping.\(^{133}\)

#### 4.3.3 Recommendations (a) and (c), are dealt with in this Part. Point (b) is dealt with in Parts 3 and 11, Point (f) is considered in Part 9 under the powers of guardians, and Points (d) and (g) are considered in Part 12 covering safeguards for representative decision-making.

### Capacity to make an instrument

#### 4.3.4 Any adult with capacity may appoint an enduring guardian. Part 6 outlines the test that assesses whether a person has capacity to make an instrument.

### Age of donors

#### 4.3.5 Only those who are 18 years or older may appoint an enduring guardian.\(^ {134}\) The Issues Paper asked whether a person under the age of 18 years ought to be able to appoint an enduring guardian.

**Should a person under the age of 18 years be able to appoint an enduring guardian?\(^ {135}\)**

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\(^{133}\) ALRC, above n 66, [5.16], Recommendation 5-1.

\(^{134}\) *Guardianship and Administration Act 1995* (Tas) s 32(1).
4.3.6 There were 11 responses to this question with eight respondents advocating that a person under the age of 18 years should be able to appoint an enduring guardian. Four of those respondents suggested that the age could be lowered to 16 years of age.

4.3.7 Members of the Elder Law and Succession Committee of the Law Society (Elder Law Committee) commented that there are existing laws enabling a child to make a Will. They noted that this example could be used to guide reform enabling a child to make an instrument.

4.3.8 Two submissions did not support reform to enable a child to appoint an enduring guardian, including the Board which commented that it considered that the existing provisions were appropriate.

4.3.9 The Institute observes existing provisions of the Act which describe the role of an enduring guardian as being akin to the relationship of parent and child. Whilst it is proposed later in this Report that this description be removed, it highlights that the role of an enduring guardian can include matters typically within the scope of a parent’s role. This Report does not make recommendations for reform to the Act to alter the existing position.

**Age of enduring guardians**

4.3.10 An enduring guardian must be an adult when they are appointed. In the Northern Territory, a person under the age of 18 years may be appointed as an enduring guardian, so long as their appointment only becomes operative after they have reached the age of 18.

4.3.11 The Institute asked whether a donor should be able to appoint a person under the age of 18 years to be their enduring guardian.

**Should a person under the age of 18 years be able to be an enduring guardian?**

4.3.12 There were five submissions addressing this question, with four supporting reform to enable a person under the age of 18 years to be appointed as an enduring guardian. Carers Tasmania commented:

> Many primary carers under the age of 18 have responsibilities beyond their years, in caring for a parent, sibling or other family member. Young carers are more likely to be living in low-resource and lone parent households with limited support from other family members. As a result, many young carers provide significant levels of decision making support.

> However, young carers often report not being recognised by their caring role by health professionals and service providers, and being excluded in discussions about their family member’s condition and treatment. Some provision in the Act for a limited guardianship order may be beneficial, in exceptional cases where the carer is under 18. Some young carer stories, collected as part of a project called ‘Young Carers Talk’ demonstrates some

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136 TLRI, above n 69, Question 15.1(i).
137 Recommendation 9.2.
138 Guardianship and Administration Act 1995 (Tas) s 32(3).
139 Advance Personal Planning Act 2016 (NT) s 15(2).
139 TLRI, above n 69, Question 15.1(ii).
examples where a young carer may have such responsibilities that considering this would make sense. The following are two examples:

'Caring for my mum involves a lot of supervision because things can escalate so quickly. She can wake up fine, and then a few hours later I am calling an ambulance because her pain is out of control. I provide her with a lot of emotional support. I help her when she needs medication and I accompany her to all her appointments so that I can understand her and advocate for her needs'.

'Mum can’t take on too many activities as it stresses her too much and she gets sick. When she is stressed, it’s hard for me because I have to help to sort it out. My sister’s conditions are moderate to severe, so when this happens I am left with a lot of responsibility'.

4.3.13 PCT similarly commented that it might be appropriate to enable a donor to appoint a child carer as their enduring guardian in certain circumstances.

4.3.14 The OPG stated that, whilst it supports reform to enable a child to be appointed as an enduring guardian, they should not be able act until they attain the age of 18 years. Members of the Elder Law Committee also commented that ‘If there is concern about the ability of the person to act, this appointment could be conditional upon the person attaining 18.’ They commented that the benefit to permitting a young person being able to be appointed as an enduring guardian is that it ‘would better allow for a person to appoint family members particularly if children are close to 18 and dementia is an issue for the appointor.’

4.3.15 The Institute agrees with the observations of members of the Elder Law Committee that it can be unduly restrictive to require an enduring guardian to be an adult when they are appointed, particularly where there is an urgent desire to appoint an enduring guardian because of a donor’s declining ability. It also restricts individuals who do not have others from within their social network suitable to appoint as their enduring guardian apart from a young person who may already be assisting the donor with decision-making informally.

4.3.16 The Institute therefore proposes that a person aged 16 years or older be able to be appointed as an enduring guardian, but that their appointment not become effective until they attain the age of 18 years. This allows the opportunity for the enduring guardian to decline the appointment upon reaching adulthood.

Recommendation 4.3

That a person aged 16 years and older be eligible to be appointed as an enduring guardian but that an enduring guardian not be permitted to act until they attain the age of 18 years.

Eligibility to be an enduring guardian

4.3.17 A person who is directly or indirectly responsible for the medical care or treatment of a donor in a professional or administrative capacity cannot be their enduring guardian.\[140\] The Issues Paper noted that this description makes it unclear whether the owners or staff of aged care facilities,
allied health care providers or other services providers are included within this group.\(^\text{141}\) It was noted that individuals ineligible to be an enduring guardian in other jurisdictions include:

- a donor’s care worker;\(^\text{142}\)
- a donor’s health provider;\(^\text{143}\)
- a donor’s accommodation provider;\(^\text{144}\)
- a donor’s support service provider;\(^\text{145}\) and
- the spouse, parent, child, brother, or sister of any of these people.\(^\text{146}\)

4.3.18 Feedback was requested about who ought to be eligible to be an enduring guardian.

Who should be eligible to act as an enduring guardian?\(^\text{147}\)

4.3.19 Respondents suggested that those eligible to be an enduring guardian should include:

- those with a demonstrated and positive social and emotional connection to the donor;
- the person who knows the donor well and has spoken to them about their wishes; and
- individuals who are sensible and reasonable.

4.3.20 The Board commented that the Public Guardian should be eligible to be appointed as an enduring guardian. This matter is considered at \([4.3.26]\) below.

4.3.21 Members of the Elder Law Committee commented that they considered it a better approach to state who is ineligible to be an enduring guardian. The Institute agrees with this statement, although age requirements are considered at \([4.3.10]\) above, and the Public Guardian’s eligibility considered in the following paragraph.

4.3.22 The Issues Paper also asked who ought to be ineligible to be appointed an enduring guardian.

Who should be ineligible to act as an enduring guardian?\(^\text{148}\)

4.3.23 The Board noted the Institute’s observations in the Issues Paper and commented that ‘[i]t appears that further clarity in the Act is appropriate including the possibility of enlarging the group of those ineligible, to reduce conflict of interests when dealing with external service, accommodation, and other providers.’ The OPG also stated ‘[t]he general view of the OPG is that anyone who has a direct or indirect role in the provision of paid care or medical treatment to the donor should be ineligible.’ Members of the Elder Law Committee endorsed reform in accordance with the list of


\(^{142}\) \textit{Powers of Attorney Act 2014} (Vic) s 28(1)(d); \textit{Powers of Attorney Act 1998} (Qld) ss 59, 59AA.

\(^{143}\) \textit{Powers of Attorney Act 2014} (Vic) s 28(1)(d).

\(^{144}\) Ibid.

\(^{145}\) \textit{Guardianship Act 1987} (NSW) s 6B; \textit{Powers of Attorney Act 1998} (Qld) ss 59, 59AA.

\(^{146}\) \textit{Guardianship Act 1987} (NSW) s 6B.

\(^{147}\) TLRI, above n 69, Question 15.2(i).

\(^{148}\) Ibid Question 15.2(iii).
The purpose of this type of document is to give a person the choice to appoint the person they want. Sometimes in practice the person who might be considered an ideal appointment is not who a person wants. The circumstances in which prima facie ineligibility and/or possible automatic revocation occurs need to be considered carefully and there needs to be some flexibility.

4.3.24 One submission stated that there is no need for reform to the existing position.

4.3.25 The Institute considers that the current classes of individuals excluded from appointment as an enduring guardian are too narrow. Descriptions do not neatly fit with those who are responsible for accommodation or other health care or services that the donor receives. It is therefore proposed that the Act be revised to exclude anyone with a direct or indirect role in the provision of paid care, accommodation or other services from being appointed as an enduring guardian. The rationale is that these classes of individuals have a conflict of interest between their role in providing paid services to the individual and their duties as an enduring guardian involving decision-making about care and services received. Conflicts (actual or perceived) may negatively impact the donor and compromise their rights and interests being paramount. A reform of this type would strengthen the existing exclusions, provide consistency with other jurisdictions and align with submissions received.

**Recommendation 4.4**

That any person who is directly or indirectly responsible for the health care or treatment, support services or accommodation of the donor in a professional or administrative capacity also be ineligible to be the donor’s enduring guardian under s 32(4) of the Act.

### The Public Guardian as an enduring guardian

4.3.26 The Act does not state that a donor can appoint the Public Guardian as their enduring guardian. The Board’s submission clarified that it can appoint the Public Guardian as an enduring guardian via its power to amend instruments.

4.3.27 In contrast, the Public Trustee may be appointed as a person’s attorney under the *Powers of Attorney Act*. In Queensland, the Public Guardian may be appointed as an enduring guardian. In the ACT, a donor may appoint the Public Trustee and Guardian (PTG) as their enduring guardian, but the PTG retains a discretion to decline an appointment.

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149 Ibid [15.3.9].
150 *Powers of Attorney Act 2014* (Vic) s 28(1)(d); *Powers of Attorney Act 1998* (Qld) ss 59, 59AA; *Guardianship Act 1987* (NSW) s 6B.
151 Although *Guardianship and Administration Act 1995* (Tas) s 32A(1) provides that “[a]n instrument of appointment of an enduring guardian under section 32(1) who is not the Public Guardian …”
152 Ibid s 34(1)(b)(i).
153 *Public Trustee Act 1930* (Tas) s 12(1).
154 The NSWLRC recommended that the proposed new Public Representative (formerly Public Guardian) not be eligible to be appointed as an enduring representative: NSWLRC, above n 24, Recommendation 8.3(1).
155 *Public Trustee and Guardian Act 1985* (ACT) s 13(4).
4.3.28 The Issues Paper noted that the inability to appoint the Public Guardian may restrict people’s choice when appointing an enduring guardian. On the other hand, the Public Guardian often will not have an existing relationship with a donor which may make it more difficult to make personal decisions for them than it would for someone who has an existing personal relationship with the donor.

4.3.29 The Institute sought feedback about whether the Public Guardian should be able to be appointed as an enduring guardian.

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<th>Should the Public Guardian be eligible to appointed as an enduring guardian?</th>
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4.3.30 Five responses expressed support for this reform, whilst two did not.

4.3.31 Both the OPG and PCT considered that the Public Guardian should not be eligible for appointment as an enduring guardian. The OPG stated that:

Enduring instruments provide for an alternative to the state stepping in as a substitute decision-maker. They enable the principle or donor to appoint someone of their own choosing to take on this role, usually a close family member or friend. There is a very small number of people who have no-one in their life who they want to fill this role, and a small number of those people would like to appoint the Public Guardian to provide some certainty or peace of mind. However, in the event that a person who has not made an enduring guardian appointment loses capacity and requires a substitute decision-maker, the state will in any case step in with the Public Guardian’s appointment if there is no suitable private person. Our view is that this is the preferred route to this outcome.

We also hold the view that with further community education and support, and potentially with the introduction of a statutory scheme, the making of an advance care directive may provide a satisfactory alternative for those who have no one to appoint as an enduring guardian.

It is not practical for the Public Guardian to hold enduring guardianship appointments for unknown people with whom we have no familiarity and no insight into their wishes. Appointing the Public Guardian as enduring guardian would preclude the appointment of a suitable person who might emerge after that appointment was made — for example, new relationships might develop, or new family members (e.g., children growing into adulthood) may become available.

In the relatively rare case where the donor does have close family members or friends, but expressly wants them precluded from appointment as guardian in the event they lose capacity, this should be noted in an advance care directive.

4.3.32 PCT commented that ‘[t]he Public Guardian should always be the Guardian of last resort.’

4.3.33 Two members of the public commented that this reform would make meaningful improvement to their life as they do not consider anyone from within their existing social networks appropriate to appoint as their enduring guardian. One indicated that this has caused distress to them and others in similar situations, whilst the other respondent commented:

I keep meaning to fill and file an Enduring Guardian and/or advance care directive form, but these seem to need me to nominate someone I know really well and who will still have their marbles after I’ve lost mine. Despite there being 7,000,000,000 people on the

156 TLRI, above n 69, Question 15.2(ii).
planet, none seem to meet these criteria. I’ve considered appointing a lawyer or an accountant, but being a person responsible seems not to be something they relish doing, and even if they did it, it is the sort of task for which they’d expect fees that’d leave me destitute… I can’t think of anyone more appropriate.

4.3.34 Appointing an enduring guardian is one of the ways that a person can exercise control and choice in determining their potential future representative, if the need were to arise. It can be part of advance care planning, a process that the Convention Committee endorses on the basis that it supports a person to communicate their will and preference.\textsuperscript{157}

4.3.35 The creation of an instrument requires the appointment of an enduring guardian. This is unlike an advance care directive (ACD), which does not require the appointment of a decision-maker as a pre-condition to completing the document. Effectively rendering a person unable to make an instrument if they have no one within their network from which to draw a suitable or available enduring guardian whom they would want to act in that role creates a barrier to those individuals exercising their will and preference. They are then limited to making an ACD as their means by which they can communicate and express their will and preference. Some individuals may prefer the alternative of an instrument which allows them to also nominate a person who can advocate on their behalf to ensure that their wishes and views are upheld.

4.3.36 Enabling a person to appoint the Public Guardian as their enduring guardian enables the donor to avoid the otherwise default statutory provisions that could result in their spouse, child, or other close friend or family member from acting as their ‘person responsible,’ if it would be inconsistent with their will and preference. As explained in Part 13, an individual’s ‘person responsible’ has power to make medical treatment decisions if the patient is unable to give or communicate their own consent to that treatment. The current definition of ‘person responsible’ does not require assessment of the suitability of the person, with the only pre-requisite being the nature of the relationship — for example, as the patient’s spouse or child. Recommendation 14.5 proposes that this test be revised, to require an assessment of whether the person is willing and able to act in the role (implicitly requiring consideration of their suitability). Nevertheless, the person’s suitability would be assessed at the time, by others on a patient’s behalf, typically the treating health professional seeking substitute consent to treatment. Suitability is not a matter that the individual would determine themselves. It is proposed\textsuperscript{158} that a person’s guardian be their ‘person responsible’ if the guardian has been granted specific powers in relation to health care matters. Permitting appointment of the Public Guardian as a person’s enduring guardian enables a person to plan and document wishes to circumvent operation of the default ‘person responsible’ scheme.

4.3.37 The present situation results in some individuals having limited options available to plan for future decision-making impairments. If a person without an enduring guardian becomes unable to make their own personal decisions, this may require an application to the Board. The Board must then determine, based on the information available at the time, the individual’s will and preference and who they may want to act on their behalf. Applications to the Board involve time, often in urgent and/or stressful circumstances. This might not be in the best interests of the person when compared to the alternative of the person having planned for and documented their will and preferences whilst they had the ability to do so. At a practical level, the more individuals who appoint

\textsuperscript{157} Convention Committee, above n 21, [17].

\textsuperscript{158} See Recommendation 14.3.
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an enduring guardian, the lesser workload for the Board who may otherwise be called upon to consider the appointment of a guardian for a person if the need arises.

4.3.38 In contrast, a person may appoint the Public Trustee as their attorney for financial matters. This allows individuals who are socially isolated to appoint the Public Trustee rather than requiring the Board’s appointment of an administrator. The Board commented that, for the sake of consistency, it would seem appropriate to enable a person to appoint the Public Guardian as an enduring guardian.

4.3.39 One assertion put forward to justify a different approach is that the Public Trustee acting as an attorney does not require as close a relationship to the represented person as is desirable for guardians. The Institute does not accept that this is necessarily correct. Decisions about a represented person's money should involve consideration of the represented person's individual circumstances and wishes. As recommended in Part 3, it is the person’s will and preferences that should have primacy when making decisions about the person’s life, consistent with the Convention. For one individual, it might be important to them that money is saved and spent conservatively to provide for a ‘buffer’ or contingency for future unknowns. For another individual, it might be important to them that money is spent on their lifestyle or leisure activities in priority to saving. There are also many situations where the decisions of an attorney and enduring guardian overlap or interact.

4.3.40 Accepting that the presence of an existing relationship is important; the reality is that some people may not have individuals from within existing social networks willing or able to act as their enduring guardian. There may, therefore, be no-one more suitable than the Public Guardian to act in the role. The Act already contemplates that there may be some individuals for whom there is no one within their personal relationships suitable to act in the role. That is one of the rationales for the role of the Public Guardian, to provide a decision-maker of last resort for those who do not have anyone else able to make decisions about personal matters.

4.3.41 Appointment of the Public Guardian as enduring guardian at an early opportunity, rather than a reactive appointment via the Board provides an opportunity for the Public Guardian to build a relationship with the donor. This may assist the Public Guardian with its potential future role and lead to better understanding of the donor’s will and preference. It is envisaged that the Public Guardian would be able to develop forms for donors to complete, to communicate further information including their values, wishes and preferences. In supporting this reform, members of the Elder Law Committee commented that: ‘It may be more practical to allow this appointment, but to have a system in place where the appointor can communicate with the Public Guardian about wishes and how the appointment would work.’

4.3.42 The OPG commented that if the legal framework surrounding ACDs were strengthened, this may reduce or eliminate the need for a person to appoint a representative by them being able to effectively make their own decisions in advance. Whilst ACDs can play an important role in enabling a person to convey their will and preference and make decisions for themselves (a matter considered in the following Part), the Institute foresees that it is likely to be difficult for a person making an ACD to give advance consent or make decisions about all potential matters impacting them in the
future. It may be that a representative is still needed to consider and make decisions consistent with a donor’s values directive, for example.  

4.3.43 Some people may not wish to appoint the Public Guardian as their enduring guardian due to the absence of an existing relationship. But the critical point is to facilitate individuals being able to appoint the Public Guardian if that is their choice. It ensures that, particularly for individuals who are socially isolated, they have the same opportunity to plan and express their will and preference in who they would want to make personal decisions for them in the future if they became unable to do so.

4.3.44 It is not expected that there would be a large group of individuals wishing to take advantage of this reform by appointing the Public Guardian as their enduring guardian. It is therefore not envisaged that this reform would result in a substantially increased workload for the Public Guardian. The Institute notes that the ACT model enables the Public Trustee and Guardian to decline an appointment. Whilst this approach is not preferred, it may provide a workable solution if there were strong opposition to this reform, particularly from the Public Guardian as the key stakeholder affected by the proposal.

Recommendation 4.5
That a donor be able to appoint the Public Guardian as an enduring guardian.

Substitute appointments

4.3.45 Substitute enduring guardians may be appointed to act during the ‘absence or incapacity’ of the first appointed enduring guardian. Other jurisdictions clarify that a substitute enduring guardian may act if the first appointed enduring guardian dies or resigns. For the avoidance of doubt, the Institute recommends equivalent revision to the relevant section, to confirm that a substitute enduring guardian may act upon the death or resignation of the enduring guardian.

Recommendation 4.6
That s 32A(2) of the Act confirm that an alternative enduring guardian has the functions of the enduring guardian not only upon the absence or incapacity of the enduring guardian, but also upon the death or resignation of the enduring guardian.

Refer to [5.4.3]–[5.4.5] in relation to the difference between a values directive and an instructional directive. In summary, an instructional directive gives directions about matters that they either do or do not give consent to — for example, ‘I object to a blood transfusion.’ A values directive, on the other hand, might make broad statements about views about particular matters without expressly indicating consent or refusal to consent to any specific treatment — for example, ‘I want to be kept comfortable.’ Statements such as ‘keep me comfortable’ may still require involvement of a representative to assist to promote the donor’s stated values and beliefs in relation to a particular decision — for example, where the individual is to reside or what treatment they have.

Public Trustee and Guardian Act 1983 (ACT) s 13(4).
Guardianship and Administration Act 1995 (Tas) s 32A.
See for example Guardianship Act 1987 (NSW) s 6DA(3).
4.4 The instrument

4.4.1 This section reviews the formal requirements to appoint an enduring guardian.

4.4.2 An enduring guardian is appointed by instrument in writing in accordance with a standard form contained in the Act, or a form with similar effect.\(^{163}\)

**Execution requirements**

4.4.3 The Act does not set out how an instrument can be executed by another person on a donor’s behalf. These provisions are included in some other guardianship Acts.\(^{164}\) The Institute recommends that equivalent provisions be included in the Act to confirm that a person who is physically unable to execute an instrument can still complete the document. This ensures that a person’s physical condition is not a barrier to the creation of an instrument if they otherwise have the ability to create an instrument.

4.4.4 The Victorian Act also clarifies how an instrument may be created using the assistance of an interpreter.\(^{165}\) It requires the interpreter to certify on the document that the donor appeared to understand the nature and effect of the document. It is suggested that an equivalent provision also be included in the Act, for the avoidance of doubt and to ensure that individuals for whom English is not their first language: 1) have the same ability to make an instrument as others; and 2) understand the nature and effect of the document. This may also function as a safeguard by reducing the risk of fraud or deception in the creation of an instrument.

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<th>Recommendation 4.7</th>
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<td>(1) That the Act enable a third party to execute an instrument or revocation of instrument on behalf of the donor, at the donor’s direction. The third party should be an adult and not an enduring guardian or witness to the instrument.</td>
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<td>(2) That the Act require interpreters to certify on an instrument or revocation of instrument that they are not aware of anything that causes them to believe that the donor does not understand the nature and effect of the instrument or revocation of instrument.</td>
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**Witnessing requirements**

4.4.5 The Act requires two adult witnesses to be present together to witness a donor execute an instrument.\(^{166}\) Witnesses do not need any special qualifications or experience. The Issues Paper commented that this is also the position for enduring powers of attorney under the *Powers of Attorney Act*, and for other documents, for example Wills and contracts of sale.

\(^{163}\) *Guardianship and Administration Act 1995* (Tas) ss 32(1), 32(2)(a).

\(^{164}\) This is included in Victoria and New South Wales: *Medical Treatment Planning and Decisions Act 2016* (Vic) s 37; *Powers of Attorney Act 2014* (Vic) s 34; *Guardianship Act 1987* (NSW) ss 6B(1)(b)(ii), 5 (definition of ‘eligible signer’). The NSW LRC has recently recommended that their Act permit an eligible signer to sign for the person in the presence of the person and at their discretion: NSW LRC, above n 24, Recommendation 8.4(2).

\(^{165}\) *Medical Treatment Planning and Decisions Act 2016* (Vic) s 99.

\(^{166}\) *Guardianship and Administration Act 1995* (Tas) s 32(2)(c).
4.4.6 The ALRC has recommended that two people should need to witness an instrument, with one being a professional ‘whose licence to practise is dependent upon their ongoing integrity and honesty and who is required to regularly undertake a course of continuing professional education that covers the skills and expertise necessary to witness an enduring document.’\textsuperscript{167} The ALRC recommended that witnesses should be required to explain key aspects of the document to donors.\textsuperscript{168} Some jurisdictions require witnesses to an instrument to have professional qualifications, for example be a person able to witness affidavits, a medical practitioner or another authorised class of people.\textsuperscript{169}

4.4.7 The Issues Paper noted that witnessing requirements must balance the need to avoid the potential for undue influence and exploitation with the need to not make requirements so onerous that they deter people from completing an instrument.\textsuperscript{170} In light of the ALRC’s recommendations and approaches in some jurisdictions, the Institute asked whether there needs to be any change to witnessing requirements.

| Should there be any changes to the witnessing requirements for instruments? |

4.4.8 The Board and OPG endorsed reform consistent with the ALRC’s recommendation that one witness be a professional medical or legal witness with ongoing and professional development requirements. They commented that this reform acts as an appropriate safeguard.

4.4.9 Members of the Elder Law Committee did not support this view. They commented that it could have the potential to act as a barrier to people completing an instrument:

This makes sense to see that documents are properly witnessed but it can be hard to find people and the witnesses who are ‘qualified’ often do not understand what they are actually witnessing. The Committee does not support the ALRC’s recommendations noted in 15.4.5 of the Issues paper as it may constitute a barrier and abandonment or indefinite postponement of the task/intention (including due to likely associated costs).

4.4.10 Two submissions stated that doctors should not be permitted to act as witnesses to instruments. Speak Out submitted that witnesses should ‘need to understand what they are doing.’

4.4.11 The ALRC’s recommendations are based on the need to ensure adequate safeguards for those requiring decision-making support, consistent with the Convention. Its proposal aims to address the risk of undue influence or fraud in the preparation of an instrument, or donors conferring powers upon an enduring guardian without understanding the nature and effect of the appointment.

4.4.12 The Institute has considered the ALRC’s recommendations and feedback from stakeholders and does not make recommendations for reform to the Act at this time. This is on the basis that:

\textsuperscript{167} ALRC, above n 66, [5.44]. This is part of implementation of Recommendation 5-1(c) which requires enhanced witnessing requirements.

\textsuperscript{168} Ibid [5.44], endorsing the recommendation of the Law Council of Australia. The requirement for witnesses to confirm that they have explained aspects of the document is included in the \textit{Powers of Attorney Act 2003} (NSW) s 19(1)(e).

\textsuperscript{169} \textit{Powers of Attorney Act 2014} (Vic) s 35(1)(b); \textit{Advance Personal Planning Act 2016} (NT) s 10(5). The NSWLRC’s recent recommendations propose retention of eligible signers: NSWLRC, above n 24, Recommendation 8.4(2).

\textsuperscript{170} See ALRC, above n 66, [5.26]–[5.27].

\textsuperscript{171} TLRI, above n 69, Question 15.3.
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- the Act already provides a safeguard in requiring there to be two adult witnesses, reducing the risk that an individual might be unduly influenced to make or revoke an instrument;
- the Act already limits those who are eligible to witness instruments to exclude relatives of a party to the instrument.\footnote{Guardianship and Administration Act 1995 (Tas) s 32(2)(c).} This limits the risk of collusion between an appointed enduring guardian and their family members who may have improper motives for the creation of the document;
- the Act already provides for the registration of instruments, enabling the Board to oversee the preparation of instruments. Whilst it is not expected that it would typically enquire beyond the face of the instrument, there may be information on the face of the document that causes the Board to enquire further. It might also investigate of its own motion, or require the Public Guardian to do so, if the donor were to register several instruments and/or revocation of instruments in close succession;
- there are currently no equivalent requirements under the Powers of Attorney Act for one of the witnesses to an enduring power of attorney to have any special qualification. Similarly, there is no special requirement for a Will to have a professional witness. Both of these documents involve risk of undue influence or fraud in their preparation, perhaps more so than the creation of instruments which deal with non-financial matters; and
- the Institute is unaware of any research or data that provides an indication of the number of Tasmanian cases where fraud or undue influence is involved in the preparation of an instrument. It is therefore an unquantified problem, raising the question of the necessity for legislative reform if it may potentially only resolve a small number of cases.

4.4.13 In the Institute’s view, it would be insufficient to merely require that one of the witnesses to an instrument have professional qualifications. To have maximum effect, then, consistent with the ALRC’s recommendation, those professional witnesses should be required to undertake a course of continuing professional education covering the skills and expertise needed to witness an enduring document. In the absence of that training, professional witnesses may not be any better placed to understand the nature and effect of an instrument, the test for capacity to complete an instrument or identify concerns about undue influence than any other member of the community. Professionals may not have adequate time to meet with a donor to gain any better perception about issues of concern than another member of the public, for example a friend or neighbour.

4.4.14 Education and training for professionals about the preparation and execution of instruments would require adequate resourcing. It would need to be decided how that cost would be funded, and who would be responsible for monitoring the quality of training provided or overseeing any accreditation process. In addition to the financial cost would be the increased workload for professionals. If these matters were not satisfactorily addressed, then it is foreseeable that professionals would not undergo the necessary training to become a qualified professional witness. There may then be a reduced pool of available witnesses, which would in turn increase the workloads of those willing to undertake the role, as well as potentially creating a barrier to making an instrument.

4.4.15 Primarily, the Institute does not recommend revision to the existing witnessing requirements for instruments because of the risk that it would act as a barrier to individuals
appointing an enduring guardian. Some respondents commented that they consider that the appointment of attorneys and enduring guardians is already overly cumbersome and complicated. Empirical evidence of the existence of a problem, and that this reform would alleviate that problem, may warrant legislative reform. Reform may also be appropriate if requirements under the Powers of Attorney Act were revised to require one of the two witnesses to an enduring power of attorney to have special qualifications, or the framework was changed to enable individuals to appoint an attorney and enduring guardian within the one document (as discussed at [4.2]). It is outside of the Institute’s Terms of Reference to make recommendations about potential reform to the Powers of Attorney Act in this regard as part of this review.

Witnesses certification

4.4.16 Witnesses must certify that the donor signed freely and voluntarily in their presence and that they appeared to understand the effect of the instrument.

4.4.17 The ALRC supports the Law Council of Australia’s recommendation that, instead of witnesses certifying that the donor signed freely and appeared to understand, they should need to certify that they are not aware of anything that causes them to believe that the donor did not sign freely or did not understand the document. The OPG’s submission addressed this issue, providing support for reform. The Institute also agrees that this would be a useful reform to the standard form.

4.4.18 In the Northern Territory, a witness must also certify that the donor is who they purport to be. Members of the Elder Law Committee supported this reform. The Institute agrees, considering that this provides an appropriate safeguard to reduce the risk of fraud in the preparation of instruments.

**Recommendation 4.8**

That the standard form instrument (form 1) and revocation of instrument (form 2) require witnesses to certify that:

(a) they are not aware of anything that causes them to believe that the donor did not sign freely or did not understand the instrument or revocation of instrument;

(b) the donor signed in their presence; and

(c) the donor is who they purport to be.

Ineligible witnesses

4.4.19 Witnesses must not be a party to the instrument or a relative of a party. The Act does not define what ‘relative of a party’ means. The Powers of Attorney Act provides that a ‘close relative of a party’ cannot witness an enduring power of attorney. It defines a ‘close relative of a party’ as:

- a spouse;
- parent;

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173 Law Council of Australia, cited in ALRC, above n 66, [5.46].
174 Advance Personal Planning Act 2016 (NT) s 10(3).
175 Guardianship and Administration Act 1995 (Tas) s 32(2)(c).
176 Ibid s 9(1)(b)(i).

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- sibling (including step-siblings);
- child (including step-children);
- parents-in-law;
- grandparent; and
- aunt or uncle.  

4.4.20 Unlike the standard form enduring power of attorney, the standard form instrument does not confirm that witnesses may not be a party to the document, or a relative of a party. Having this information on the face of a document enables parties to understand the technical requirements of the Act and may reduce instances where ineligible witnesses inadvertently breach this requirement. It makes sense to provide consistency.

4.4.21 The OPG’s submission supported revision to the standard form instrument to indicate that witnesses may not be a party to the document or a relative of a party. It, along with members of the Elder Law Committee, also supported inclusion of a definition of the phrase ‘relative of a party’ within the Act consistent with the Powers of Attorney Act. The Board also supported consistency between the Act and Powers of Attorney Act. The Institute supports these views.

4.4.22 Members of the Elder Law Committee commented that there ought to be an avenue for redress where an ineligible person acts as a witness. It commented:

There needs to be a practical rectification or confirmation method where ineligible people have witnessed an instrument. These documents can be prepared by people who have capacity at the time of preparation but if the issue with the witness is discovered at a later time this may result in a person’s wishes not being followed.

This matter is considered further at [4.4.40] below.

4.4.23 The Act does not create penalties for witnesses who fail to comply with witnessing requirements. The Powers of Attorney Act makes it an offence for an attorney to be a witness or for the witness to know that they are a ‘close relative of a party.’ A fine may be imposed in cases of a breach. The Institute asked whether there ought to be consistent provisions in the Act.

Should there be a penalty for a person who acts as a witness when they are ineligible?

4.4.24 Three respondents addressed this question, with one supporting reform. The OPG commented:

Our general view is that penalties are not helpful to the process and are resource-intensive to instigate, and resources are better directed to community education around the issue of enduring guardianship.

The provisions in the Act to review and revoke an appointment with the option of addressing who is appointed as guardian provides a measure of redress.

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177 Powers of Attorney Act 2000 (Tas) s 3(1).
178 Ibid s 9(1)(ba).
179 Ibid s 9(7).
180 TLRI, above n 69, Question 15.4.
4.4.25 Members of the Elder Law Committee commented ‘[i]f this were to occur there would need to be substantial education on this.’ On the other hand, another respondent commented ‘[i]t makes little sense to define a restriction for which there is no penalty.’

4.4.26 Whilst the Institute is mindful that the Act not place an over-reliance on penalties, it considers it appropriate that there be discretionary penalties available for those who witness an instrument knowing that they are ineligible to do so. The rationale is that, presently, the only consequence when individuals witness an instrument when they are ineligible to do so is the revocation of the instrument. This effectively penalises the donor without providing any direct consequences for the witness. In certain circumstances it may be appropriate to impose a penalty for the breach. It is not expected that this would be appropriate in all circumstances, especially when a witness was ignorant of the law or were themselves unduly influenced to act as a witness. The merits of this first argument would, however, be reduced if Recommendation 4.9(3) were enacted. That recommendation proposes that the standard form instrument outline and explain witness eligibility requirements.

4.4.27 It is appropriate to have equivalent consequences for non-compliance with witnessing requirements under the Act as already exist under the Powers of Attorney Act.

**Recommendation 4.9**

1. That ss 32(2)(c) and 33(2)(b) of the Act be revised to provide that a party and ‘close relative of a party’ are ineligible to act as a witness to an instrument or revocation of instrument.

2. That the phrase ‘close relative’ be defined consistently with s 3(1) of the Powers of Attorney Act 2000 (Tas).

3. That witnesses to instruments and revocations of instruments be required to declare that they are not a party to the instrument or a close relative of a party and that the term ‘close relative’ be explained on the standard form instrument (form 1) and revocation of instrument (form 2).

4. That the Act provide an equivalent fine to that contained in s 9(7) of the Powers of Attorney Act 2000 (Tas) for a person who is a party to an instrument or who knows he or she is a close relative of a party to an instrument acting as a witness to the signature of the donor, or initialling by the donor of an alteration of an instrument.

5. That any alteration of an instrument need to be initialled by the donor and the enduring guardian, with the donor’s initialling of the alteration to be witnessed by two adult witnesses who are not a party to the instrument or close relative of a party, with those witnesses able to be the same, or different, to the witnesses to the instrument.

**Acceptance of the role**

4.4.28 An enduring guardian must sign an instrument to accept their appointment. Their signature does not need to be witnessed.

4.4.29 When accepting an appointment, the enduring guardian undertakes to exercise their powers honestly and in accordance with the Act. In Victoria, decision-makers must also declare that:

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181 Guardianship and Administration Act 1995 (Tas) s 32(2)(b).

182 Ibid s 32(2).
• they are eligible to act;
• they understand their obligations;
• they understand the consequences of failing to comply with their obligations;
• they undertake to act in accordance with the donor’s known preferences and values;
• they undertake to promote the personal and social wellbeing of the donor; and
• they undertake that they have read and understood any advance care directive of the donor.\textsuperscript{183}

4.4.30 It was asked whether reform should be made to require enduring guardians to certify any particular matters upon their appointment.

When accepting the role, should an enduring guardian have to undertake to do anything, and if so, what?\textsuperscript{184}

4.4.31 The OPG supported reform requiring enduring guardians to certify matters as required in Victoria. Members of the Elder Law Committee also supported this reform in principle, but expressed the view that education would need to be available for enduring guardians if this reform were made. Social Work Services Royal Hobart Hospital (RHH) also supported this reform, commenting that the Board’s ‘Handbook for Enduring Guardians’ could be supplied to enduring guardians.\textsuperscript{185} PCT also supported enduring guardians educating themselves about what their role might entail. Another submission agreed that an enduring guardian should need to ‘agree to do the chores defined in the rest of the document.’

4.4.32 The Issues Paper also asked whether enduring guardians should need to certify any particular level of knowledge or understanding when accepting the role.

Should enduring guardians have to confirm that they have a certain level of knowledge and understanding of the document or other circumstances?\textsuperscript{2186}

4.4.33 In response to this question, the OPG stated that:

Our observations are that enduring guardians often appear to lack clear understanding of when and how the instrument should be enacted — an undertaking that their obligations are understood would assist. The OPG also considers that it is crucial that any appointed guardian has read and understood any advance care directive the donor has made, and must make decisions consistent with any advance care directive. Any changes to the instruments to address these concerns would be welcome.

4.4.34 Members of the Elder Law Committee observed that education would need to be available for enduring guardians if this reform was enacted. A third submission did not support any reform.

\textsuperscript{183} Powers of Attorney Act 2014 (Vic) s 37(c); Medical Treatment Planning and Decisions Act 2016 (Vic) s 29(c).
\textsuperscript{184} TLRI, above n 69, Question 15.5(i).
\textsuperscript{186} TLRI, above n 69, Question 15.5(ii).
4.4.35 It is proposed that the Act require enduring guardians to declare certain matters and undertake to do certain things when accepting the role. This assists to educate enduring guardians about their role and duties and provides an opportunity for them to reflect and ask questions about the role. It enables an enduring guardian to ensure that they have read any ACD of the donor which may be relevant to the scope and exercise of their authority. It signifies to an enduring guardian the importance of their role and promotes enduring guardians acting in accordance with their duties under the Act. This reform would strengthen the existing requirements which provide that, when accepting an appointment, an enduring guardian must undertake to exercise their powers honestly and in accordance with the Act.\footnote{Guardianship and Administration Act 1995 (Tas) s 32(2).}

**Recommendation 4.10**

That, when signing an instrument to accept the role of enduring guardian, an enduring guardian be required to declare that they:

- are eligible to act;
- understand their obligations;
- understand the consequences of failing to comply with their obligations;
- undertake to act in accordance with the Act; and
- have read and understood any advance care directive of the donor.

### Failure to comply with formal requirements

4.4.36 The Board may declare an instrument invalid if satisfied that it is contrary to the Act.\footnote{Ibid s 34(1A)(b).}

4.4.37 The *Powers of Attorney Act* includes detailed provisions dealing with the registration of enduring powers of attorney.\footnote{These include requiring enduring powers of attorney to comply with the Act in order to be registered, the ability of the Recorder of Titles to refuse to register an enduring power of attorney if it does not comply with formal requirements. At a practical level, the Board advises that it is its usual practice to do so, but suggests that its power ought to be confirmed. This would provide a pragmatic solution to ensure that any errors or omissions in an instrument are rectified at an early stage.} This includes the ability for the Recorder of Titles to refuse to register an enduring power of attorney if it does not comply with formal requirements.\footnote{Ibid s 11(3).} At a practical level, the Board advises that it is its usual practice to do so,\footnote{See Guardianship and Administration Board, *Presidential Direction*, (4 September 2012)} but suggests that its power ought to be confirmed. This would provide a pragmatic solution to ensure that any errors or omissions in an instrument are rectified at an early stage.

4.4.38 The Board does not have power to declare an instrument valid despite it not complying with formal requirements. As noted above, members of the Elder Law Committee submitted that:

> There needs to be a practical rectification or confirmation method where ineligible people have witnessed an instrument. These documents can be prepared by people who have capacity at the time of preparation but if the issue with the witness is discovered at a later time this may result in a person’s wishes not being followed.

\footnote{Guardianship and Administration Act 1995 (Tas) s 32(2).}

\footnote{Ibid s 34(1A)(b).}

\footnote{Ibid s 11(3).}

4.4.39 In Victoria, VCAT has the power to declare an appointment of a medical treatment decision-maker valid despite the appointment not complying with formal requirements. The test is whether VCAT is satisfied that the person's intention to appoint a decision-maker is sufficiently clear.\(^{192}\) A more detailed provision is included in Victoria’s *Powers of Attorney Act 2014* which provides that, to declare a power of attorney valid despite non-compliance with formal requirements, VCAT must be satisfied that:

- the principal and attorney intended the document to be an enduring power of attorney;
- at the time the document was signed, the principal had decision making capacity in relation to the making of the enduring power of attorney; and
- the principal:
  - signed the document freely and voluntarily; or
  - freely and voluntarily directed the person who signed the document for the principal to do so, and was present when the person signed the document.\(^{193}\)

In Tasmania, the *Wills Act 2008* (Tas) also enables the Supreme Court to declare a Will valid despite non-compliance with the formal requirements for the execution of a Will imposed under that Act.\(^{194}\)

4.4.40 The Institute concurs with members of the Elder Law Committee that it is appropriate to give flexibility to enable the Board to declare an instrument valid despite non-compliance with the formal requirements of the Act. This enables the Board to uphold the donor’s will and preferences where it is clear they intended the appointment to be effective. Whilst presently it may achieve this by itself appointing the person, a preferred alternative is to enable the Board to declare the donor’s appointment of their enduring guardian valid if satisfied that they intended the appointment to be valid.

Recommendation 4.11

(1) That comparative powers be given to the Registrar of the Board in relation to the registration of instruments as are provided to the Recorder of Titles under s 11 of the *Powers of Attorney Act 2000* (Tas), with the exception that the Registrar not be permitted to retain any portion of the registration fee upon refusing to register an instrument.

(2) That the Board be able to declare an instrument valid despite it not complying with the formal requirements of the Act.

### 4.5 Conditions and limits on the powers of enduring guardians

4.5.1 A donor may limit an enduring guardian’s powers or make their appointment subject to conditions.\(^{195}\) Subject to any conditions or limitations, an enduring guardian has the same powers and duties as a full Board-appointed guardian.\(^{196}\) Those powers and duties are considered in Part 9.

\(^{192}\) *Medical Treatment Planning and Decision Act 2016* (Vic) s 45.

\(^{193}\) *Powers of Attorney Act 2014* (Vic) s 117(1).

\(^{194}\) *Wills Act 2008* (Tas) s 10.
4.5.2 An instrument can include directions to an enduring guardian about how they must act. The enduring guardian must act in accordance with those directions, unless the Board directs otherwise.197 Recommendation 11.2 outlines a proposed decision-making process to be followed when making decisions for a represented person. This process confirms that it is the will and preferences of the person that are paramount. It provides that representatives may only depart from a represented person’s will and preference in exceptional circumstances, consistent with the ALRC’s Decision-Making Principles.

4.6 Revocation of instruments

4.6.1 The following section considers reform to those parts of the Act that deal with termination of the powers of an enduring guardian.

Revocation by a donor

4.6.2 A donor may revoke an instrument using a standard form.198 The donor’s execution of a Revocation of Instrument must be witnessed in the same way as an instrument. It must be registered.199 A registration fee is payable, with the current fee being $49.60. The Act does not state that a ‘form to similar effect’ to the prescribed form can be used.200 The Act also does not state that registration of a later instrument revokes an earlier instrument.201

4.6.3 To provide consistency with other parts of the Act that enable a donor to make an instrument in a form ‘to similar effect’ to the standard form, it is recommended that the wording of s 32(2)(a) be revised to confirm that a donor may revoke an instrument using the standard form, or a form to similar effect. This provides flexibility and avoids argument that a revocation is ineffective if there is not strict compliance with the standard form revocation. It would also enable a donor to revoke an instrument as part of creating a new instrument, rather than the revocation having to be completed in a separate document.

4.6.4 The Powers of Attorney Act enables a donor to revoke their enduring power of attorney by giving notice to the appointed attorney(s).202 The Institute considers that, for consistency and to provide flexibility and reduce formality, a donor also be able to revoke an instrument by giving notice to the appointed enduring guardians.

4.6.5 In Tasmania, a donor is not required to advise an enduring guardian that their appointment has been revoked, unlike the position in Victoria, New South Wales and Queensland.203 There are

195 This is consistent with the ALRC’s recommendation that legislation recognise the ability of a donor to make a document granting limited or restricted powers, or that are subject to conditions: ALRC, above n 66, Recommendation 5-1(a).
196 Guardianship and Administration Act 1995 (Tas) s 32(7).
197 Ibid s 32(6).
198 Ibid s 33.
199 Ibid s 33(2)(c).
200 Ibid s 32(2)(a).
201 See Powers of Attorney Act 1998 (Qld) s 50.
202 Powers of Attorney Act 2000 (Tas) s 32AE(1).
203 Powers of Attorney Act 2014 (Vic) s 50; Guardianship Act 1987 (NSW) s 6H(2)(d); Powers of Attorney Act 1998 (Qld) s 46.
similar provisions in the *Powers of Attorney Act* requiring donors of an enduring power of attorney to give notice to their former attorneys advising that their appointment has been revoked, for example, upon divorce.\(^{204}\)

4.6.6 Short of searching the register of instruments, there is no clear process for an enduring guardian to learn that their appointment has been revoked. This creates the risk of a former enduring guardian inadvertently carrying out the functions of an enduring guardian, unaware that their appointment has been revoked. Notice also provides a former enduring guardian opportunity to make inquiries if there are concerns about the donor’s ability to revoke the appointment, or potential undue influence. It is preferable that these issues are identified at an early stage, rather than some time later when a former enduring guardian learns of his or her removal.

4.6.7 It is therefore proposed that the Act be revised to require donors to take reasonable steps to advise their former enduring guardians of the revocation of their appointment. The OPG endorsed this reform, as did a participant at a consultation meeting facilitated by Carers Tasmania, who commented that this approach would serve as a safeguard against abuse.

**Recommendation 4.12**

1. That a donor be able to revoke an instrument using a form ‘to similar effect’ to the standard form revocation of instrument (form 2) included in the Act.
2. That an equivalent provision to s 32AE(1) of the *Powers of Attorney Act 2000* (Tas) be included in the Act, enabling a donor to revoke an instrument by giving notice to the enduring guardian(s).
3. That donors be required to take reasonable steps to give notice to their enduring guardian(s) of the revocation of their appointment. Failure to give notice should not invalidate the revocation.

**Deemed revocation in certain circumstances**

4.6.8 There are no circumstances where an instrument is automatically revoked. The *Powers of Attorney Act* provides that an enduring power of attorney is revoked:

- if the donor dies;\(^{205}\)
- if the donor and the attorney cease to be married, or parties to a registered personal relationship under the *Relationships Act*;\(^{206}\) or
- upon an attorney being subject to a mental incapacity or becoming bankrupt or insolvent.\(^{207}\)

4.6.9 In New South Wales and Queensland, a donor’s later marriage to someone other than the appointed enduring guardian automatically revokes the appointment of an enduring guardian, although the NSWLRC has recently recommended that this be removed.\(^{208}\)

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\(^{204}\) *Powers of Attorney Act 2000* (Tas) s 32AE(4).
\(^{205}\) Ibid s 32AE(3). The ending of a marriage or relationship also automatically revokes the appointment of a representative in Queensland and Ireland: *Powers of Attorney Act 1998* (Qld) s 53; *Assisted Decision-Making (Capacity) Act 2015* (Ireland) s 40.
\(^{206}\) *Powers of Attorney Act 2000* (Tas) s 32AE(5)(b); See *Powers of Attorney Act 1998* (Qld) s 56.
\(^{207}\) *Guardianship Act 1987* (NSW) s 6HA; *Powers of Attorney Act 1998* (Qld) s 52; NSWLRC, above n 24, Recommendation 8.18.
4.6.10 The Issues Paper sought feedback about whether there should be automatic revocation of instruments upon the happening of certain events. This matter is also considered separately in Part 12 in relation to the revocation of the appointment of Board-appointed representatives.\(^{209}\)

Should the appointment of an enduring guardian be automatically revoked in certain circumstances? If so, when?\(^{210}\)

4.6.11 Responses stated that it may be appropriate to provide for automatic revocation of an instrument:

- at the request of the donor (if they are assessed as having capacity);\(^{211}\)
- upon the death of the donor;\(^{212}\)
- upon the death of the enduring guardian (in the case of a single appointment of an enduring guardian);\(^{213}\)
- upon the enduring guardian having decision-making incapacity;\(^{214}\)
- where there is evidence of a conflict of interest;\(^{215}\)
- where the enduring guardian no longer wishes to continue with the role due to inability or unwillingness;\(^{216}\)
- where the appointed person cannot be contacted and therefore cannot fulfil the role;\(^{217}\)
- where there is significant concern or harm to the represented person or sufficient evidence that the appointed person is not acting in their best interests;\(^{218}\) or
- where there has been a breach of the enduring guardian’s powers.\(^{219}\)

The OPG supported consistency with the *Powers of Attorney Act* on the basis that it may minimise confusion.

4.6.12 The Institute agrees that, to provide consistency with the *Powers of Attorney Act*, the Act should confirm that an instrument is revoked upon the death of the donor.

4.6.13 It is also proposed that the Act provide that the appointment of an enduring guardian be suspended if the enduring guardian does not have decision-making ability to act as the enduring guardian. By way of clarification, it is only the appointment of that enduring guardian that should be suspended. There may be substitute appointments made in an instrument or directions or statements

\(^{209}\) See [12.5] and Recommendation 12.9.
\(^{210}\) TLRI, above n 69, Question 15.6.
\(^{211}\) OPG.
\(^{212}\) OPG.
\(^{213}\) The Board; Members of the Elder Law Committee.
\(^{214}\) The Board, OPG, Members of the Elder Law Committee; Keith Anderson.
\(^{215}\) Social Work Services RHH, Keith Anderson.
\(^{216}\) Social Work Services RHH.
\(^{217}\) Social Work Services. The Institute notes that an unregistered Power of Attorney may be revoked in these circumstances by lodging a notice with the Recorder of Titles: *Powers of Attorney Act 2000* (Tas) s 32AE(6).
\(^{218}\) Social Work Services RHH, PCT.
\(^{219}\) PCT, Margaret Rolph.
of a donor’s wishes about personal and medical decisions. The incapacity of an enduring guardian is unrelated to these other parts of the document and ought not have the effect of revoking it in its entirety.

4.6.14 The appointment of an enduring guardian should only be suspended because of an enduring guardian’s incapacity. This enables the powers of an enduring guardian to be restored if the enduring guardian regains decision-making ability. By way of example, if an enduring guardian has a stroke rendering them unable to act, but their health improves, and they become able to act in the role again, then their suspension of powers would be removed. Temporary inability to act in the role should not permanently terminate the appointment.

4.6.15 Circumstances where enduring guardians no longer wish to continue in the role are considered later in this Part. Part 12 considers revocation of the appointment of an enduring guardian in other circumstances as part of a broader discussion about safeguards for representative decision-making. It is considered that these remaining events should not result in the automatic revocation of an instrument, but that the Board have power to make orders to revoke or amend an instrument in these circumstances.

**Recommendation 4.13**

1. That the Act confirm that an instrument is revoked on the death of the donor.
2. That the Act provide that the authority of an enduring guardian is suspended at any time that the enduring guardian does not have decision-making ability to act as the enduring guardian.

**Change to the donor and enduring guardian’s relationship**

4.6.16 No submissions received supported the automatic revocation of an instrument upon the ending of the relationship between the donor and the enduring guardian. In addressing this issue, the Board commented that it ‘may be deemed inflexible in allowing for the wishes of the donor to be considered.’

4.6.17 The OPG made similar observations:

There are examples of where individuals have been married and are subsequently separated or divorced, but are able to maintain caring and supportive connections in the long term. Therefore, ceasing to be married or in a registered personal relationship should not necessarily be grounds for automatic revocation of enduring guardianship... our view is that the Board should maintain discretion to revoke or amend instruments.

4.6.18 The Institute agrees that there should not be situations where the appointment of an enduring guardian is automatically revoked upon the ending of a relationship of marriage or registered personal relationship.

**Negating an automatic revocation**

4.6.19 Members of the Elder Law Committee submitted that, if there were to be automatic revocation of an instrument upon the ending of a relationship, then it should be possible for a donor to negate this. The Institute agrees, noting that the *Wills Act 2008* (Tas) enables a testator to negate the automatic revocation of a Will upon the marriage or divorce of the testator.220 It is observed that

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220 *Wills Act 2008* (Tas) ss 16(4), 17(4).
there is no equivalent provision in the *Powers of Attorney Act*.\(^{221}\) This is included in Queensland and the ACT.\(^{222}\) The present drafting of the *Powers of Attorney Act* also does not contemplate a partial revocation of an appointment of a former spouse as attorney, but retaining the appointment of any other attorney. This situation is also contemplated under the *Wills Act 2008* (Tas).\(^{223}\) Whilst the Institute’s Terms of Reference require review of the Act, noting the submissions received, the Institute considers that it is appropriate to propose that these revisions be made to the *Powers of Attorney Act*.

### Recommendation 4.14

That, if s 32AE(3) of the *Powers of Attorney Act 2000* (Tas) remains, it be revised to:

(a) enable a donor to negate the automatic revocation of their enduring power of attorney upon the ending of their marriage or registered personal relationship in their enduring power of attorney; and

(b) provide that only the appointment of the attorney who was party to a marriage or registered personal relationship with the donor is revoked upon the ending of their marriage or personal relationship without revoking the entire document, to the extent that it appoints a substitute or joint attorney (where their appointment was expressed to be joint and several).

### Resignation of the enduring guardian

#### 4.6.20

This Part reviews the ways in which an enduring guardian may resign from the role.

**Resignation before the enduring guardian’s powers become operative**

4.6.21 The Act does not presently provide any specific method for an enduring guardian to resign prior to their appointment becoming operative. In practice, an enduring guardian can advise the donor that they no longer accept the role, with the donor then able to appoint a new enduring guardian if they wish to do so.

4.6.22 In Victoria, an enduring guardian can resign by completing a standard form.\(^{224}\) They must take reasonable steps to notify the donor and any other enduring guardian that they have resigned.\(^{225}\) The Institute sought to ascertain whether there was support for a similar reform to the Act.

**Should an enduring guardian be able to resign by completing and registering a standard form?**\(^{226}\)

4.6.23 This reform was endorsed by members of the Elder Law Committee, Social Work Services RHH, and the OPG,\(^{227}\) with the latter commenting that:

An enduring guardian should be able to resign by completing and registering a standard form. Many factors influence whether a guardian considers they are able to continue to

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\(^{221}\) See *Powers of Attorney Act 2000* (Tas) s 32AE.

\(^{222}\) *Powers of Attorney Act 1998* (Qld) s 52; *Powers of Attorney Act 2006* (ACT) s 58(2).

\(^{223}\) See *Wills Act 2008* (Tas) ss 16, 17.

\(^{224}\) *Powers of Attorney Act 2014* (Vic) ss 57, 60.

\(^{225}\) Ibid ss 58, 61.

\(^{226}\) TLRI, above n 69, Question 15.

\(^{227}\) PCT also supported enduring guardians having the ability to resign without expressing a view about whether this should be via this option.
fulfil the role such as the relationship with the donor, the physical or mental health of the
guardian and/or their personal circumstances. There should be a formal requirement that
the donor and any other guardian is advised of the resignation.

4.6.24 The Board also highlighted the importance of ensuring that a donor has notice of the
enduring guardian’s resignation to ensure that they have the option of making a new appointment:

If notification of the donor is not required, this essentially denies the donor their right to
appoint another person to be their enduring guardian, as they would assume their
enduring guardian instrument can become operative if and when they lose capacity.

4.6.25 Consistent with responses received, the Institute considers it beneficial to enable an
enduring guardian to resign by completing and registering a standard form. This would assist where
an enduring guardian no longer has a relationship with the donor. It also enables the enduring
guardian to publicly record their resignation which would assist third parties, notably health
professionals or service providers, to quickly obtain accurate details about who is presently appointed
and willing and able to act as a person’s enduring guardian. The Act already provides a role for
substitute enduring guardians to act if the first appointed enduring guardian is unable to do so.228
This reform would enable that circumstance to be established quickly.

4.6.26 The Institute agrees with respondents that it would be unsatisfactory to permit an enduring
 guardian to resign by simply lodging a form with the Board with nothing further. It is important that
the enduring guardian be required to take reasonable steps to advise the donor that they no longer
wish to accept the role. This is to ensure that the donor can make a new instrument and appoint a
new enduring guardian. A useful example of this approach is included in the Victorian Act.229

**Recommendation 4.15**

That an enduring guardian be able to resign by completing and registering a standard form to be
included in the Act, or by using a form to similar effect. The enduring guardian should then be
required to take reasonable steps to advise the donor and any other appointed enduring guardian of
that resignation.

Resignation after the enduring guardian’s powers become operative

4.6.27 If an enduring guardian wishes to resign after their appointment has become operative, and
there is no substitute enduring guardian nominated, then an application needs to be made to the
Board.230 When an attorney wishes to retire, an application to the Board does not necessarily need to
be made. The *Powers of Attorney Act* enables a solely appointed attorney to appoint the Public Trustee
to act in their place without the Board’s approval.231 Social Work Services RHH noted this position
under the *Powers of Attorney Act* and submitted that the Act should be revised to enable a retiring sole
enduring guardian to appoint the Public Guardian in their place.

4.6.28 A similar issue is also discussed in Part 8 in relation to the automatic appointment of the
Public Guardian or Public Trustee as guardian or administrator upon the death of a solely appointed

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228 Recommendation 4.6 proposes that the Act confirm that a substitute enduring guardian may also act upon the
resignation of the first appointed enduring guardian.


230 *Guardianship and Administration Act 1995* (Tas) s 32A.

231 *Powers of Attorney Act 2000* (Tas) s 32A.
trustee.\textsuperscript{232} That part concludes that, based on submissions received, it is more appropriate that this circumstance result in a fresh assessment by the Board to determine who might be appropriate to act in substitution. It is noted that the Act already permits the Board to appoint a substitute enduring guardian via its power to amend an instrument under s 34. This approach enables the Board to consider the suitability of other applicants so that the Public Guardian is a guardian of last resort, consistent with stakeholder feedback. This approach promotes outcomes being consistent with a donor’s will and preferences.

\textit{Revocation by the Board}

4.6.29 The Board may also revoke instruments in certain circumstances. This matter is discussed in Part 12.

\section*{4.7 Registration of instruments}

4.7.1 To be effective, an enduring guardian must be registered with the Board which maintains the register of instruments.\textsuperscript{233} The Recorder of Titles maintains a separate register for enduring powers of attorney. The Regulations provide for a fee for the registration of an instrument of $69.75 and $49.60 for the revocation of an instrument.\textsuperscript{234} These fees provide a source of revenue for the Board. In 2016–17, the Board received income of $172,262.00 from the registration of instruments and revocations of instruments.\textsuperscript{235}

4.7.2 The Board may waive the registration fee payable on an instrument.\textsuperscript{236} The Board’s website advises of the ability to seek a waiver of fees.\textsuperscript{237} There is a form for applicants to complete and submit to seek a waiver.\textsuperscript{238} The cover sheet required to be submitted when lodging an instrument or revocation for registration refers to the fact that a waiver of fees form may be submitted.\textsuperscript{239} In 2016–17, the Board waived the registration fee on 12 occasions, which was less than one per cent of the instruments registered in the reporting year.\textsuperscript{240}

4.7.3 The Institute is concerned that the payment of a registration fee may act as a deterrent to people completing instruments. This is particularly so as a registration fee is also imposed for the registration of an enduring power of attorney, a document commonly completed at the same time as an instrument. It was commented in the Issues Paper that it was Parliament’s intention when

\begin{footnotesize}
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\item[232] See [8.6].
\item[233] Guardianship and Administration Act 1995 (Tas) ss 32(2)(d), 89.
\item[234] Guardianship and Administration Regulations 2017 (Tas) reg 14 sch 1.
\item[236] Guardianship and Administration Regulations 2017 (Tas) reg 16.
\item[240] Guardianship and Administration Board, above n 235, 20.
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enacting the Act that ‘people should be encouraged to make their own decisions about who should be their guardian should they subsequently suffer a disability which requires a Guardian.’

4.7.4 Whilst imposing a registration fee is consistent to the provisions of the *Powers of Attorney Act*, which provides for a registration fee on the registration of an enduring power of attorney, the nature of the documents are different given that an instrument relates to personal matters, whilst powers of attorney apply to financial transactions.

4.7.5 The Institute notes that the VLRC recommended that there not be a registration fee to register an instrument, but that a fee could be imposed where more than one document was registered in the calendar year.

4.7.6 Considering these matters, the Institute asked whether the registration fee should be removed.

**Should a fee be payable for the registration of an instrument/revocation of an instrument?**

4.7.7 There was a split in views about whether there should be a fee for the registration of an instrument.

4.7.8 The OPG supported continuation of the payment of a registration fee. It submitted that:

this office is supportive of consistency between the current Act and the Powers of Attorney Act. There is a current provision for application for the waiver of fees for registration of enduring guardianships in cases of financial hardship and this should be continued. A registration fee may be preferable to a search fee being imposed. A registration fee may also assist with resourcing an upgrade of and accessibility to the Enduring Guardianship Register. There are currently significant issues with lack of accessibility to the register out of business hours.

4.7.9 Other respondents supported continuation of the payment of a fee on the basis that it may prevent individuals from being unduly influenced to complete and register multiple instruments. A ‘minimal’ fee was considered acceptable. It was also reinforced that the opportunity to apply for a waiver of the fee payable should remain.

4.7.10 Several respondents considered that the registration fee provides a barrier to the completion of instruments. Members of the Elder Law Committee commented that ‘[t]he legal profession has experience of clients who have not proceeded because of the filing fee.’ Similar observations were made by Social Work Services RHH, and another respondent with experience assisting patients with advance care planning. Members of the Elder Law Committee commented, however, that:

> It is more important that there be no impediment to a revocation of an instrument as if all that is stopping it is the fee may result in a person acting who should not be.

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242 VLRC, above n 24, Recommendation 268.

243 TLRI, above n 69, Question 15.8.

244 Four respondents supported the payment of a fee whilst four respondents did not.

245 Hilda Nilsson.
4.7.11 The Institute commends the State Government on having a long-established system providing for the registration of instruments. Registration of enduring instruments is not mandated across the country, but has the strong support of law reform commissions.246

4.7.12 The Institute considers that it is critical that the appointment of an enduring guardian be accessible to all and that cost not create a barrier. The Institute notes feedback from respondents that the registration fee can prevent individuals from completing an instrument. It therefore recommends that there not be a registration fee imposed on the registration of an instrument. To ensure that this provision is not misused, or instruments made and revoked flippantly, it is suggested, adopting the VLRC’s proposal, that the Board have discretion to impose a registration fee if more than one instrument is registered in any calendar year.

4.7.13 If this recommendation is not accepted, then the Institute makes the following recommendations:

- that the registration fee for the revocation of an instrument be removed; and
- that the revenue received from registration fees be used to develop the register’s functionality, including an online search function. This issue is considered further in the following paragraph.

Recommendation 4.16

(1) That there not be a registration fee payable on the registration of an instrument, but that the Registrar have discretion to impose a registration fee where more than one instrument is registered for a person in a calendar year.

(2) That there not be a fee for the registration of a revocation of instrument.

Search of the register

4.7.14 The public may search the register of instruments.247 A search fee is included in the Regulations.248 There is no online or electronic search function, resulting in people being unable to search the register outside of business hours. The OPG explained:

There is currently no capacity for an online or electronic search of the register outside business hours which means that authority cannot be sought often when it is most critically needed, and thus the donor’s wishes may not be upheld. It is the understanding of the OPG that the register currently takes the form of an Excel spreadsheet held at the office of the Board.

4.7.15 An online search function is available via the Tasmanian Government Land Information System Tasmania (LIST) to search for an enduring power of attorney.249 It is observed that the personal nature of instruments can result in a greater need to search the register of instruments outside business hours than exists for enduring powers of attorney which are used for financial transactions commonly occurring during business hours.

246 ALRC, above n 66, Recommendation 5-3; ACTLRAC, above n 24, 7.5.
247 Guardianship and Administration Act 1995 (Tas) s 89(2).
248 Guardianship and Administration Regulations 2017 (Tas) reg 13(4).
4.7.16 It is critical to the success of the system that those with a legitimate interest can quickly and easily search the register to establish whether someone has an instrument and, if so, obtain a copy. The OPG submitted:

Operationally, the Board should be resourced to upgrade the storage mechanism and assisted to make the register accessible outside of business hours — especially to medical personnel.

4.7.17 Members of the Elder Law Committee also expressed concerns about the present difficulty to search for an instrument:

Having a mandatory online accessible register and search facility (also fee-free) for the appointment instruments would make it easier for others to find out and verify who is appointed when these are needed.

In an emergency situation a person appointed as a guardian may not have the ability to get a copy of the document when they need to use it. E.g. if the person creating the document is taken to hospital and they don’t appoint a spouse, it can be difficult for the person who is appointed to get others (including the hospital/medical profession) to revert to them and not to revert to the spouse. The appointed person may have the document filed at home and not have the time or the ability to get the appointment document when treatment decisions need to be made.

4.7.18 Another submission also raised the issue of searching the register of instruments.

4.7.19 The Institute agrees with these remarks. It compromises the effectiveness of the system if a person appoints an enduring guardian, registers the document, but then those who require access to it are unable to search the register and obtain a copy outside of business hours. It is unsatisfactory to consider that there may be circumstances where a person’s documented will and preference is not given effect due to the absence of an accessible register with a user-friendly search functionality. Improvements in this area ought to be a priority.

4.7.20 The OPG also noted:

In terms of access to enduring documents, there is the potential for public confusion. Powers of Attorney are registered with the Lands Titles Office under DPIPWE (not necessarily a logical source point). ACDs may be optionally lodged with major hospitals, and enduring guardianships are registered with the Board. There is a logical argument for a single repository for these registers, allowing 24/7 access. In Victoria, the Registry of Births, Deaths and Marriages is under consideration, and this may also be appropriate in Tasmania.

4.7.21 The Institute acknowledges these remarks and agrees that any improvements that assist end-users to have easy access to a donor’s enduring documents would be welcomed.

**Recommendation 4.17**

(1) That the Board be properly resourced to develop an online search function to search the register of instruments.

(2) That there be no search fee payable to search the register of instruments.

(3) That consideration be given to establishing a single repository for the registration of enduring powers of attorney, instruments and advance care directives.
4.8 Other matters

4.8.1 The Institute enquired whether there were additional matters that ought to be considered in relation to the appointment of enduring guardians.

**How else could the Act better safeguard the granting of authority to an enduring guardian?**

4.8.2 Responses to this question have either been dealt with elsewhere in this Part, or within other Parts of this Report, including Parts 9 (the powers of guardians) and Part 12 (safeguards for representative decision-making). Two matters that are not addressed elsewhere were raised by Social Work Services RHH:

- that instruments not be able to be registered when there is a current emergency order; and
- that there should be some provision to alert the Board where an enduring guardian loses capacity: ‘Example: A Geriatrician deems Mr Smith can’t make informed decisions re: accommodation or health care for himself but family advise you he is the Enduring Guardian for his wife.’

**Current guardianship order and subsequent registration of instrument**

4.8.3 The first matter raised by Social Work Services RHH is the lack of clarity about the effect of an instrument that is registered at a time when the donor is already the subject of a guardianship order. This issue was also raised in the OPG and the Board’s submissions in addressing other questions in the Issues Paper. The Board explained:

In practice the Board has had situations where it has made an emergency guardianship order and then a number of days later receives an enduring guardian instrument to register which conforms with section 32(2) of the Act and which the Board is required to register. The Act does not set out whether the emergency order or the enduring guardian instrument takes priority.

4.8.4 In New South Wales, for example, legislation provides that ‘[i]f a person who is the subject of a guardianship order purports to appoint an enduring guardian, the purported appointment is of no effect.’

4.8.5 It is appreciated that this may create difficulties in practice, particularly where the result is potentially concurrent, conflicting powers between representatives. Complexity might arise particularly because a 'guardian' becomes the represented person's 'person responsible' with priority to consent to medical treatment. Other recommendations made in this Report may alleviate this issue, including proposals to enable the Board to refuse to register an instrument, and giving the Board power to review an instrument of its own motion. These approaches enable the Board to consider the issues and determine how the situation ought to be resolved.

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250 TLRI, above n 69, Question 15.9.
251 Guardianship Act 1987 (NSW) s 61(2).
252 This matter is considered further in Part 13.
253 Recommendation 4.11.
254 Recommendation 12.5.
4.8.6 Emergency orders do not require a finding that the represented person does not have the ability to make decisions, only that there is reasonable ground for believing that the person may require a guardianship order. Precluding a person from creating an instrument where there has not been an investigation or enquiry into the person’s ability to make an instrument and no finding of fact that they do not have decision-making ability denies them their right to appoint their own decision-maker. For these reasons, it is not proposed that there be legislative reform to preclude a represented person the subject of an emergency order from registering an instrument. It is suggested, however, that the Act confirm that a Board appointed guardian takes priority over an enduring guardian to the extent of any duplicated powers.

Recommendation 4.18
That the Act state that the authority of a Board-appointed guardian takes priority over the authority of an enduring guardian to the extent that the same functions are conferred upon both.

Notification of guardians losing decision-making ability

4.8.7 The second matter raised related to notification of an enduring guardian losing decision-making ability. In regard to this point, the Institute agrees that it could be useful for there to be a mechanism facilitating notice to the Board upon an enduring guardian being declared unable to make their own personal decisions. Notification to the Board of the change of circumstances gives the Board the opportunity to review the situation and make alternative arrangements if required.

4.8.8 It is noted that the Act already enables a person to apply to the Board for the review of an instrument in these circumstances, allowing the Board to amend an instrument if the enduring guardian is incapable. It is problematic to mandate compulsory reporting requirements in these circumstances, particularly where a treating doctor may be unaware that their patient has been appointed as someone’s enduring guardian. Issues of privacy also need to be considered. It is suggested that this relates to matters of policy and procedure and education rather than a matter for legislative reform.

255 Guardianship and Administration Act 1995 (Tas) s 65(2).
Part 5

Advance Care Directives

5.1 Introduction

5.1.1 An advance care directive (ACD) is a document that contains a person’s wishes and/or directions about future medical care and treatment. Among other names, they are sometimes also called a ‘Living Will’, ‘advance health directive’ or an ‘advance statement.’ They can be prescriptive, by giving directions about future consent or non-consent to treatment, or they can be values based, by providing guidance to decision-makers about the views and values important to the person which should be considered when making decisions.

5.1.2 ACDs have effect at common law. They do not have legislative recognition in Tasmania as a distinct document. The Act enables an adult to give directions about future medical treatment in an instrument. Donors often include directions or guidance to an enduring guardian about treatment in an instrument.

5.1.3 The Terms of Reference do not specifically ask the Institute to address the legislative framework surrounding ACDs in Tasmania. Nevertheless, as noted in the previous Part, the Institute considers it both appropriate and necessary to do so as part of this review. Firstly, ACDs are a mechanism to communicate a person’s will and preference. They are therefore consistent with the Convention as they enable a person to retain control of decision-making. Secondly, the Institute notes the interrelationship between ACDs and instruments. Both documents enable a person to communicate their will and preference by expressing who they wish to be involved in future decision-making and/or by stating their views about future treatment.

5.1.4 This Part recommends that ACDs be given statutory recognition in Tasmania, and outlines proposals for key elements of the legislative framework.

5.2 Benefits of advance care directives

5.2.1 Overwhelmingly, respondents expressed support for the use of ACDs. PCT advocated the following benefits of ACDs:

An ACD often is the difference between having a ‘good death’, i.e. carers and service providers understanding what is important to you and adapting their care accordingly, and a death that can lead to complex grief for loved ones. In fact many studies have shown that when a person has an ACD, their loved ones experience less cases of complex grief because they know the wishes of the dying person and are able to intervene accordingly.

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256 Although it must also be acknowledged that a direction can also be verbal.
257 Guardianship and Administration Act 1995 (Tas) s 32(6).
258 Ashby observed in 2010 that almost half of the registered instruments sampled contained directions to enduring guardians about future treatment: Michael Ashby and Robert Thornton, An analysis of the specific directions regarding medical care and lifestyle decisions within completed Enduring Guardianship Forms (Tasmania, 2010).
An ACD is really the only means in which a person can communicate what care they want and what is important to them in the event they become incapacitated. It allows the person to still maintain control of their care. Appointing an Enduring Guardian does not provide for this. It is simply appointing a person who can make decisions about your care if you cannot ...

5.2.2 The Board commented that ACDs:

- allow a person to retain choice, control and dignity where their own health is concerned
- provide an ascertainable record of a person’s expectations and values with respect to their future care, including end of life care
- articulate and to give effect to the rights, wishes and preferences of a person without capacity in line with those of a competent person
- reassure and inform those who are required to make health care decisions for another person, including the decision to withhold medical treatment
- can operate if and when the person becomes incapable of giving consent, if specific enough

5.2.3 EOT also highlighted that ACDs enable a person to express their will and preference:

ACDs have the capacity to form an important mechanism for individuals to make their preferences known when health and related decisions are required. As such they may provide a critical alternative to the appointment of representative decision makers in some circumstances or provide an important statement of the will and preference of those for whom the appointment of substitute decision makers are considered also warranted. In this way they can provide an important mechanism for guiding decision making when a person enters the stage where communication is impaired or capacity is lacking.

5.2.4 Given the positive feedback received about the use of ACDs, it is important that the Act complements their use.

5.3 Advance care directives in Tasmania

5.3.1 Whilst ACDs do not have legislative recognition in Tasmania, they have effect at common law. At common law, an ACD must be respected and given effect where:

- it was made voluntarily by a capable adult;
- it is clear and unambiguous;
- it extends to the situation at hand;\(^259\) and

\(^{259}\) *Hunter and New England Area Health Service v A* [2009] NSWSC 761 (6 August 2009) 40–41. NSW also presently relies upon the common law in relation to the effect of advance care directives. The NSWLRC has recently made recommendations proposing that legislation confirm that a patient should be able to consent to health care in an advance care directive and that health care must not be given if it would be strictly against a patient’s will and preference as expressed in an advance care directive that is clear and extends to the situation at hand. The NSWLRC recommends that legislation confirm that an advance care directive can be made orally: NSWLRC, above n 24, Recommendation 10.5(3).
their circumstances have not changed such that the person would no longer intend it to apply.

5.3.2 The Board’s submission clarified the interrelationship between ACDs and the Act as follows:

Part 6 of the Act contains detailed provisions in relation to consent to medical treatment, which operates in addition to the common law. The provisions in the Act do not oust the common law, and therefore advance consent or advance refusal of treatment can apply. Part 6 of the Act only applies when a person with a disability is incapable of giving consent to treatment, which would not be the case if a person had previously given consent or refusal to the treatment in question.

5.3.3 In 2016, the House of Assembly Standing Committee was engaged to conduct a review of palliative care in Tasmania, including the use of ACDs. The Standing Committee found that ACDs are used in Tasmania, but that there was a variety of views about what legal weight they have.260

5.3.4 The following options were identified in the Issues Paper:

- to continue to rely on the common law to give effect to ACDs; or
- to enhance existing provisions in the Act that explain how instruments may be used to record a person’s wishes or directions. This could include articulating how health practitioners should consider, or follow, directions in an instrument. This option would necessitate better systems to ensure that health professionals can easily search and obtain copies of a patient’s instrument when needed, a matter discussed in Part 4; or
- to enact legislation formally recognising ACDs separate to instruments. This could be achieved by incorporating provisions into the Act or enacting separate legislation.

Public Consultation

5.3.5 The Issues Paper asked for views about whether ACDs should be given statutory recognition in Tasmania.

Should Tasmania have legislation dealing with advance care directives?261

5.3.6 There was broad support for introduction of legislation in Tasmania articulating the role and use of ACDs. Only two submissions stated that there should not be legislative reform to deal with ACDs. One stated a preference for reform to the legislative framework to establish a single document governing all future decision-making — personal, financial, and medical matters — and therefore did not support introduction of ACDs as a further layer in addition to instruments and enduring powers of attorney. Mrs Hilda Nilsson, having worked in advance care planning for several years, stated that the lack of recognition and understanding of the role of ACDs is due to lack of knowledge and that education about their role and effect is the solution to resolving the knowledge gap, rather than legislative reform.

260 Standing Committee, above n 122, [6.12].
261 TLRI, above n 69, Question 12.1(i).
5.3.7 Fourteen respondents supported legislative reform, although MIGA’s submission qualified its position that:

Legislation should only recognise the existence of ACDs under common law, or otherwise made under statutory schemes in other Australian states, without imposing additional manner or form requirements.

5.3.8 Several submissions commented that legislative reform could remove uncertainty about the role of ACDs. The Board commented:

The fact that ACD’s have effect at common law can still create some uncertainties for medical practitioners. There is also some uncertainty in the community about the legal effect of such directives and whether they are an expression of a person’s wishes or are legally binding. In relation to treatment decisions, and when consent is given a considerable time before treatment, its validity may be questioned because of the increased chance that it will not be specific enough to apply to the treatment in question…

5.3.9 The OPG commented:

On balance, we favour the introduction of statutory ACDs in order to give clarity as to their use, erase any doubt as to the validity of ACDs at common law, and ensure medical treatment is provided (or withdrawn or refused) consistent with the wishes and decisions made by the person at a time when they had capacity. It may well help with promoting the uptake of ACDs — anecdotally it seems there is some reluctance for people to make ACD’s and reduced support or encouragement for them to do so by health professionals, based on the perception that they are not legal documents.

5.3.10 The OPMHS also commented that ‘[l]egislation might help clarify the medico legal fears or ambiguities for practitioners, who might be reluctant or uncertain about following ACDs.’

5.3.11 Professors White and Willmott\(^{262}\) submitted:

Legislative schemes provide clarity and improved recognition of directives within the medical profession and may promote the uptake of advance directives in the community.\(^ {263}\)

5.3.12 One attendee of a consultation meeting facilitated by COTA gave his own example of how legal uncertainty has deterred him from completing an ACD. He commented that he had had the ACD form for three years but had not yet completed it because there is no clarity about the role of the document and the power that it has. He expressed the view that, if legislation confirmed the priority of an ACD (for example over the decisions of an enduring guardian or person responsible), then this would place greater protection around the wishes of the person.

\(^{262}\) Directors of the Australian Centre for Health Law Research (ACHLR), a specialist research Centre within the Queensland University of Technology’s Faculty of Law. Their submission is in their personal capacities, rather than on behalf of the Centre.

The Institute’s view

5.3.13 The Institute recommends that legislation in Tasmania codify the effect of ACDs under common law. This recommendation is made for several reasons, outlined below.

5.3.14 ACDs are widely used in the community and have the support of medical professionals.264 Given their prevalence, there must be clarity about the effect of directions in an ACD. As noted earlier, several respondents observed confusion amongst health professionals and the public about the effect of ACDs and how they interrelate with instruments. Statutory recognition would provide certainty about these matters. The House of Assembly Standing Committee recently commented that legislative recognition of ACDs might help to clarify what effect they have, and if, how, and when a person can provide advance consent or refusal of consent to medical treatment.265 There is presently a draft Bill before Parliament which proposes to establish a legislative framework dealing with the creation and use of ACDs.266

5.3.15 An ACD provides a means for an individual to express their will and preferences. They enable a person to decide in advance, avoiding the need for a representative decision. For this reason, ACDs have the Convention Committee’s endorsement.267 Legislative clarity about the effect of directions in an ACD assists to ensure that a person’s prior expressed will and preference is given effect.

5.3.16 While ACDs have effect at common law, it should not be expected that members of the community understand what effect they have. It will assist understanding to state within legislation the legal position in relation to ACDs rather than requiring individuals to understand the position at common law.

5.3.17 One argument against statutory recognition of ACDs in Tasmania is that the Act already enables donors to give directions to their enduring guardian in an instrument.268 The effect is to allow donors to include equivalent directions about medical treatment as may be included in an ACD. Whilst this is correct, the Institute observes that ACDs serve a distinct function to instruments. Instruments require the appointment of an enduring guardian; ACDs do not. An instrument therefore continues to require the involvement of a representative. Conversely, an ACD enables a person to make their own decision without requiring the appointment of a representative. This advances a person’s will and preferences, removes the need for a representative decision and respects the rights of the individual to make their own decisions about matters affecting their lives.

264 Standing Committee, above n 122, [6.12], [6.89], [6.90]; Standing Committee, Submission, 16; Clinical, Technical and Ethical Principal Committee of the Australia Health Ministers’ Advisory Council, National Framework for Advance Care Directives (September 2011) (‘National Framework for Advance Care Directives’); Tasmanian Government, above n 114, 23; Specialist Palliative Care Service, Department of Health and Human Services, Advance Care Planning Factsheet (2009); House of Representatives Standing Committee on Legal and Constitutional Affairs, Parliament of Australia, Older People and the Law (September 2007) [3.149].


267 Convention Committee, above n 21, [17].

268 Guardianship and Administration Act 1995 (Tas) s 32(6).
5.3.18 Because instruments require the appointment of a representative, this can act as a barrier to the completion of the document where a person is socially isolated or does not have anyone that they wish to appoint. This issue is presently compounded by the fact that the Act does not permit a donor to appoint the Public Guardian as their enduring guardian, as discussed in Part 4.\textsuperscript{269} ACDs might, therefore, have particular use for this group of individuals who do not have anyone appropriate to appoint as their enduring guardian.

5.3.19 All other Australian jurisdictions, apart from New South Wales, have legislation dealing with the preparation and use of ACDs.\textsuperscript{270} Whilst this is does not itself justify revision to the position in Tasmania, the Institute considers it relevant to the question of whether there is utility in having legislation dealing with ACDs, noting that this has been the conclusion reached in all other states and territories.

5.3.20 As a supplementary question, the Institute asked for stakeholder's views about whether legislative provisions surrounding ACDs should be incorporated as part of the Act or contained in separate legislation.

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<th>Recommendation 5.1</th>
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<tr>
<td>(1) That Tasmania adopt a legislative framework for advance care directives.</td>
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<tr>
<td>(2) That the legislative framework for advance care directives be included in the Act.</td>
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5.3.21 A majority of respondents supported statutory provisions dealing with ACDs being housed within the Act.\textsuperscript{272} One rationale commonly asserted was alignment, given that the Act already governs instruments and provisions relating to health care.

5.3.22 The Institute agrees. It is logical that one piece of legislation encompasses all statutory provisions governing consent to treatment rather than requiring review of two Acts. It saves duplication and provides consistency. A further benefit is that it facilitates a clear articulation of the interrelationship between ACDs and instruments.

5.4 Other suggestions for statutory reform

5.4.1 Whilst it has been recommended that ACDs have statutory recognition, the Institute has also considered other ways that the Act could better recognise and clarify how people can give directions and document their wishes. The Issues Paper called for suggestions about how the Act might be improved in this regard.

| If advance care directives were not adopted in legislation, are there ways that the Act could be improved to confirm how people are able to document their wishes and views?\textsuperscript{273} |

\textsuperscript{269} It is noted, however, that Recommendation 4.5 makes recommendation for this to be amended to enable the Public Guardian to be appointed as an enduring guardian.

\textsuperscript{270} Although the NSWLRRC has recently recommended that ACDs be recognised within legislation in New South Wales, without affecting the common law: NSWLRRC, above n 24, Recommendation 10.5.

\textsuperscript{271} TLRI, above n 69, Question 12.1(ii).

\textsuperscript{272} Six out of nine responses.
5.4.2 Responses are detailed below.

**Clarifying how directions are to be treated**

5.4.3 By way of background, ACDs may take two forms: they can provide directions about future treatment (an ‘instructional directive’), or they may articulate a person’s values that should be considered when a decision is being made (a ‘values directive’). Two submissions suggested that there should be greater clarity about the extent to which both instructional directives and values directives should be taken into account or followed. This matter is relevant both when considering legislative provisions surrounding the effect of ACDs, as well as reform to the existing provisions of the Act which enable a donor to provide directions to their enduring guardian or express wishes about future treatment (effectively an instructional directive or values directive within an instrument).

**Instructional directives**

5.4.4 The OPG commented that there could be greater clarity about the extent to which enduring guardians and health practitioners must comply with directions in an instrument. It observed that the Act presently requires that the powers of an enduring guardian must ‘be exercised in accordance with any lawful directions specified in an instrument.’ The OPG suggested that, instead, a more explicit statement be included, requiring enduring guardians and health practitioners to follow lawful directions. The Institute agrees with these observations and considers this matter further below.

**Values directives**

5.4.5 Whilst MIGA supported the creation of values directives, it stated that there must be careful consideration given to the extent to which health practitioners be required to give effect to them. It noted:

> By their varying nature, such directives may be capable of differing interpretations in various clinical situations. It may be difficult for both substitute decision-makers and medical and other health practitioners to work out how to give effect to such directives. Given this, they should only be something to consider, not be determinative to the situation at hand.

5.4.6 It suggested that this could be resolved through legislation:

- giving recognition to the potential relevance of a person’s expressed values, as in Victoria;
- setting out a step-by-step process for representatives and medical and other health practitioners to follow when considering a values directive; and
- providing a test of ‘reasonable practicality’ or similar, for representatives and health professionals in giving effect to such a directive.

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273 TLRI, above n 69, Question 12.2.
274 See Medical Treatments Planning and Decision Act 2016 (Vic) s 6.
275 Guardianship and Administration Act 1995 (Tas) s 32(6).
276 See [5.5.20]–[5.5.28], [5.5.32].
The Institute notes that the proposed Decision-Making Process details a step-by-step process for representatives to follow in order to give effect to a person’s values, wishes, and preferences. This matter is further addressed in Recommendation 5.6 below which considers the effect of directions in an ACD.

**Accessibility of ACDs**

5.4.7 MIGA commented that it is ‘imperative that medical and other health practitioners know where to find ACDs.’ The OPMHS considered that a register of ACDs, readily accessible by health care professionals would assist. It was suggested that this could be linked to the Tasmania Health Service (THS) Digital Medical Records, as this is already in regular use and serves as ‘a central information tool for health care in the public sector.’ The registration of ACDs is discussed at [5.5.53]–[5.5.60] below.

**Education**

5.4.8 Consistent with submissions summarised earlier in this Part, PCT stated that greater understanding of the role and use of ACDs is required. The need for community education is discussed in greater detail in Part 18.

**Practices**

5.4.9 MIGA commented that there should be a focus upon:

- Improving uptake of ACDs
- Increasing the knowledge and availability of relevant and succinct decision-making tools and case studies to assist practitioners in determining their validity and applicability in particular circumstances, including through differing platforms such as apps.

These suggestions are endorsed. Several of the recommendations in this Report are intended to address the need to improve advance care planning within the community. Any practical tools, including the use of innovative technologies, that assist people in understanding and applying the legislative framework in practice are also supported.

**Other ways to improve how a person’s views and wishes are considered**

5.4.10 Social Work Services RHH stated that guardians should be required to:

- seek to understand the views of the represented person so far as possible;
- seek input from the represented person and any other appropriate significant person; and
- seek any views that the person has previously expressed in relation to advance care planning.

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277 Refer to Recommendation 11.2.
These suggestions are incorporated in recommendations elsewhere in this Report.278

5.5 Statutory provisions surrounding advance care directives

5.5.1 The Issues Paper asked a series of questions about matters that would need to be resolved if Tasmania introduced legislation dealing with ACDs. Those questions, and the responses received, are discussed below.

Who should able to make an advance care directive?

Age

5.5.2 At common law, any capable person can make an ACD, so long as it is made voluntarily. In Victoria, statute provides that children can make ACDs.279

5.5.3 The Institute asked who ought to be able to complete an ACD.

If advance care directives were given legislative force, then who should be able to make an advance care directive?280

5.5.4 Three written submissions281 referred to the need for a person to be an adult to be ‘competent’ to make an ACD. Other submissions did not refer to age, instead focussing upon the person’s ‘capacity’ or ‘competence’ to make an ACD. Three submissions282 specifically endorsed legislation permitting a child to make an ACD. PCT commented that: “Capacity” should not be related to age.’ Similarly, the OPG recommended that a child who is Gillick competent should be able to make an ACD. The Interim Children’s Commissioner observed that:

Having regard to the principles of the CRC [Convention on the Rights of the Child], particularly article 12, the views of children and young people on all matters affecting them should be given serious consideration and be taken into account. It is a natural consequence of these principles that the views of children and young people be considered in the planning and execution of future medical treatments.

On this basis, the Interim Children’s Commissioner supported those children with the capacity to give informed consent to medical treatment having the ability to provide instructions or express preferences in relation to their future medical treatment.

5.5.5 The Institute considers that legislation should permit a child with decision-making ability to make an ACD. This is consistent with the common law principle that a child who is Gillick competent can provide their own consent to medical treatment. Such a child should be able to prepare a document that effectively serves as a communication aid for times when they may be unable to communicate their consent or refusal to consent. It is nonsensical for a child with the

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278 See Part 8.
279 Medical Treatment Planning and Decision Act 2016 (Vic) s 13.
280 TLRI, above n 69, Question 12.3(i).
281 Older Persons Mental Health Service and Elder Law and Succession Committee, Speak Out.
282 Public Guardian, Palliative Care Tas, Interim Children’s Commissioner.
ability to give their own consent to treatment to be able to do so at the time, but not be able to
document that consent in a form that can be recognised in the future, so long as the child
understands the nature and effect of doing so. The focus should be upon whether the person has
‘decision-making ability’ to make an ACD, rather than a pre-condition based solely on age.

**Recommendation 5.2**

That the Act not preclude children with decision-making ability making an advance care directive.

**Decision-making ability**

5.5.6  The decision-making ability required to complete an ACD is considered in Part 6.

**In what form should an advance care directive be made?**

5.5.7  The Issues Paper asked for views about any formal requirements that should be imposed to
create an ACD.

If advance care directives were given legislative force, then what should be the witnessing
requirements?\(^{283}\)

**Formal requirements**

5.5.8  Some commented that there are no formalities for the making of an ACD at common law
and that statute should not impose formal requirements that might create a barrier to a person
making an ACD or having their lawful directions recognised. The OPG, for example, commented
that a person is able to give an ACD verbally at common law, and ‘there is a case for maintaining this
possibility.’ Others similarly commented upon the importance of formalities not preventing a
person’s wishes being upheld, and that the law should allow wishes and directions to be conveyed
orally.

5.5.9  Given that the fundamental rationale for adopting a legislative framework is to enhance
recognition of ACDs, it is recommended that provisions give sufficient flexibility to maximise the
possibility that a person’s directions and wishes will be followed. It is therefore proposed that the
Act contain an equivalent provision to that enacted in South Australia which confirms that, although
an ACD may not have particular characteristics, this should not prevent the ACD from being given
effect.\(^{284}\) Members of the Elder Law Committee endorsed this approach.

**Recommendation 5.3**

(1) That the Act confirm that an advance care directive is not invalid merely because it does not
possess certain formal characteristics.

(2) That legislation contemplate a person making a valid advance care directive orally.

**Witnessing requirements**

5.5.10 Despite comments in the earlier paragraph expressing a desire for informality, most
responses supported witnessing requirements for ACDs being the same as for other documents —

\(^{283}\) TLRI, above n 69, Question 12.3(ii).

\(^{284}\) Guardianship and Administration Act 1995 (Tas) s 11(5).
some referring specifically to instruments, enduring powers of attorney and Wills. The OPG stated that it did not hold firm views but leaned towards a requirement that one of the witnesses be a medical practitioner. Another submission stated that one witness should be a lawyer, whilst another supported the use of independent witnesses.

5.5.11 MIGA did not support witnessing requirements for ACDs:

Given the common law does not require an ACD to be witnessed, MIGA does not support a requirement that an ACD be witnessed …

It went on to comment that:

As witnessing can be a helpful indicia of ACD validity, its use should be encouraged, but not mandated. The best way to encourage this would be through the development of a template ACD by the Tasmanian Department of Health and Human Services, with input from key stakeholders, including MIGA. This is similar to an approach adopted by NSW Health for its ROAD project to develop a template ACD. Such a template could then be distributed widely as a best practice approach.

5.5.12 The THS Advance Care Directive form requires one witness who is over the age of 18 years, not related to the person concerned or known beneficiary of their Will. It also provides that the witness may be a registered health care professional, but not a paid personal carer.285

5.5.13 It is not intended that a legislative framework restrict the existing ability of a person to make an ACD at common law. It is, however, considered appropriate for the Act to include witnessing requirements for written ACDs as evidence of the person’s ability to understand the nature and effect of the ACD and that they appeared to create the document freely and without undue influence.

5.5.14 Equivalent witnessing requirements to instruments are endorsed in order to provide consistency. It is critical, however, that the Board have the ability to declare an ACD valid despite non-compliance with witnessing requirements, as is recommended in relation to instruments.286

**Recommendation 5.4**

(1) That witnessing requirements for a written advance care directive be consistent with requirements for instruments.

(2) That the Board be able to declare an advance care directive valid despite any non-compliance with formal requirements.

**Prescribed form**

5.5.15 The Issues Paper asked whether the Act should prescribe a standard ACD form.

If advance care directives were given legislative force, then should there be a prescribed form?287

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286 Refer to Recommendation 4.11(2).

287 TLRI, above n 69, Question 12.3(iii).
5.5.16 Respondents did not support a particular form ACD being mandated. It was considered that legislation needs to be sufficiently flexible and not impose unnecessary restrictions: ‘Restriction to a prescribed form could create a bureaucratic obstacle to people’s wishes being met.’ COTA submitted that ‘professional advice and assistance should be available as to how best to write an advance care directive.’

5.5.17 There was, however, support for the development of a template form. One submission commented:

Although we often grizzle about forms and the bureaucracy implied, forms help us to know what information to provide. They also help carers discover relevant information in a consistent way.

5.5.18 The OPG supported development of a clear template with solid instructions and guidelines. Others commented on the need for the form to be user-friendly and accessible for those with low literacy levels. Members of the Elder Law Committee suggested that a suitable template should be developed with medical and legal input. MIGA also encouraged emphasis being placed upon the development of a widely used template in consultation with key stakeholders.

5.5.19 It is proposed that the Act include a template ACD form, but that it also be possible to use a form with similar effect. This adopts the existing approach in relation to instruments. The Institute agrees with submissions received that the focus should be upon ensuring strong stakeholder input into the development of the standard form ACD. Community consultation would help to ensure that the form is user-friendly, clear and functional. Stakeholder ‘buy in’ through the consultation process is also likely to improve uptake and use of the form. This promotes advance care planning in the community, facilitating individuals retaining control of decisions affecting their life.

**Recommendation 5.5**

(1) That a form advance care directive be included in a Schedule to the Act but that use of this form not be mandatory.

(2) That there is strong community and stakeholder engagement and consultation in relation to the development of the form advance care directive including consumer, medical and legal input.

**Should an advance care directive be binding, or only taken into account?**

5.5.20 Legislation needs to articulate the effect of an ACD. Examples of approaches from other jurisdictions include:

- in South Australia, a refusal of treatment is binding, so long as it applies to the specified circumstances. A person cannot direct that treatment be performed, and any directions...

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288 Older Persons Mental Health Service.
289 It referred the Institute to the approach adopted by NSW Health for its ROAD project in developing a template ACD, endorsing this approach.
290 Guardianship and Administration Act 1995 (Tas) s 32(2)(a).
291 Advance Care Directives Act 2013 (SA) s 19.
292 This is a matter for a medical practitioner to decide, having regard to the person’s wishes: ibid s 6(1).
that direct treatment to be performed are not binding.\textsuperscript{293} Guardians must give effect to an ACD as far as reasonably practicable;\textsuperscript{294}

- in Queensland and Western Australia, directions about treatment, including special treatment, must be followed;\textsuperscript{295}

- in the ACT, guardians must act consistently with an ACD unless it is not reasonable do so.\textsuperscript{296} Examples are provided of where it might not be reasonable, including where treatment is urgent or where a decision-maker has been unable to locate an ACD after reasonable enquiries; and

- in the Northern Territory, an advance consent decision in an ACD has the same effect as if the person made the decision with fully informed consent whilst they had capacity to do so.\textsuperscript{297} It cannot be overridden by a substitute decision-maker, unless one of the permitted exceptions applies.\textsuperscript{298}

5.5.21 Examples where directions may not be given effect include:

- where there is no reasonable possibility that the person intended the direction to apply in the circumstances or to the treatment proposed;\textsuperscript{299}

- where there has been a change in circumstances, the person’s wishes or standards of health care between when the ACD was made and when a treatment decision needs to be made;\textsuperscript{300}

- where the person relied upon incorrect information or assumptions when making the ACD;\textsuperscript{301}

- where it would result in unacceptable pain and suffering for the person;\textsuperscript{302}

- it is so wholly unreasonable\textsuperscript{303} or unlawful, or would result in a health practitioner breaching a professional standard or code of conduct;\textsuperscript{304}

- if the direction is uncertain;\textsuperscript{305}

- the direction relates to mandatory treatment, for example under the provisions of mental health laws;\textsuperscript{306} or

\begin{itemize}
  \item \textsuperscript{293} Ibid s 19(3).
  \item \textsuperscript{294} Guardianship and Administration Act 1993 (SA) s 31A(1)(b); Advance Care Directives Act 2013 (SA) s 35.
  \item \textsuperscript{295} Guardianship and Administration Act 2000 (Qld) s 65(2); Guardianship and Administration Act 1990 (WA) s 110ZJ.
  \item \textsuperscript{296} Medical Treatment (Health Directions) Act 2006 (ACT) s 18(3).
  \item \textsuperscript{297} Advance Personal Planning Act 2016 (NT) s 41(1), see also s 45.
  \item \textsuperscript{298} Ibid s 41(4); Guardianship of Adults Act 2016 (NT) s 4(7).
  \item \textsuperscript{299} Advance Personal Planning Act 2016 (NT) s 41(3); Advance Care Directives Act 2013 (SA) s 36(2); Consent to Medical Treatment and Palliative Care Act 1995 (SA) s 13(1a)(c).
  \item \textsuperscript{300} Guardianship and Administration Act 1990 (WA) s 110S(3); Advance Care Directives Act 2013 (SA) ss 36(2)(b), (3).
  \item \textsuperscript{301} Medical Treatment Planning and Decisions Act 2016 (Vic) s 23(b)(ii).
  \item \textsuperscript{302} Advance Personal Planning Act 2016 (NT) s 41(3)(b).
  \item \textsuperscript{303} Ibid s 41(3)(b)(ii).
  \item \textsuperscript{304} Advance Care Directives Act 2013 (SA) s 12(1).
  \item \textsuperscript{305} QLRC, above n 25, Recommendation 9-3(b)(i).
  \item \textsuperscript{306} Advance Care Directives Act 2013 (SA) s 12(1)(b), see also s 37 where a medical practitioner can refuse to comply with an advance care directive on conscientious grounds.
\end{itemize}
Part 5: Advance Care Directives

• directions about the withholding or withdrawal of life sustaining measures.\(^{307}\)

5.5.22 In the Northern Territory, whether a direction can be disregarded is a matter that the tribunal decides, rather than a decision for a medical practitioner or person responsible.\(^{308}\)

5.5.23 The Institute called for submissions about the extent to which directions in an ACD ought to be binding on decision-makers and treating professionals. The following questions were posed:

Should directions in an advance care directive be binding on decision-makers? Should there be any exceptions? Who should determine whether an exception applies? What penalties should apply where directions are not followed?\(^{309}\)

5.5.24 There were 11 responses to this question. All respondents expressed a view that certain decisions ought to be binding. This was typically suggested to occur where:

• the person had the decision-making ability to make the ACD;\(^{310}\)
• the person was not under duress;
• the direction was not made based on misinformation or misunderstanding about the nature of their condition or the treatment;
• there has not been a material change in circumstances (for example, advances in medical treatment);
• the direction is unambiguous; and
• the direction applies to the situation at hand.

A number of respondents expressed support for the exceptions listed at [5.5.21] being adopted as circumstances where an ACD may not be binding. Many stated that directions in an ACD should only be non-binding in exceptional circumstances. One respondent stated that there should be no situations where directions are not binding.

5.5.25 Two respondents clarified their position that only directions expressing a refusal to consent to treatment ought to be binding. It was submitted that a patient should not be able to compel a medical practitioner to provide treatment. It was suggested that directions in those circumstances ought only be binding where the treatment is proposed, offered, or recommended by a medical practitioner.

5.5.26 The Institute agrees with these submissions. This accords with the common law position and is consistent with other jurisdictions, as outlined above.

5.5.27 The Institute recommends the following approach:

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\(^{307}\) In Queensland, a person’s binding directions to stop or withhold life sustaining measures only operate in limited circumstances: *Powers of Attorney Act 1998* (Qld) s 36(2).

\(^{308}\) See *Advance Personal Planning Act 2016* (NT) s 41(3).

\(^{309}\) TLRI, above n 69, Questions 12.3(iv), (v).

\(^{310}\) The Social Work Services RHH commented that this should include circumstances where the person was subject to a mental illness, for example a depressive episode, that affected the directions made.
• that the Act confirm the difference between being able to direct that treatment not be performed, as distinct from directing that a particular treatment be performed (other than the withdrawal or withholding of health care and treatment);

• that the Act confirm that certain directions may not be made in an ACD — for example, where they would be unlawful, would require a health practitioner to breach professional standards or relate to compulsory treatment (for example under mental health laws). The Institute endorses the approach in South Australia in this regard. Provisions purporting to make these directions ought to be void and of no effect; and

• that the Act confirm the common law position that a direction to refuse treatment is binding if:
  o it was made voluntarily by a person with decision-making ability to make an ACD;
  o it is clear and unambiguous; and
  o it extends to the situation at hand; and
  o that health practitioners be able to decline to comply with a direction in an advance care directive if they are satisfied that it does not reflect the current wishes of the person. This approach promotes the views, wishes, and preferences of a person being given effect to.

5.5.28 The Institute also endorses the approach in the Northern Territory which expressly states that the effect of a binding direction in an ACD is to operate as if the person had made the decision themselves with fully informed consent and whilst they had capacity to do so. This provides clarity and understanding and eliminates confusion about the effect of a binding direction.

Recommendation 5.6

(1) That an advance care directive or instrument not be permitted to contain directions that:
  • are unlawful;
  • would require an unlawful act to be performed;
  • would result in a health practitioner breaching a professional standard or code of conduct; or
  • relate to mandatory treatment, for example under the Mental Health Act 2013 (Tas).

Any directions of this type should be void and of no effect.

(2) That legislation clarify that a direction in an advance care directive or instrument cannot compel a health practitioner to perform a particular form of health care and treatment other than the withdrawal or withholding of health care and treatment.

(3) That legislation confirm that a direction amounting to a refusal of health care and treatment is binding if:
  • it was made voluntarily by a person with decision-making ability to make the directive;

311 Advance Care Directives Act 2013 (SA) s 12(1).
312 Advance Personal Planning Act 2016 (NT) s 41.
• it is clear and unambiguous; and
• it extends to the situation at hand.

(4) That the Act confirm that a directive in these circumstances has the same effect as if the person made the decision whilst they had the decision-making ability to do so.

(5) That health practitioners be able to refuse to comply with a binding direction in an advance care directive if they believe on reasonable grounds that it does not reflect the current wishes of the person.

5.5.29 There were a range of views about who ought to determine when the directions in an ACD ought not be followed. The OPG considered that a dispute should initially be referred to the Public Guardian and, if unable to be resolved, the matter should then be referred to the Board. EOT considered that the determination is a matter that could be made by the Board or OPG, also commenting that there ought to be dispute resolution processes within the Act. MIGA supported the Board being the body to determine whether a direction ought not be followed. Social Work Services RHH supported the matter being referred to a hospital ethics committee (where arising in the acute care setting). Members of the Elder Law Committee stated that the matter should be determined by a decision-maker.

5.5.30 The Institute considers that, consistent with recommendations made elsewhere in this Report, the Public Guardian have power to consider a matter initially and attempt to resolve disputes. A useful example of this approach is included in the South Australian legislation. If the matter is unable to be resolved this way, or the Public Guardian considers that it is more appropriate that the matter be dealt with by the Board, then it should have power to refer the matter to the Board for resolution.

5.5.31 This is similar to the approach already adopted in relation to instruments, where the Board is able to order that directions in an instrument may not be followed. The independence and expertise of the Board acts as a safeguard aimed at protecting the rights and interests of the patient.

**Recommendation 5.7**

(1) That the Public Guardian have power to mediate matters and attempt to resolve disputes in relation to advance care directives and instruments, broadly consistent with ss 45(1)–(4) of the *Advance Care Directives Act 2013 (SA)*.

(2) That if the Public Guardian is not able to resolve a matter, or it considers it more appropriate that the matter is determined by the Board, that the Public Guardian be able to refer a matter to the Board for determination.

(3) That the Board have power to give advice and directions and make declarations to resolve disputes relating to advance care directives.

5.5.32 The Institute further recommends that the Act confirm that guardians (enduring and Board-appointed) and health practitioners have a duty to seek to give effect to a represented person’s

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313 Recommendations 7.10, 12.4, and 14.1.
314 *Advance Care Directive Act 2013 (SA)* s 45.
315 See for example, *Advance Care Directives Act 2013 (SA)* s 46.
316 *Guardianship and Administration Act 1995 (Tas)* s 32(6).
ACD as far as possible. This is intended to promote the represented person’s expressed will and preferences in circumstances where a direction in an ACD is not binding. This might occur, for example, where a direction in an ACD expresses a wish for a particular form of treatment or treatment outcome, or expresses other wishes or values that they wish to be taken into account when making decisions (sometimes called ‘values directives’). It is not intended that this vary the proposed Decision-Making Process outlined in Recommendation 11.2, but is suggested on the basis that explicitly stating a duty to give effect to a person’s ACD reinforces the role of representatives in advocating for the represented person. It also promotes a person’s will and preference being given maximum effect.

Recommendation 5.8

That there be an express duty upon enduring guardians, guardians and health practitioners to give as much effect as possible to the advance care directive of a person without decision-making ability to consent to a particular health care and treatment decision.

Should medical practitioners or decision-makers be under any obligation to ascertain whether a person has an advance care directive?

5.5.33 The Issues Paper noted that some jurisdictions require medical practitioners and representatives to take reasonable steps to ascertain whether a person has an ACD. The intention is to promote a person’s ACD being given effect. Clearly the first step to upholding a person’s ACD is to know that the patient has one and to obtain a copy.

5.5.34 In Victoria, medical practitioners and operators of health facilities must make reasonable efforts to ascertain whether a person has an ACD. In the ACT, any person who becomes aware that a patient of a health care facility has made or revoked an ACD must notify the person in charge of the health care facility. In South Australia, a guardian has a duty to take all reasonable steps to ascertain whether a represented person has made an ACD. An enduring guardian must confirm that they have read the donor’s ACD upon accepting the role in Victoria. Recommendation 4.10 proposes that an equivalent reform be made to the Act.

5.5.35 The Institute requested views about whether legislation should provide an obligation upon representatives or medical professionals to ascertain whether a patient has an ACD prior to seeking or providing substitute consent to treatment.

Should medical practitioners and decision-makers have a duty to take steps to ascertain whether a patient has an advance care directive?

317 See Medical Treatment Planning and Decision Act 2016 (Vic) s 6, 12.
318 Medical Treatment Planning and Decisions Act 2016 (Vic) s 50; Medical Treatment Planning and Decisions Act 2016 (Vic) s 98. The NSWLRCL has recently made the same recommendation: NSWLRCL, above n 24, Recommendation 10.5(7). A similar position applies in South Australia: Consent to Medical Treatment and Palliative Care Act 1995 (SA) s 13(1)(d).
319 Medical Treatment (Health Directions) Act 2006 (ACT) s 13.
320 Guardianship and Administration Act 1993 (SA) s 31A(1)(a).
321 Medical Treatment Planning and Decision Act 2016 (Vic) s 29(c)(iv).
322 TLRI, above n 69, Question 12.3(vi).
5.5.36 All responses endorsed this approach.\(^{323}\) Qualifications were made that only ‘reasonable’ attempts should be necessary.

5.5.37 PCT commented that one of the biggest failings of the system presently is the absence of a central repository for health professionals to search for an ACD. The OPMHS also commented that health professionals should have a duty to make enquiries particularly in circumstances where the document is readily available and accessible. The issue of the registration of ACDs is considered below.\(^{324}\)

5.5.38 Although Recommendation 4.10 already proposes that enduring guardians be required to confirm when accepting the role that they have read a copy of the donor’s ACD, it is recommended that a separate provision confer a duty upon guardians to enquire whether a represented person has an ACD. This would capture Board-appointed guardians and also addresses the circumstance where some time passes between the making of an instrument and the appointed enduring guardian being required to act. During that intervening period, the donor may have made an ACD or altered any ACD that existed at the time the instrument was made.

5.5.39 Based on unanimous support for this reform, the Institute recommends that health professionals and guardians have a duty to take reasonable steps to ascertain whether a patient/donor has an ACD. The Victorian approach is endorsed, which extends to operators of health facilities.

**Recommendation 5.9**

(1) That the Act provide that, except in relation to urgent health care and treatment, before administering health care and treatment to a person who does not have decision-making ability to give consent to that health care or treatment, health professionals must make reasonable efforts in the circumstances to ascertain whether that patient has either or both an advance care directive or instrument.

(2) That the Act provide a duty upon prescribed health facilities (to be defined in the Regulations) to make reasonable enquiries to ascertain whether a patient in their facility has either or both an advance care directive or instrument and, if so, ensure a copy is placed with the patient’s clinical records.

(3) That guardians have a duty to make reasonable enquiries to ascertain whether a represented person has an advance care directive.

**Should an advance care directive also provide the ability for a person to appoint a medical treatment decision-maker?**

5.5.40 Currently, to appoint a representative with power to consent to medical treatment, an adult may appoint an enduring guardian. An enduring guardian has power to consent to medical treatment as a ‘person responsible.’\(^{325}\) They also have power to consent to health care or refuse consent to health care.\(^{326}\)

\(^{323}\) There were 11 responses to this question.

\(^{324}\) See [4.5.59].

\(^{325}\) Guardianship and Administration Act 1995 (Tas) s 4(1)(e)(i).

\(^{326}\) Ibid s 25(2)(e).
5.5.41 In Victoria, a person nominates a medical treatment decision-maker separately to appointing an enduring guardian. Enabling the separate appointment of a medical treatment decision-maker could benefit those individuals who want to appoint different people to make decisions about personal matters to medical treatment decisions, in the way that adults can presently by appointing attorneys for financial matters and enduring guardians for personal decisions. On the other hand, reform enabling separate personal, financial and medical treatment decision-makers may increase complexity and lead to confusion.

5.5.42 The Issues Paper asked whether the community considered there would be any benefit to legislation enabling a person to appoint a separate decision-maker with power to consent to medical treatment, as distinct from the appointment of an enduring guardian for personal matters.

Should separate decision-makers be able to be appointed for medical treatment decisions, separate to personal and financial matters?  

5.5.43 There were six responses to this question, all of which supported the ability to appoint a medical treatment decision-maker separate to a representative for personal and financial matters. Respondents supported this approach on the basis that the roles may involve different skill sets and possibly suit different individuals and that this approach enables a person to appoint who they consider best for each role. MIGA stated that the powers of a medical treatment decision-maker could be specified in the document as either providing full or limited powers in relation to health care. In the absence of the donor specifying, the medical treatment decision-maker would then have powers consistent with a person responsible.

5.5.44 The Institute also enquired separately whether there was support for the appointment of a medical treatment decision-maker within an ACD.

Should a person be able to appoint a medical treatment decision-maker in an advance care directive?  

5.5.45 There were eight responses to this question, with six supporting the Act permitting (but not requiring) a person to appoint a medical treatment decision-maker in an ACD. Members of the Elder Law Committee suggested that an ACD could be used to appoint a decision-maker for care planning, but not medical treatment decisions as these fall within the scope of an enduring guardian’s power. Social Work Services RHH did not support this alternative on the basis that it would complicate the system, given the existing roles of the person responsible and enduring guardian. It considered that the appointment of a medical treatment decision-maker should continue by way of appointment of an enduring guardian.

5.5.46 PCT commented:

the Person/s Responsible should be a signatory to the form. That way the person would not have to appoint an Enduring Guardian, and the Person Responsible could be someone outside of the hierarchy.

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327 Medical Treatment Planning and Decision Act 2016 (Vic) s 26.
328 TLRI, above n 69, Question 10.6.
329 MIGA’s submission commented that it supported the ability to appoint a medical treatment decision-maker without explicitly stating that it endorsed the ability to do this separate to an enduring guardian for personal matters.
330 TLRI, above n 69, Question 12.3(vii).
5.5.47 The Institute observes that a person is already able to appoint a representative to consent to medical treatment by appointing an enduring guardian. If an ACD could also be used to appoint a medical treatment decision-maker, then:

- this would raise the question of what continuing role an instrument plays — the effect may be to limit the role of an enduring guardian to lifestyle and other personal matters, but not those related to medical treatment or health care;
- if an enduring guardian’s role were limited to personal decisions, then for a person to appoint a ‘full suite’ of representatives as part of comprehensive estate planning, it would be necessary for the person to make an enduring power of attorney, instrument, and an ACD. The Institute is unpersuaded that there is merit to this level of complexity, noting that one of the most commonly expressed issues with the system currently is that it is already overly complex;
- if, on the other hand, an enduring guardian’s role were not limited to personal matters and there remained an ability to delegate powers to make medical treatment and health care decisions, then the system would create confusion. Health professionals would need to enquire whether a patient had both an instrument and/or an ACD and then review the terms of both documents to determine whether a decision-maker had been appointed in either or both. There would need to be statutory provisions resolving who ought to have priority in circumstances where a patient may have granted powers to (different) enduring guardians and medical treatment decision-makers within separate documents;
- those with existing instruments would assume that their appointed enduring guardians have power to consent to medical treatment decisions — this group of individuals would need to be considered and appropriate provisions enacted during a transition phase to ensure that there were no unintended consequences of the reform;
- there is also a risk that a person may (incorrectly) assume that they have appointed a medical treatment decision-maker by appointing their enduring guardian, unaware that this appointment needs to be made separately in an ACD; and
- it would need to be resolved whether there would be any oversight of a medical treatment decision-maker via the Board, noting that currently the Board has jurisdiction to review the activities of enduring guardians and remove them if necessary.\footnote{Guardianship and Administration Act 1995 (Tas) s 34.}

5.5.48 There were no responses indicating a particular need to divide the role of personal and lifestyle decisions with medical treatment and health care decisions. Respondents did not, for example, express their desire to appoint a different medical treatment decision-maker to their enduring guardian. Similar skill-sets and personal attributes are likely to be desirable for both roles. There is also likely to be overlap between matters that might be ‘personal’ decisions and those that relate to a person’s health care — for example, decisions about where a person is to live temporarily for the purpose of receiving health care.\footnote{Note that this debate already exists in relation to whether it falls within the scope of a person responsible’s powers to consent to the admission of a patient within the Roy Fagan Centre. One view is that this is a decision for a person responsible as the decision is intrinsically linked to the provision of medical treatment (as admission is necessarily required in order for the treatment to be performed). The alternative view is that it is a
5.5.49 Whilst Victoria provides for the separate appointment of medical treatment decision-makers separate to personal matters, it has single appointments of attorneys for personal and financial matters. The result is the need for two documents to be completed to appoint a full suite of decision-makers. In South Australia, whilst individuals may appoint decision-makers via an ACD, those decision-makers have powers in relation to both personal and health care matters. The result is effectively the same as the position applying in Tasmania, but with the document called an ‘advance care directive’ rather than an ‘instrument’. A renaming of instruments adopting this approach could alleviate the present community confusion about the enduring document framework.

5.5.50 In all Australian jurisdictions, the enduring appointments of representatives occur within either one or two documents. No jurisdiction provides for three documents to complete appointments of representatives for personal, financial and medical treatment matters. Given the desire to simplify the framework, and noting Recommendation 4.2 which proposes that the State Government investigate community support for combining the appointments of attorneys and enduring guardians within a single enduring document, the Institute is unpersuaded of the merit of providing separate appointments of medical treatment decision-makers, either within, or separate to ACDs.

5.5.51 The Institute views the role of an ACD as being two-fold — first, to enable a person to provide advance consent or refusal to consent, effectively making their own decisions in advance; and secondly, to provide guidance and assistance to health professionals and representatives about values, views and beliefs that they must consider and promote when making decisions consistent with the patient’s views, wishes and preferences. It is then the function of an instrument to appoint representatives who could act as a last resort, where the ACD does not extend to circumstances requiring a representative decision.

5.5.52 As discussed earlier in this Part, an instrument already effectively enables a person to do all the things that an ACD does. The only difference is that the creation of an instrument requires the appointment of a representative. An ACD enables a person to effectively avoid the need for a representative by making and communicating their own decisions in advance. The result is that an ACD is not needed so that a person can appoint a representative — it is needed so that people do not have to appoint a representative. In summary, the Institute sees the role of an instrument as enabling appointment of a representative, and the role of an ACD as serving as a communication aid. The Institute does not, therefore, propose that the Act provide for an ACD being used to appoint a medical treatment decision-maker.

**Should advance care directives be registered?**

5.5.53 Presently, ACDs do not need to be registered. The ALRC has suggested that they should not need to be registered because it is already possible to lodge an ACD on the ‘My Health Record’ online resource. The Institute notes that the Standing Committee found almost unanimous support

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333 Powers of Attorney Act 2014 (Vic) s 22(2).
334 Advance Care Directives Act 2013 (SA) ss 21, 23.
335 ALRC, above n 66, [5.103].
for the implementation of a secure register of ACDs for health care workers to access.\textsuperscript{336} As already noted earlier in this Part, a number of respondents raised the issue of the lack of central repository for ACDs as being a significant failing of the system at present.

5.5.54 The Issues Paper asked for feedback about whether legislation should provide for the registration of ACD. As a secondary question, if ACDs were registered, the Institute asked which agency should maintain that register.

\begin{center}
\textbf{Should advance care directives be registered? If so, who should maintain the register?}\textsuperscript{337}
\end{center}

5.5.55 All responses to this question\textsuperscript{338} supported introduction of a scheme enabling registration of an ACD. Two respondents supported registration of ACDs but commented that the lack of registration of an ACD should not affect its validity. This is because at common law an ACD is not required to be registered and statutory provisions should adopt the same approach. To do otherwise would impose a barrier to a person’s will and preference being given effect. The Institute agrees with these observations.

5.5.56 The Institute also notes the submission of Speak Out advocates that there should not be a registration fee imposed for the registration of an ACD. They considered that this could act as a barrier to a person making an ACD, noting that they observe this is one of the reasons that people do not complete instruments. This issue was also considered in Part 4 in relation to the registration of instruments. The Institute refers to and repeats the observations made in that Part and makes the same recommendations in relation to the registration of ACDs as made for the registration of instruments.

5.5.57 There were a range of views about which body ought to be responsible for maintaining the register of ACDs. Responses included:

- the Board (the most common response);
- the Recorder of Titles, via the Land Titles Office;
- the Public Guardian;
- the Public Trustee; and
- the Department of Health and Human Services (DHHS).

The OPMHS commented that the register could be linked to the THS Digital Medical Records.

5.5.58 The Institute considers that there are benefits to having a single repository for both instruments and ACDs. It therefore supports the Board having responsibility for maintaining the register of ACDs.\textsuperscript{339} It is noted that, for this reason, it is imperative that the Board be adequately

\textsuperscript{336} Standing Committee, above n 122, [6.79], Recommendation 5.
\textsuperscript{337} TLRI, above n 69, Question 12.3(viii).
\textsuperscript{338} Thirteen submissions.
\textsuperscript{339} The Board did not make a submission in relation to this question.
funded to maintain the register and to develop systems enabling a person with a legitimate interest\textsuperscript{340} to search the register of ACDs, including on an urgent basis and outside of business hours.

5.5.59 The Board also made comments about the need for a national approach:

while it is certainly desirable that medical practitioners and decision makers have an obligation to ascertain whether a person has an ADC, this is hampered by the piecemeal regulation of directives across Australia, and the absence of a national health database which can be accessed outside of business hours. Clarification in the Act as to whether ACD's made and possibly registered outside the State have effect in Tasmania is necessary.

5.5.60 The Institute considers that recommendations made earlier in this Part address the issue of clarity about the effect of ACDs made or registered in other jurisdictions. This includes Recommendation 5.10(2) that the failure to register an ACD should not affect the validity of the document. The Institute agrees that it is desirable that efforts are made to develop a national repository for ACDs to address the transient nature of the Australian population. This assists to ensure that those who require access to a person's ACD have easy access to do so when required.

**Recommendation 5.10**

(1) That the Act provide for the registration of advance care directives.

(2) That failure to register an advance care directive not affect the validity of the document.

(3) That there not be a registration fee payable on the registration of an advance care directive, but that the Registrar be given a discretion to impose a registration fee where more than one advance care directive is registered for a person in a calendar year.

(4) That there not be a fee for the registration of a revocation of advance care directive.

(5) That an online search function be developed to search the register of advance care directives.

(6) That there not be a search fee to search the register of advance care directives.

(7) That the State Government work with other state and territory governments to develop a national repository for advance care directives.

**5.6 Offences**

5.6.1 Legislation in some jurisdictions incorporates offences for people who dishonestly induce a person to create an ACD.\textsuperscript{341} In South Australia, it is an offence for a person to fail to advise the tribunal as soon as reasonably practicable if they become aware that the donor of an ACD wishes, or may wish to revoke their ACD but they do not have capacity to revoke it.\textsuperscript{342}

5.6.2 The Institute did not seek specific feedback about whether legislation ought to impose any offences in relation to the preparation or use of ACD. It does, however, consider it appropriate that

\textsuperscript{340} At [12.9.19]–[12.9.21] below, safeguards in relation to access to the proposed register of ACDs are considered. See also Recommendation 12.24.

\textsuperscript{341} See for example Medical Treatment (Health Directions) Act 2006 (ACT) s 20, Advance Care Directives Act 2013 (SA) s 56.

\textsuperscript{342} Advance Care Directives Act 2013 (SA) s 31(3).
there be broad consistency in the provisions between ACDs and instruments. This matter is addressed in Part 12 which deals with safeguards for representative decision-making.
Part 6

Decision-Making Ability

6.1 Introduction

6.1.1 Assessment of a person’s decision-making capacity is critical to the Act’s operation. In broad terms, the Act provides that a person who has a certain level of decision-making capacity can make their own decisions. A person whose decision-making capacity does not meet that test may have decisions made for them. Whilst the Institute’s Terms of Reference did not specifically ask for consideration of whether there needs to be reform to those parts of the Act dealing with a person’s decision-making ability, it is implicit that this is required. This is because the Terms of Reference called for consideration of the role and powers of representatives, provisions in relation to consent to medical treatment, consideration of safeguards and any reforms desirable in light of international and national trends in relation to guardianship law. None of these matters can be properly addressed without first reviewing when the Act’s jurisdiction is invoked.

6.1.2 Except in relation to emergency orders, the Act presently provides for substitute decision-making only for people with a disability. 

6.1.3 This Part then reviews and makes recommendations about how the Act deals with the assessment of a person’s decision-making abilities. The Part concludes by examining whether and how the Act can improve safeguards that promote assessment of a person’s decision-making ability being conducted appropriately.

6.2 Need for a disability

6.2.1 All of the tests in the Act that assess whether a person is able to make decisions require the person to have a disability.

6.2.2 The Convention requires equality before the law and non-discrimination for people with disability. The Convention Committee has stated that: ‘States parties must holistically examine all areas of law to ensure that the right of persons with disabilities to legal capacity is not restricted on an unequal basis with others.’

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343 Apart from the making of emergency orders, where proof of a disability is not necessary for the making of an emergency order, although the Board must be satisfied that there are grounds for the making of a guardianship or administration order. This necessarily requires the Board to consider whether the person has a disability.

344 Guardianship and Administration Act 1995 (Tas) ss 32(5), 20(1)(a), 51(1)(a), 36(1). Note that emergency orders can be made without needing to establish that a person has a disability.


346 Convention Committee, above n 21, [7].
6.2.3 Guardianship legislation in the Northern Territory and Queensland do not require the existence of a disability as a pre-condition for substitute decision-making.347 Recent recommendations by the NSWLRC also propose removal of the precondition of disability in New South Wales’ legislation.348

6.2.4 The VLRC recommended that the existence of a disability remain a pre-condition to the operation of guardianship laws.349 This was endorsed on the basis that it gives an objective element to the test to ensure that people are not subject to guardianship orders because they engage in harmful behaviour which is not the direct result of a disability.350 Whilst it made this recommendation, the VLRC considered that the existence of a disability should not be a separate condition to the appointment of a representative.351 Instead, it advocated that a single test be adopted to require a person’s decision-making incapacity to be caused by a disability.352 Victoria’s recent draft Bill adopts this approach — enabling the tribunal to appoint an administrator or guardian where it is satisfied that, because of a disability, the person does not have decision-making capacity in relation to financial or personal matters.353 The Victorian Powers of Attorney Act does not, however, require the existence of a disability before an attorney can commence acting on the donor’s behalf — only that the donor does not have decision-making capacity in relation to a particular matter.354

6.2.5 Currently, the Act already requires an assessment of whether the person is unable to make a reasonable judgment because of their disability.355 In essence, adopting the VLRC approach would involve removing the need for a disability as a separate element, with the Act continuing to refer to whether a person is unable to make a reasonable judgment because of their disability.

6.2.6 The Issues Paper sought community feedback about whether the Act should continue to require a person’s decision-making incapacity to be the result of disability.

| Should the need for a disability remain part of the test that assesses a person’s capacity? |

6.2.7 There were 18 written responses to this question, along with three verbal submissions. Five responses supported retention of disability as part of the test that assesses a person’s ability to make decisions. Four of those submissions endorsed the Act adopting a test similar to the VLRC’s recommendations that disability not be a stand-alone test, but that the test require consideration of whether a person is unable to make decisions because of a disability.

6.2.8 Dr Eckstein submitted that there should be a high threshold for a person’s liberty to be effectively removed from them. She stated that the requirement for a disability provides such an objective test. The OPG and members of the Elder Law Committee considered that it is appropriate

347 See Medical Treatment Planning and Decisions Act 2016 (Vic) s 4; Advance Personal Planning Act 2016 (NT) s 6; Guardianship of Adults Act 2016 (NT) s 5; Guardianship and Administration Act 2000 (Queensland) sch 4, definitions of ‘impaired capacity’ and ‘capacity’.
348 NSWLRC, above n 24, Recommendation 6.1.
349 VLRC, above n 24, Recommendation 52.
350 Ibid Recommendation 53.
351 Ibid Recommendation 170.
352 Ibid Recommendation 172.
353 Guardianship and Administration Bill 2018 (Vic) cl 30(2)(a).
355 See for example Guardianship and Administration Act 1995 (Tas) s 20(1)(b).
356 TLRI, above n 69, Question 3.1(i).
to retain disability as a pre-condition so that application of the Act is not extended and to reduce the risk of guardianship laws being used in relation to people who might make unwise decisions or exhibit harmful behaviour.

6.2.9 Both the Board and Speak Out advocates observed that removing the pre-requisite for a disability would likely impact individuals with dependencies, such as alcohol or drug dependencies. This is considered in Part 17.

6.2.10 Thirteen written respondents and two verbal submissions expressed support for removing the need for a disability to trigger operation of the Act. Many supported removing disability as a pre-condition on the basis that it would provide greater compliance with the Convention. Under the Convention, people with disability must be treated equally before the law and not be subject to discrimination. Having guardianship laws apply only to people with disability amounts to unequal treatment. Nevertheless, Sandra Taglieri SC commented that the criterion of disability is necessary because it is the fact of existence of disability which may deprive a person of the cognitive function required for decision making. Further, she submitted that:

the test is not to be assumed automatically to be discriminatory, because the absence of capacity to make decisions that are in a person's best interest could mean that they are treated better rather than 'less favourably' if disability is recognised and an order made. Further, the legal principles governing the meaning of 'person with disability' are well known and established by authorities which have evolved over time. This promotes expediency and good decision making when an application for appointment of a guardian or administrator is heard. In contrast, removing the ‘test’ will lead to potential ambiguity in relation to any alternative ‘test’, resulting in uncertainty and potential for disadvantage to the very persons whose rights and quality of life the legislation is intended to protect.

On this basis, she endorsed adoption of a test that requires the existence of incapacity because of disability.

6.2.11 Another reason that respondents supported removal of the need for a disability was that the Act should instead focus upon a person’s capacity or ability. The Public Trustee commented, for example, that if the term ‘capacity’ is adopted, then the need for a disability becomes otiose. Similarly, Social Work Services RHH agreed that the focus should be upon assessing a person’s capacity, observing that a medical diagnosis might be a relevant factor to this assessment. EOT also noted that the existence of a disability might be a factor that is considered relevant when assessing a person’s ability to make decisions. Speak Out also submitted that the Act should apply to ‘anyone who needs that sort of help.’

6.2.12 Only having the Act apply to people with disability treats people with disability differently. It effectively puts people with disability at a higher standard of proving their decision-making abilities than those without a cognitive impairment. The Institute acknowledges comments that removal of the need for a disability may extend the Act’s operation to people without disability. The Institute notes, however, the view that: ‘Wherever a society decides to allow a State to interfere with an individual's autonomy rights in the name of “protection,” it must do so on the same basis for people with and without disabilities.’

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Arstein-Kerslake, above n 6, 20.
6.2.13 The OPG’s concerns that the Act not be sought to be used to control those who might display harmful behaviour or make unwise decisions are noted. There is, however, already the risk of the Act being used to control individuals exhibiting harmful behaviour or unwise decisions — except only in relation to people with disability. As discussed below, it is proposed that the Act adopt a functional assessment of a person’s ability to make decisions. Whether a person has a cognitive disability affecting their ability to make decisions could be a relevant consideration. It is proposed that the focus be upon assessing a person’s ability to make decisions, not the outcome or quality of their decision. It is also proposed that it be confirmed that a person not be assumed to lack the ability to make decisions merely on the basis that they make unwise decisions or display harmful behaviour. These proposals are discussed below.\(^{358}\)

6.2.14 The *Powers of Attorney Act* does not require the existence of a disability to trigger the powers of an attorney. The Act only refers to the powers of an attorney during any ‘mental incapacity’ of the donor.\(^{359}\) The term ‘mental incapacity’ is not defined. As a result, and subject to the terms of the instrument, the existence of a disability is not a prerequisite to an attorney commencing to act for the donor.\(^{360}\) The *Powers of Attorney Act* is therefore an example of existing legislation in Tasmania where substitute decision-making is permitted irrespective of whether a person has a disability. This challenges concerns about extending operation of the Act to people without disability.

6.2.15 The Institute is unpersuaded that a potential increase in workload ought to itself be a consideration that should outweigh the overriding need to uphold the provisions of the Convention and ensure that the Act does not discriminate against people with disability. If people without disability are able to choose not exercise their cognitive abilities and make unwise decisions, then why should people with disability not be able to? In either case, if a person does not have the ability to make a decision, then they should equally be afforded access to support, and if necessary, the protection of representative decision-making. This ensures that support is available for those who, for whatever reason, might require support when making decisions.

6.2.16 The Institute accepts that this reform might require amendments to other legislation. One example is the *Alcohol and Drug Dependency Act 1968* (Tas). If it is intended that those the subject of alcohol and drug dependency remain subject to special provisions, then the Act could confirm that the provisions of the Act do not apply to those individuals to the extent that they conflict. This approach is already adopted in relation to the division of jurisdictions between the Act and the *Mental Health Act*. This matter is discussed in Part 17.\(^{361}\)

6.2.17 A new definition of ‘decision-making ability’ should focus on a person’s *ability* to make decisions. Whether a person in fact exercises that ability in relation to a particular decision should be immaterial — the focus of the assessment is on the person’s ability to do so. This serves an important protective function as it would arguably be discriminatory to not acknowledge the support needs of those who are determined to lack the ability to make their own decisions.

6.2.18 This reform gives people with disability the equal right to make a decision that might not be considered by others to be ‘rational’. People without disability have the right to make ‘bad’

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\(^{358}\) See [6.8].

\(^{359}\) See for example *Powers of Attorney Act 2000* (Tas) ss 30, 32.

\(^{360}\) The standard form enduring power of attorney included in the Act does not refer to the existence of a disability as being a trigger to the operation of the Act — only the ‘mental incapacity’ of the donor.

\(^{361}\) See [17.6]. See also Recommendation 17.5(2).
decisions that could be assessed as being irrational or unreasonable or at odds with their ‘best interests’. People with disability should have the same right to do so if they wish.

Recommendation 6.1

That the test that assesses a person’s ability to make decisions for the purposes of the Act not require the person to have a disability.

6.3 Definition of disability

6.3.1 Despite Recommendation 6.1, it may be necessary for the Act to continue to refer to the term ‘disability’. For example, the term may be used when describing the functions and powers of the Public Guardian (discussed in Part 16).

6.3.2 The Act defines ‘disability’ as ‘any restriction or lack (resulting from any absence, loss or abnormality of mental, psychological, physiological or anatomical structure or function) of ability to perform an activity in a normal manner.’ An equivalent definition is adopted in the Mental Health Act. The Review Committee conducting the recent review of the Disability Services Act did not support the Act’s definition of disability, commenting that ‘policy and practice have moved considerably over those two decades [since the Act was enacted].’ It instead endorsed consistency with the NDIS Act which outlines ‘disability requirements’ rather than defining the term ‘disability’.

6.3.3 The Convention describes persons with disabilities to ‘include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others’. As noted in the Issues Paper, the Convention distinguishes between an impairment, which is a malfunction of the body or mind, and a disability which is ‘a restriction in activities of a person with an impairment resulting from society’s failures to socially include persons with disabilities’. The emphasis is not upon a medical condition itself, but the way in which barriers create inability to participate in the community. This ‘social model’ of disability shifts the focus to making available supports that eliminate the barriers that turn a person’s impairment into disability.

6.3.4 The Institute sought feedback about whether there needs to be any change to the existing definition of ‘disability’ in the Act.

If ‘disability’ remains part of the test, how should it be defined?

6.3.5 There were five responses to this question, with three specifically addressing the question of how the term ‘disability’ ought to be defined.

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362 Guardianship and Administration Act 1995 s 3(1).
363 Mental Health Act 2013 (Tas) s 3(1).
365 Ibid. See National Disability Insurance Scheme Act 2013 (Cth) s 24.
368 TLRI, above n 69, Question 3.1(ii).
6.3.6 Both EOT and the MHT supported the Act containing a definition that confirms the social model of disability to focus upon the way in which a person’s impairment interacts with external factors within society and it is this interaction that creates ‘disability’. Both supported the Act adopting the Convention definition of disability.

6.3.7 The Institute agrees with these submissions, observing that the existing definition does not reflect a social model of disability, and instead focuses on the individual’s ‘absence, loss or abnormality’. ‘Ability to perform an activity in a normal manner’ is also neither respectful, nor adequately descriptive or helpful.

**Recommendation 6.2**

That, where necessary, the Convention definition of ‘disability’ be used in the Act.

### 6.4 Inability to make decisions or consent

6.4.1 Under the Act, the existence of a disability is itself insufficient to establish lack of decision-making capacity. The disability must affect a person’s decision-making ability. At certain levels, a person is deemed incapable of making their own decisions:

- an enduring guardian can only commence acting where a donor is unable to make reasonable judgments about their personal circumstances;\(^{369}\)
- an administrator or guardian may only be appointed where a person is unable to make reasonable judgments about all or any part of their estate;\(^{370}\) and
- substitute consent to medical and dental treatment can only be given where a person is incapable of understanding the general nature and effect of proposed treatment, or incapable of indicating whether they consent.\(^{371}\)

6.4.2 Each of these is a functional approach to assessing a person’s capacity as it is based upon an assessment of mental functioning and ability. The first two, however, combine an outcomes perspective, as they call for consideration of the ‘reasonableness’ of a decision.

6.4.3 The reasonableness of a person’s judgment is not part of the test for the appointment of a representative in the more contemporary guardianship legislation. The focus is instead upon a person’s ability to make a decision, not the outcome of their decision-making process.\(^{372}\) The ACT, South Australia, Queensland, Northern Territory, the UK, Irish Republic, and Victoria, adopt a test that focuses upon a person’s ability to:

- understand relevant information (including the consequences of a decision);
- retain that information to the extent necessary to make the decision;
- use or weigh that information in the course of making the decision; and

\(^{369}\) *Guardianship and Administration Act 1995* (Tas) s 32(5). Note that ‘enduring guardians’ are called different things across the country, for example, ‘decision-makers’ or ‘attorneys.’

\(^{370}\) Ibid ss 20(1)(a), 51(1)(a).

\(^{371}\) Ibid s 36.

\(^{372}\) Note that a functional approach to determining application of guardianship legislation has also been criticized: see Arstein-Kerslake, above n 6, 89.
• communicate a decision.\textsuperscript{373}

6.4.4 A similar test is adopted in Alberta in Canada.\textsuperscript{374} It is also the test that the \textit{Mental Health Act} adopts.\textsuperscript{375} The NSW Capacity Toolkit sets out a similar test,\textsuperscript{376} and it has ALRC and NSWLRC endorsement.\textsuperscript{377}

6.4.5 The Issues Paper commented that adopting a single test to assess a person’s decision-making capacity could provide clarity and consistency. The Issues Paper sought to establish the extent of community support for this proposition.

**Should the Act provide a single test of decision-making capacity for all matters?\textsuperscript{378}**

6.4.6 There were 19 responses to this question, although some appeared to misinterpret the intent of the question.

6.4.7 Eight respondents indicated support for the Act adopting a single test outlining a person’s decision-making ability. A single test was supported primarily for simplicity and clarity. It was observed that it can be difficult for assessors to have to apply different tests to establish a person’s decision-making abilities, for example, under the \textit{Mental Health Act}, \textit{Powers of Attorney Act}, and under the Act. The Board commented that it would also be useful for the \textit{Powers of Attorney Act} to outline a consistent test.

6.4.8 Those respondents that expressed concern about adopting a single test did so because of the relative nature of a person’s decision-making ability. It was observed that decision-making is context specific, depending upon the subject matter. For example, a person might have the ability to make personal decisions but not have the ability to make complex financial decisions, for example, in relation to the sale of a home or share portfolio. As EOT commented, ‘the absence of capacity may be decision-specific, time specific or support dependent.’

6.4.9 The Institute agrees with these observations. It is not intended that the Act fail to acknowledge the nature of each decision to be made. Instead, it is proposed that the Act refer to a person’s ‘decision-making ability’ in relation to personal matters, financial matters and health care. ‘Decision-making ability’ would then be defined to refer to the process of a person having the ability to understand relevant information (including the consequences of a decision), retain that information to the extent necessary to make the decision, use or weigh that information in the course of making the decision and communicate a decision.\textsuperscript{379} What is meant by ‘decision-making ability’ would therefore be governed by a single overarching test. Relevant sections would then refer to this

\textsuperscript{373} \textit{Advance Care Directives Act 2013} (SA) s 7(1); \textit{Powers of Attorney Act 2014} (Vic) s 4(1); Guardianship and Administration Bill 2018 (Vic), cl 5. Note that this approach has been criticised as being ‘a relatively high burden’ and that ‘it is not the role of the State to regulate the standard of individual decision-making.’: ibid 92–93.

\textsuperscript{374} \textit{Adult Guardianship and Trusteeship Act 2008} (Alberta) s 2(b).

\textsuperscript{375} \textit{Mental Health Act 2013} (Tas) s 7.


\textsuperscript{377} ALRC, above n 66, [5.187]; NSWLRC, above n 24, Recommendation 6.1.

\textsuperscript{378} TLRI, above n 69, Question 3.2.

\textsuperscript{379} \textit{Advance Care Directives Act 2013} (SA) s 7(1); \textit{Powers of Attorney Act 2014} (Vic) s 4(1); Guardianship and Administration Bill 2018 (Vic), cl 5.
6.4.10 The Institute called for feedback about what test(s) the Act should outline in relation to a person’s ability to make decisions.

What test(s) should the Act provide to assess a person’s decision-making capacity?

6.4.11 There were 12 written submissions in response to this question, along with observations made during public consultation meetings. The Board, OPG and members of the Elder Law Committee supported the Act adopting a test of ‘decision-making capacity’ as exists under the Mental Health Act. This test was endorsed as providing a rights-based approach to assessing a person’s ability, rather than considering the ‘reasonableness’ of a person’s decision. Advocacy Tasmania also emphasised that the Act should not require assessment of whether an individual is making a rational decision. It commented that:

People, whether they have a disability or not, make decisions for a whole range of reasons. Some decisions are emotive, some decisions are reactive, some decisions might be considered unwise or irresponsible by other people. If you do not have a disability, no one requires you to show a purely rational cost-benefit type analysis of the processes that went into making a decision. It is not a reasonable standard to require people with disability to either show more decision making logic than everyone else, nor to have their capacity doubted because of the outcomes of the decisions they make.

6.4.12 It is noted that the Mental Health Act definition of ‘decision-making capacity’ properly directs assessors to consider a person’s ability to make a decision, not whether they have in fact, in relation to a particular decision, undertaken a ‘rational’ or logical approach to decision-making.

6.4.13 The Institute proposes a minor revision to the terminology used in the Mental Health Act. It suggests that the Act refer to a person’s ‘decision-making ability’ rather than ‘capacity’.

This is for three reasons:

- first, it properly directs an assessor’s attention to a person’s abilities. This implicitly requires consideration of a person’s ability to make decisions with support, rather than a person’s ‘capacity’ which implies a more static concept;
- secondly, the term ‘capacity’ is often misunderstood. The terms ‘mental capacity’ and ‘legal capacity’ can be confused or conflated; and
- thirdly, and linked to the previous point, the word ‘ability’ is likely to be more broadly understood by members of the community. This is consistent with one of the Institute’s overarching objectives of making the law more accessible.

380 TLRI, above n 69, Question 3.3.
381 This approach is consistent with the NSWLRC’s recent recommendations: NSWLRC, above n 24, Recommendation 6.1.
Recommendation 6.3

(1) That the Act adopt the term ‘decision-making ability’ when referring to a person’s ability to make decisions or give consent.

(2) That the definition of ‘decision-making ability’ be consistent with the definition of ‘decision-making capacity’ contained in s 7(1)(b) of the Mental Health Act 2013 (Tas) which provides that an adult is taken to have the ability to make a decision unless a person or body considering that capacity is satisfied that they are unable to understand information relevant to the decision, retain information relevant to the decision, use or weigh information relevant to the decision, or communicate the decision (whether by speech, gesture or other means).

(3) That ‘information relevant to a decision’ be defined consistently with s 7(1)(d) of the Mental Health Act 2013 (Tas) to include information on the consequences of:
   - making the decision one way or the other; and
   - deferring the making of the decision; and
   - failing to make the decision.

(4) That the Act refer to a person’s decision-making ‘ability’ rather than ‘capacity’.

6.4.14 The OPG emphasised that the Act should confirm that the test requires consideration of whether a person is able to make a decision with support. EOT similarly expressed concern that currently: ‘Capacity can be removed in circumstances where it is not clear that a rigorous assessment has been made or where the capacity for decision making to be retained with the assistance of aids and supports has not been tested.’ Speak Out member’s submission commented that ‘often we haven’t had any support to make decisions. There should be training and support to help us make decisions.’

6.4.15 The Convention emphasises the need to focus upon a person’s ability to make decisions with support and the need to make available the supports necessary for a person to make their own decision. The ALRC and VLRC recommended that a person not be considered to lack the ability to make a decision if they could make the decision with support. Some jurisdictions adopt this approach. For example:

- the Victorian Powers of Attorney Act 2014 provides that ‘a person has decision-making capacity for a matter if it is possible for the person to make a decision in the matter with practicable and appropriate support’, and

- in the Irish Republic and the UK, a person cannot be considered unable to make their own decision unless all practicable steps have been taken to help them do so, without success. This position is also soon to be adopted in Queensland, providing that an adult is not to be treated as unable to make a decision about a matter unless all practicable steps have been taken to help them do so, without success.

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382 ALRC, above n 3, [3.39]; VLRC, above n 24, Recommendation 27(e).
383 See Powers of Attorney Act 2014 c) s 4(4)(c). A recommendation to this effect has recently been made by the NSWLRC: NSWLRC, above n 24, Recommendation 6.3(2)(e).
384 Assisted Decision-Making (Capacity) Act 2015 (Ireland) s 8(3), see also ss 37, 38; Mental Capacity Act 2005 (UK) s 1(3).
taken to provide the adult with the support and access to information necessary to make and communicate a decision.\textsuperscript{385}

6.4.16 If a person can make a decision with support, then there is no need for operation of the Act. The Institute therefore recommends that the Act confirm that a person has the ability to make decisions if they can make a decision with practicable and appropriate support. It further recommends that the Act provide that a person cannot be deemed unable to make their own decision without having first attempted to support the person to make their own decision.

\begin{boxedtext}
**Recommendation 6.4**

(1) That the definition of decision-making ability provide that a person has decision-making ability if they are able to make a decision with practicable and appropriate support.

(2) That the Act provide that it may not be determined that a person does not have decision-making ability unless all practicable steps have been taken to provide the person with appropriate support to make and communicate a decision.
\end{boxedtext}

6.4.17 The OPG commented that the test that assesses a person’s ability to make decisions needs to highlight that a person’s ability is relative to the subject matter. A person’s ability might also fluctuate. Other respondents also highlighted this issue, as outlined previously in this Part. The Institute therefore proposes that, consistent with the *Mental Health Act*, the definition of ‘decision-making ability’ confirm that a person need only have the ability to retain information for a sufficient time to make a decision. The *Mental Health Act* also confirms that a person is taken to understand information relevant to a decision if it reasonably appears that they are able to understand an explanation given in a way that is appropriate to their circumstances.

\begin{boxedtext}
**Recommendation 6.5**

That the definition of ‘decision-making ability’ in the Act adopt equivalent provisions to s 7(3) of the *Mental Health Act 2013* (Tas), which confirm that:

(a) a person may be taken to understand information relevant to a decision if it reasonably appears that he or she is able to understand an explanation of the nature and consequences of the decision given in a way that is appropriate to his or her circumstances (whether by words, signs or other means); and

(b) a person may be taken to be able to retain information relevant to a decision even if he or she may only be able to retain the information briefly.
\end{boxedtext}

6.5 **Statutory test of capacity to make an instrument**

6.5.1 There is no statutory test for capacity to make an instrument. The common law test of capacity requires a donor to have the capacity to understand the nature and effect of an instrument when it is explained to them.\textsuperscript{386} Capacity is assessed in light of relevant facts and circumstances.\textsuperscript{387}

\textsuperscript{385} Guardianship and Administration and other Legislation Amendment Bill 2018 (Qld) cl 8.

\textsuperscript{386} Gibbons v Wright [1954] HCA 17. See, for example, BN [2013] TASGAB 21, [24].

\textsuperscript{387} Gibbons v Wright [1954] HCA 17, 438.
6.5.2 The following statutory test of capacity to make an enduring power of attorney is contained in the *Powers of Attorney Act*:

- a donor is taken to understand the nature and effect of a deed or instrument only if he or she understands the following matters:
  - (a) that the donor may, in the enduring power of attorney, specify or limit the power to be given to an attorney and instruct an attorney about the exercise of the power;
  - (b) when the power begins;
  - (c) that, once the power for a matter begins, the attorney has power to make, and will have full control over, the matter subject to terms or information about exercising the power included in the enduring power of attorney;
  - (d) that the donor may revoke the enduring power of attorney at any time when he or she has the mental capacity to do so;
  - (e) that the power the donor has given continues even if the donor subsequently loses his or her mental capacity;
  - (f) that the donor is unable to oversee the use of the power if he or she subsequently loses mental capacity.  

6.5.3 In Victoria, Queensland and the ACT, a person must meet a similar test to appoint an enduring guardian. In those jurisdictions, a person may appoint an enduring guardian in the same document as appointing an attorney. In the Northern Territory, the test of capacity to appoint an enduring guardian focuses on a person’s ability to understand and retain information, weigh up that information, and communicate a decision. There is no statutory test for capacity to complete an instrument in New South Wales or Western Australia.

6.5.4 The Institute proposes that the Act outline a test of decision-making ability required to make an instrument. It is suggested that the Act outline what ‘information relevant to a decision’ means in relation to appointing an enduring guardian, as the *Powers of Attorney Act* effectively does presently. This provides guidance to those assessing a person’s ability to make an instrument about what the relevant considerations are in order to understand the nature and effect of appointing an enduring guardian.

6.5.5 This reform will provide greater clarity about the test that applies for a person to be able to make an instrument. The intention is to reduce the likelihood of a person making an instrument when they do not have the decision-making ability to do so. This acts as a safeguard, by ensuring that a person is able to properly understand the delegation of powers to an enduring guardian. It is also intended to reduce the likelihood of third parties seeking to procure the creation of an instrument when the donor does not have the decision-making ability to do so.

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388 *Powers of Attorney Act* 2000 (Tas) s 30(3).
389 *Powers of Attorney Act* 2014 (Vic) s 23(2); *Powers of Attorney Act* 1998 (Qld) s 41; *Powers of Attorney Act* 2006 (ACT) s 17.
390 See *Advance Personal Planning Act* 2016 (NT) ss 4, 6, 8.
391 The NSWLRC has recommended that the legislative framework in that state provide a single enduring document dealing with the appointment of representatives for financial, personal, health care and restrictive practices. It proposes that the new Act require a person to have ‘decision-making ability’ to make an enduring representation agreement: NSWLRC above n 24, Recommendations 8.1, 8.2.
Recommendation 6.6

(1) That the Act require a donor to have decision-making ability to make and revoke an instrument.

(2) That the Act outline what ‘information relevant to a decision’ includes in relation to a donor’s decision-making ability to make or revoke an instrument.

6.6 Statutory test of capacity to make an advance care directive

6.6.1 Part 5 recommends the introduction of a legislative scheme providing for the creation and use of ACDs. This necessitates consideration of whether the Act should prescribe a test of ability to make an ACD and if so, what that test should be.

6.6.2 The Convention Committee has stated that people with disabilities must be given the opportunity to complete advance planning on equal basis with others. In South Australia and Victoria, the common law test of capacity to create an ACD has been codified, requiring a person to understand the nature and effect of an ACD. In Queensland, a person must understand that the document will only operate while the person has impaired capacity and that they can revoke the document at any time that they have capacity to do so.

6.6.3 Feedback was requested about who ought to be able to complete an ACD.

If advance care directives were given legislative force, then who should be able to make an advance care directive?

6.6.4 There were 11 written, and one verbal submission to this question. Most responses identified that a person should be able to make an ACD for themselves. Social Work Services RHH commented that even a person deemed unable to make their own decisions must still be able to express wishes and have those wishes taken into account and that an ACD is a vehicle or communication aid to assist the person to do so.

6.6.5 Consistent with Recommendation 6.6, the Institute considers that the statutory test to make an ACD be that the person making the ACD has ‘decision-making ability’ to complete an ACD. It is proposed that the test require assessment of a person’s decision-making ability in relation to each statement in an ACD, consistent with Victoria. This provides flexibility and maximises opportunity for a person’s directions to be followed, noting, for example, that a person may have the decision-making ability to make a ‘values directive’ (expressing broad values relevant to a decision), but not have the ability to make an ‘instructional directive’ (giving binding directions or consent or refusal to health care and treatment). Within one ACD might be both values directives and instructional directives. Similarly, a person might be able to understand information relevant to one

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392 Convention Committee, above n 21, [17].
393 Medical Treatment Planning and Decisions Act 2016 (Vic) s 13(a)(i); Advance Care Directives Act 2013 (SA) s 11(1).
394 Powers of Attorney Act 1998 (Qld) s 42(1).
395 TLRI, above n 69, Question 12.3(i).
396 Medical Treatment Planning and Decision Act 2016 (Vic) s 13.
treatment decision but not another. This approach recognises that decision-making ability is context specific.

**Recommendation 6.7**

1. That any person with decision-making ability to make an advance care directive be able to make an advance care directive.
2. That the Act acknowledge that a person’s decision-making ability should be assessed in relation to each directive or statement in an advance care directive.

### 6.7 Presumption of capacity

6.7.1 The Act does not state that there is a presumption that a person has capacity unless established otherwise. Whilst this is the case, the Capacity Toolkit, developed to assist those assessing a person’s abilities, states that an assessment must start with an assumption that a person has capacity.\(^{397}\) As the Board noted in its submission, this is the position at common law, and thus the approach that it adopts at a hearing.

6.7.2 Some groups have recommended that legislation explicitly state that a person is presumed to have capacity to make their own decisions unless it is objectively assessed otherwise.\(^{398}\) This is to ensure that a person is not assumed to lack the ability to make a decision, particularly on the basis of status, such as having a disability. On the other hand, the ALRC does not endorse legislation that provides a presumption of capacity, on the basis that this necessarily creates delineation between those who have capacity and those who do not.\(^{399}\) The NDIS Act includes a presumption of capacity, as does legislation in several jurisdictions.\(^{400}\)

6.7.3 The Issues Paper asked for feedback about whether there is merit to the Act confirming that there must be a presumption of capacity.

**Should the Act include a presumption that all people have capacity to make their own decisions?**\(^{401}\)

6.7.4 There were 21 written submissions in response to this question, along with two verbal submissions. All but one indicated support for this reform, with varying levels of support expressed.

6.7.5 Recommendation 6.3(2) provides that a person is taken to have the ability to make decisions unless one or more of the four criteria is not satisfied. It therefore confirms that the starting point must be that a person is assumed to have the ability to make decisions unless there is evidence that they are unable to do one or more of the functions outlined. This is, in effect, a statutory presumption of capacity.

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\(^{397}\) *Capacity Toolkit*, above n 376, 27.

\(^{398}\) *Senate Community Affairs References Committee, Parliament of Australia, Involuntary or Coerced Sterilisation of People with Disabilities in Australia* (2013) Recommendation 8; *NSWLRC*, above n 24, Recommendation 6.2.

\(^{399}\) ALRC, above n 3, [3.14].

\(^{400}\) *National Disability Insurance Scheme Act 2013* (Cth) s 17A(1); *Medical Treatments Planning and Decision Act 2016* (Vic) s 4(2); *Powers of Attorney Act 2014* (Vic) s 4(2), consistent with the recommendations of the VLRC: see VLRC, above n 24, Recommendation 26; *Guardianship and Administration Act 1990* (WA) s 4(3); *Guardianship and Administration Act 2000* (Qld) sch 1 s 1; *Assisted Decision-Making (Capacity) Act 2015* (Ireland) s 8(2); *Adult Guardianship and Trusteeship Act 2008* (Alberta) s 2(a).

\(^{401}\) TLRI, above n 69, Question 3.4.
Part 6: Decision-Making Ability

6.7.6 The Institute considers that this formulation appropriately addresses the need and support for the Act confirming that the starting point must always be that a person is assumed to have the ability to make decisions unless proven otherwise. The Institute is not against the Act also containing a separate section confirming the common law presumption of capacity. It has not, however, made a recommendation to this effect on the basis that it may unnecessarily lengthen the Act without adding any benefit. If, however, reforms did not implement the test of ‘decision-making ability’ in accordance with Recommendation 6.3(2), then it would seem appropriate for the Act to provide a separate declaration confirming that there is a presumption of capacity.

6.8 Assumptions about capacity

6.8.1 The Act does not provide guidance about factors that must be considered irrelevant when assessing a person’s abilities. The Capacity Toolkit, however, outlines factors that should not, themselves, lead to an assumption that a person does not have capacity.\(^{402}\)

6.8.2 Some guardianship legislation lists factors that ought not be considered relevant or lead to an assumption that a person does not have the ability to make decisions. These sections provide, for example, that it must not be assumed that a person does not have decision-making capacity merely on the basis that:

- a person can only retain information for a limited time;\(^{403}\)
- a person’s capacity fluctuates;\(^{404}\)
- a person makes a decision that is, in the opinion of others, unwise;\(^{405}\)
- a decision results, or may result, in an adverse outcome for the person;\(^{406}\)
- a person engages in unconventional behaviour or personal expression, or because of a person’s appearance;\(^{407}\)
- a person chooses a living environment or lifestyle with which other people do not agree;
- a person does not have a particular level of literacy or education;
- a person engages in particular cultural or religious practices;\(^{408}\) or
- because of a person’s age.\(^{409}\)

These provisions are aimed at ensuring that people do not apply prejudice or stereotypes when assessing a person’s abilities. As the assessment of a person’s abilities is critical to the operation of the Act, it is important that an assessment of a person’s abilities is conducted appropriately.

\(^{402}\) Capacity Toolkit, above n 376.
\(^{403}\) Assisted Decision-Making (Capacity) Act 2015 (Ireland) s 3(2)(b).
\(^{404}\) Ibid ss 3(4)–(5).
\(^{405}\) Powers of Attorney Act 2014 (Vic) s 4(4).
\(^{406}\) Advance Care Directives Act 2013 (SA) s 7(2).
\(^{407}\) Mental Capacity Act 2005 (UK) s 2(3).
\(^{408}\) Guardianship of Adults Act 2016 (NT) s 5(6).
\(^{409}\) Mental Capacity Act 2005 (UK) s 2(3)(a). The NSWLR has recently made recommendations proposing similar circumstances where a person should not be assumed to lack decision-making ability: NSWLR, above n 24, Recommendation 6.3(3).
6.8.3 The Institute sought feedback about whether stakeholders felt that a list of irrelevant matters within the Act would serve any useful purpose.

Should the Act list matters that must not be considered when assessing a person’s capacity?  

6.8.4 Sixteen respondents addressed this question. Nine respondents expressed support for this reform.\textsuperscript{411} Reasons given were largely consistent with observations made above, specifically that there are factors that ought not be relevant when assessing whether a person has the ability to make decisions. The OPG commented that ‘it could be helpful to list factors that would eliminate irrelevant matters being considered that might erroneously lead to an assumption of incapacity.’ The Public Trustee noted that ‘[a]ny test of capacity should embrace legal prescriptions relating to discrimination et cetera.’

6.8.5 Some respondents identified specific factors that ought to be included in this list, including stereotypes around disability, bad decisions made long ago\textsuperscript{412} a bad credit history, making deliberate bad choices (for example, smoking), anecdotal evidence, criminal records, family history and intergenerational decision-making, educational history, IQ, age, appearance, behaviour, religion and/or political affiliation. The OPMHS noted: ‘Views that are not mainstream, but still culturally appropriate for the person’s background and personal belief system, should not be used as evidence of a lack of capacity.’ The MHT commented that ‘decisions regarding the treatment of mental illness should be included under exclusionary criteria.’

6.8.6 Three submissions did not support this reform. The Board, for example, observed that:

\begin{quote}
Whether the Act should list matters that must not be considered when assessing a person’s capacity really depends on what test, if any, the Act provides to assess a person’s decision making capacity. If the Act is amended to include a comprehensive test of capacity, then it is questionable as to whether principles stating what must not be considered when assessing capacity, is required. If only general guidelines are adopted then there may be more benefit to list such matters.
\end{quote}

6.8.7 In essence, the Board’s submission questions the utility of the Act providing a separate list of irrelevant matters if the meaning of ‘decision-making ability’ is sufficiently defined. The Institute observes that Recommendation 6.3(2) already provides that a person is taken to have the ability to make decisions unless one of four criteria is not satisfied. It therefore does provide guidance about the factors that may be considered when assessing whether a person has the ability to make a decision. This questions the utility of including a separate provision outlining a list of factors that must not lead to an assumption that a person does not have the ability to make decisions.

6.8.8 Members of the Elder Law Committee did not support the Act containing a list of factors that should not be considered when assessing a person’s decision-making ability. It also questioned whether this reform would serve any useful purpose:

\begin{quote}
the Committee does not feel that a list of matters that must not, in and of themselves, lead to an assumption of lack of capacity (see pages 24–25 of the issues paper) provides much or any utility. Each of those factors listed may in fact be evidence of lack of
\end{quote}

\textsuperscript{410} TLRI, above n 69, Question 3.5.

\textsuperscript{411} Although the OPG stated that it did not have a firm view but that it could be helpful.

\textsuperscript{412} Speak Out submitted ‘[s]ometimes people make bad decisions when they are young. They shouldn’t look at things we did when we were young. Everyone grows up and learns things.’
capacity. The Committee’s recommendation that there be a presumption of capacity would, it is submitted, be sufficient to make the starting point for any investigation into capacity sufficiently clear.

6.8.9 The Convention requires State parties to take appropriate measures to combat stereotypes and prejudices relating to people with disability. The Institute considers that the Act can, and should, play a positive role in challenging stereotypes — particularly in relation to disability, age and mental health. It should also emphasise that, just because a person makes a risky decision or a decision that most people may not agree with, does not mean that they do not have decision-making ability. A list of irrelevant matters also focuses attention on the need to ensure that there are no external factors that are impacting upon the assessment of a person’s ability.

Recommendation 6.8
That the Act list factors that must not, by themselves, result in an assumption that the person does not have decision-making ability. These should include:

- where a person makes a decision that is, in the opinion of others, unwise;
- where a decision results, or may result, in an adverse outcome for the person;
- where a person does not have a particular level of literacy or education;
- where a person engages in particular cultural, political or religious practices; and
- assumptions because of a person’s age.

6.9 Assessing a person’s decision-making abilities

6.9.1 Some jurisdictions provide guidelines or obligations for individuals assessing a person’s capacity under the Act. Recent legislative reforms proposed in Victoria, for example, provide that: ‘a person who is assessing whether a person has decision-making capacity in relation to a matter must take reasonable steps to conduct the assessment at a time at which, and in an environment in which, the person’s decision-making capacity can be assessed most accurately.’ The NSWLRC has recently recommended that New South Wales’ legislation provide similar principles to guide the assessment of decision-making ability.

6.9.2 In line with the focus on a person’s abilities rather than incapacities, the Act should ensure that the context surrounding the assessment of a person’s ability is optimum for the person to display their decision-making abilities. The assessment of a person’s ability to make decisions is fundamental to the operation of the Act and needs to be conducted appropriately. It is also one way that the Act can itself be proactive in ensuring that a person is supported with decision-making.

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413 Convention on the Rights of Persons with Disabilities art 8(1)(b).
414 This approach is consistent with the NSWLRC’s recommendations: NSWLRC, above n 24, Recommendation 6.3(3).
415 See, for example, Powers of Attorney Act 2014 (Vic) s 5.
416 Guardianship and Administration Bill 2018 (Vic) cl 6.
417 NSWLRC, above n 24, Recommendation 6.3(1).
Recommendation 6.9

That the Act require a person assessing a person’s decision-making ability to take reasonable steps to conduct the assessment at a time, and in an environment in which, the person’s ability can be most accurately assessed.

6.10 Who should assess a person’s decision-making ability?

6.10.1 As the Board highlighted in its submission, assessment of a person’s decision-making ability arises in a range of contexts:

- in relation to a person making an instrument;
- in relation to whether a representative needs to be appointed;
- in relation to whether, in relation to a particular decision, a represented person has decision-making ability; and
- in relation to whether a person has decision-making ability to consent to medical treatment.

6.10.2 Applications to the Board for the review of an instrument, or appointment of a representative must generally be submitted with an accompanying relevant health care professional report (HCPR). The term ‘Health Care Professional’ is defined to include a medical practitioner and psychologist. The term ‘psychologist’ is also defined. Applications in relation to consent to treatment require a report from a registered practitioner. ‘Registered practitioner’ is defined as ‘a person who is a medical practitioner or person registered under the Health Practitioner Regulation National Law (Tasmania) in the dental profession as a dentist.’ In relation to any application, the Board may also receive and consider other evidence relevant to the question of a person’s capacity, and acts as the finder of fact in relation to a person’s capacity.

6.10.3 The Issues Paper noted that, if guardianship laws shift towards assessing people’s decision-making capacity by reference to the supports they need to make a decision, different processes and skills may be desirable. Some provinces in Canada have developed training and accreditation requirements for those conducting assessments of a person’s abilities for the purpose of guardianship applications. For example, in Ontario, there is a separate Capacity Assessment Office that trains health professionals to be capacity assessors under their legislation. Similarly, in Alberta, capacity assessors can be not only a medical practitioner or psychologist, but also a registered nurse, a registered psychiatric nurse, an occupational therapist or a social worker. Professionals must, however, be designated as capacity assessors. The relevant minister has the power to establish or

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418 Guardianship and Administration Regulations 2017 (Tas) reg 4(1) states that an application made under the Act in respect of a person, other than an application under s 44, is to be supported by a report from a health care professional.

419 Ibid reg 3.

420 Ibid.

421 Guardianship and Administration Act 1995 (Tas) s 3.

422 ACTLRAC, above n 24, 64.

423 House of Representatives Standing Committee on Legal and Constitutional Affairs, above n 264, [3.86].

approve training courses for capacity assessors.\textsuperscript{425} Alberta’s regulations also prescribe the fees payable for an assessment and enable application to the Crown for those fees to be paid.\textsuperscript{426} The VLRC recommended that training and certification processes be developed based on the approach in Alberta.\textsuperscript{427}

6.10.4 The Issues Paper asked for comment about who ought to be able to conduct capacity assessments for the purpose of establishing a person’s decision-making ability.

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<th>Who should be able to conduct a capacity assessment?\textsuperscript{428}</th>
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6.10.5 Nineteen submissions addressed this issue.\textsuperscript{429} There was a broad range of observations but most respondents indicated that a medical opinion ought to be provided. Four respondents\textsuperscript{430} supported there being an accreditation scheme, requiring those providing medical opinion to the Board about a person’s capacity needing to have accredited qualification or training. On the other hand, two respondents considered that a person’s general practitioner is best placed to conduct an assessment. Another submission highlighted the importance of a person having a choice in who conducts an assessment.

6.10.6 Speak Out advocates commented that, because of the shift toward assessing a person’s need for decision-making support, an assessment should be collaborative, and multidisciplinary. Speak Out members submitted that ‘[i]t shouldn’t be a doctor that doesn’t know the person. A doctor doesn’t know if we are capable of looking after our money.’ They submitted that an assessment should be made by ‘[s]omeone who see you every day and knows you best.’

6.10.7 The OPMHS submitted that:

Other countries make the person requiring a capacity assessment responsible for that assessment. This has the advantage that this person usually also has the best background knowledge of the particular area of capacity in question, e.g. a solicitor giving advice on a will is already aware of the background and required considerations to do this. Asking a psychiatrist or GP to make a capacity assessment re this while refusing to provide any detail about the circumstances of the person is likely to lead to an inappropriate assessment as the complexity of the will play as much a role as the deficits the person has. It can also lead to unnecessary costs and delays to the patient. Therefore solicitors/lawyers should be able to assess capacity relating to legal matters like wills, enduring guardianship and power of attorney matters. In difficult situations like complex mental illness they should seek advice from a specialist e.g. a psychiatrist, but this would require cooperation so the specialist understands the complexity of the decisions and background to be considered.

6.10.8 Members of the Elder Law Committee commented that:

The Committee supports the continuance of the current system whereby expert opinion evidence about capacity and relevant medical conditions and impairments is given by one or more appropriately qualified health care professionals, which then, along with other

\textsuperscript{425} Ibid reg 8.
\textsuperscript{426} Ibid regs 9, 10.
\textsuperscript{427} VLRC, above n 24, Recommendation 29.
\textsuperscript{428} TLRI, above n 69, Question 3.6.
\textsuperscript{429} There were five verbal submissions.
\textsuperscript{430} Speak Out advocates, Dr Elizabeth Pickup, members of Carers Tasmania (Hobart).
evidence from family members, carers and the person themselves, is taken into account by the Board as the finder of fact.

6.10.9 The Institute agrees with the views of members of the Elder Law Committee that it is appropriate for the Board to retain discretion about the evidence it requires and the weight that it attaches to evidence presented. The OPG and the Board also supported continuation of the existing provisions. The Institute does not, therefore, propose any statutory reform in relation to who may assess a person’s decision-making abilities.

6.10.10 The Board’s submission did, however, express concern that the Act does not restrict family members from completing HCPRs in relation to family members. The Board advises that there have been situations where medical practitioners have provided reports about the capacity of their family members the subject of a Board hearing. This can lead to dispute by other family members, and the need to obtain independent assessments causing delay.

6.10.11 In South Australia, legislation excludes medical practitioners who are related by blood or marriage or their partner from signing certificates or reports about their family members’ capacity. To prevent situations similar to those described above occurring, the Institute recommends that the Act adopt an equivalent provision.

Recommendation 6.10

That the Regulations exclude health practitioners submitting a report that deals with the decision-making ability of a close relative (defined in accordance with Recommendation 4.9(2)) for the purposes of regs 4 and 8.

6.11 Obstructing the completion of an assessment of a person’s decision-making abilities

6.11.1 Apart from in relation to emergency orders, for the Board to exercise its jurisdiction, it must be satisfied that the person the subject of an application is unable to make their own decisions. If the Board is not satisfied that the person is unable to make decisions, then it has no power to appoint a representative or give consent to medical treatment. This is a threshold test impacting upon the operation of the Board’s protective jurisdiction.

6.11.2 Situations can arise where the person in respect of whom a hearing is being held refuses to undergo a capacity assessment. Or, there is a risk of family members obstructing this process for their own personal interests. The following section considers whether there needs to be reform to the Act to facilitate the collation of evidence of a person’s decision-making ability.

An individual’s refusal to attend or participate in an assessment

6.11.3 The Act does not give any direct power to the Board or Public Guardian to compel a person to submit to a medical examination for the purpose of ascertaining their decision-making ability. Under recent amendments to the Regulations, the Board is able to hear a matter in the absence of the usual HCPR having been submitted. Despite this reform, the Board has

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431 Guardianship and Administration Act 1993 (SA) s 69(1).
432 Guardianship and Administration Regulations 2017 (Tas) reg 4(3).
commented that: ‘The Board can request the Public Guardian to investigate the matter but we can do little else if there is no medical evidence commenting on disability and incapacity.’

6.11.4 This issue requires reconciliation of conflicting issues — first, the importance of protecting the interests of a person who might be vulnerable to harm or abuse, and secondly, the need to protect a person’s freedom of liberty and choice. It also requires legislation to ‘balance the potential injustice if a person is subsequently assessed to be capable against the possible need for intervention’. At a practical level, it may not be feasible to compel a person to undergo an assessment of their decision-making abilities against their will if they attend an assessment but then refuse to participate.

6.11.5 The Board’s submission provided an example of where this issue has arisen recently:

In an unreported matter, the proposed represented person (the PRP) came to the attention of Tasmania Police who were concerned for his welfare as he appeared disorientated and confused. He refused to go to the hospital and so police returned him home and contacted Older Persons Mental Health Services (OPMHS) for follow up. An emergency guardianship application was made by Tasmania Police to the Board. The application did not identify any immediate risk to the PRP and no medical evidence was provided as to whether PRP had an incapacity arising from a disability. The Board dismissed the Application. OPMHS made contact with the PRP at his home and established that he had not seen a doctor for approximately 10 years and had refused to see one. There was concern that he was at risk of malnutrition, hypothermia and unable to cope with activities of daily living. They arranged for an old age psychiatrist to attend the PRP at his residence and the psychiatrist made an initial diagnosis of dementia and possible delirium. The PRP refused to attend the hospital, contrary to medical advice. A further application for an emergency order together with a report from the old age psychiatrist was filed with the Board. On that evidence the Board deemed the PRP to be at immediate risk of harm and made an emergency order appointing the Public Guardian, who gave consent for the PRP’s conveyance and treatment at hospital. The diagnosis of dementia was confirmed. An application was made for guardianship and after a hearing, the Board made a limited order appointing the Public Guardian for 12 months.

If the PRP had refused OPMHS and the old age psychiatrist entry to his home, the Board would not have had sufficient evidence to make an emergency order. If no immediate risk existed but there still appeared to be a need for the appointment of a guardian without medical evidence from the old age psychiatrist the application would have been dismissed.

6.11.6 The Board’s submission also referred to its recent decision of KCP, demonstrating one way that the Board has developed pragmatic solutions to resolve the issue of obtaining medical evidence:

In this matter KCP appointed his daughter MP as his guardian by an Instrument appointing an enduring guardian. An application was made by TP, son of KCP to review the enduring guardianship instrument as he had had no contact with his father since August 2016 and did not know about his care and accommodation. The Act and Guardianship and Administration Regulations 2007 did not require report from a health care

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433 A Smith and D Rigby, Substitute Decision-Making and the Future of Mental Health Laws: Redveloping Australian incapacity jurisdictions to remove the stigma of mental health laws, (joint minor LLM Thesis (Tribunal Procedures), Monash University, 2008) 188. The writers do not endorse a particular approach.

professional to accompany the Application. The Board had no medical evidence before it as to disability and incapacity. TP and MP are estranged. MP stated that she had not exercised the power of an enduring guardian because KCP had capacity to make his own decisions. A directions hearing was held and MP agreed to provide the Board with a medical report. A medical report was provided to the Board which reported KCP was capable of making reasonable judgement about personal matters. This medical opinion was accepted by the Board. The Board received evidence that KCP wished to have visits from TP. The Act enables the Board to revoke or amend the instrument if the Board is satisfied that the enduring guardian is not willing or able to act in that capacity. The Board was satisfied that MP was willing but not able to act in the capacity of guardian. The reason for this conclusion was that the Board had no doubt that KCP had for some time desired a relationship with his son TP. MP because of the intensity of her feelings towards her brother TP had been unable to ascertain and give effect to KCP’s wishes to see his son. The Board varied the enduring guardian instrument of KCP by substituting the Public Guardian.

If MP had refused to facilitate KCP’s appointment with a medical practitioner or KCP had refused to attend an appointment with a medical practitioner then the Board would have had no evidence as to KCP’s capacity and his ability to make decisions as to his relationships, including visits by relatives.

6.11.7 The Issues Paper gave examples where legislation provides powers to compel a capacity assessment. In South Australia, for example, the tribunal can require a person to submit to a capacity or medical assessment. If they fail to do so, then in some circumstances it can order the Public Advocate to take them for examination and assessment. A fine may be imposed if a person hinders or obstructs this process. In the Northern Territory, the Public Guardian is given power to request a person to obtain a medical report in the first instance. If that request is not complied with, then the tribunal can make an order requiring a health assessment. In Saskatchewan and Alberta, Canada, the court also has power to require a person to submit to an examination. Where a person refuses to submit to a capacity assessment, or is prevented from attending, the court may make a determination about capacity if satisfied on the available evidence. The Board also noted that the Queensland legislation allows the Tribunal to direct a person to undergo examination by a doctor or psychologist, and that the Mental Health Act also allows for compulsory assessment of persons with mental illness.

6.11.8 The Institute asked for views about whether the Act should give the Board and/or the Public Guardian power to compel a person to submit to a medical examination, and if so, when.

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435 Guardianship and Administration Act 1993 (SA) s 69(1).
436 Ibid s 69(3).
437 Ibid s 69(6).
438 Guardianship of Adults Act 2016 (NT) s 66.
439 Ibid s 67.
441 Adult Guardianship and Trusteeship Act 2008 (Alberta) s 105.
442 Guardianship and Administration Act 2000 (Qld) s 114(1).
443 Mental Health Act 2013 (Tas) ss 23–27.
Should the Board and/or the Public Guardian have power to require a person to submit to a medical examination? If so, in what circumstances?

6.11.9 There were 16 responses and division in the views expressed. Six responses supported the Act enabling an assessment to be compelled, whilst an equal number did not. Others did not express support or rejection of either alternative — the OPG, for example, commented that it held no firm view but noted the practicalities of compelling a person to undergo a medical assessment if they then refuse to participate. Speak Out’s submission commented that members it consulted with were not sure about this issue. Its advocates also queried the practicalities of requiring a person to submit to a capacity assessment if they were not a willing participant. They commented that there should not be an assumption that a person does not have capacity merely on the basis that they refuse to answer questions.

6.11.10 Those who disagreed expressed concerns about the impact upon a person’s freedom of decision and action. PCT commented, for example, that ‘it can give rise to loss of personal freedom, discrimination or discriminatory behaviour.’

6.11.11 EOT raised similar concerns:

This concern was reflected by the Community Affairs References Committee in its report into violence, abuse and neglect against people with disability in institutional and residential settings:

‘At the heart of the issue of legal incapacity is the concept of decision-making for a number of reasons. First, when decision-making is removed from the hands of a person, it becomes easier for the decision-maker — whether it be parent, carer or departmental officer — to then make decisions on behalf of that individual that may seem “to be in their best interests” but may actually be completely counter to the wishes of that person. Second, in every situation where a person has been forced to cede their own autonomy to another, there is the opportunity for abuse of that decision-making power. Finally, when the erosion of control from people with disability is normalised it makes it easier for society to accept that even those people with disability not subject to legal guardianship order can have their will subverted as happens with the use of restrictive practices or forced medical treatments.’

6.11.12 Those in support of this option noted the importance of obtaining an assessment of a person’s ability as a protective mechanism to trigger operation of the Act. It was typically considered that there may be a limited number of circumstances in which it might be appropriate to require a person to submit to an assessment. Members of the Elder Law Committee commented:

The Committee’s view is that the protective nature of the Board’s jurisdiction could be thwarted, were a person without capacity to decline an assessment that could, if made, lead to an appointment of a substitute decision maker to act in their best interests.

The Committee suggests that a hearing should first be conducted and a test included in the Act requiring the Board to be satisfied that there are reasonable grounds for believing that the person may lack capacity, and may be in need of an Administrator and/or Guardian, and that the circumstances (as known to the Board without requiring findings

444 TLRI, above n 69, Question 3.7.
445 Senate Community Affairs Reference Committee, above n 67.
about disputed matters) warrant the person being required to undergo a capacity assessment.

The Committee’s view, however, is that the only consequence for a person who refuses to undergo a capacity assessment when ordered to do so should be a rebuttable presumption that by doing so they lack capacity.

6.11.13 Social Work Services RHH also considered that it would be appropriate to require a person to submit to an assessment where there is evidence that the person is suspected to be at risk. It submitted the following example of when this might be appropriate:

Example: A person responsible obstructs cognitive and capacity assessment because they are the perpetrator of elder abuse or neglect. Where there is sufficient evidence that the PRP is at risk and there is enough suspicion that the PRP is a likely victim of (elder) abuse, this would be a supportive safeguard.

6.11.14 The OPMHS also suggested that there are situations where it may be appropriate to require a person to undergo an assessment. It commented that provisions to this effect are already contained within the Mental Health Act in relation to assessment of mental illness, but with the Act leaving a gap in relation to the protection of those who do not fall within that jurisdiction:

- currently people with an illness or disability suffering from or at risk of self-neglect and malnourishment or symptoms of untreated illness, can only be assessed compulsory under the Mental Health Act. This, however, does not apply to people with certain illnesses including dementia, which leaves them in a very vulnerable position and puts services in a very difficult situation: Older Person’s Mental Health Services on occasion get requests to assess people thought to be cognitively impaired and at risk. In some cases it is possible to gain access and assess the person informally, but in some instances they refuse contact and any assessment, but significant concerns for the welfare of the person remain. Unless there is any indication of a mental illness as defined in the Mental Health Act, in which case this can be used, there is no pathway to actually get this person assessed. This forces services to leave people in a vulnerable situation without being able to assess capacity and risk adequately. It also creates difficult standards depending on what illness people suffer from with patients with mental illness, to which the MHA applies, can be taken into protective custody by a range of professions for assessment, while people to which the MHA does not apply cannot be taken for assessment.

The circumstances should be that:

- there is reason for concern about the person’s health and safety or evidence of an illness or impairment (e.g. not going out or shopping any more, signs of self-neglect, history of cognitive impairment or disability); and
- attempts to conduct a voluntary assessment have failed
- similar to provisions in the MHA the threshold should be a suspected, not proven lack of capacity given that often it will be community staff rather than doctors who will make initial contact and assess the patient at home. They can collect valuable information, but at least under current legislation are not able to make an official capacity assessment. If information raising significant doubt over a person’s capacity has been collected by people unable to formally assess capacity, e.g. non-medical staff, or information suggesting this has been provided by others like family members or neighbours, but the person refuses an assessment by a person able to assess capacity, the Board should be able to order the person to have an assessment. This could either provide a legal framework for an assessment at home against the wishes of the person
or if they do not cooperate admitting them to a suitable hospital. This would allow an assessment re diagnosis, treatable causes of impairment and capacity.

6.11.15 At consultation meetings convened by Carers Tasmania, attendees shared stories demonstrating the practical difficulties that can arise. Examples included family members applying to the Board but experiencing difficulties when the person the subject of an application refused to attend or participate in an assessment. Inability to obtain medical evidence has resulted in the Board being unable to intervene, despite the concerns of family members and their desire to promote the interests of the proposed represented person.

6.11.16 The Institute has not made recommendations for reform in relation to the gathering of evidence of a person’s decision-making ability for the purpose of operation of the Act. This is on the basis that:

- it would be contrary to a person’s will and preference and this ought to be paramount;
- the Board has demonstrated ways in which it currently manages to resolve this circumstance despite not having direct powers to compel a person to undergo an assessment;
- if the Board is unable to proceed because of the absence of a medical report about a person’s decision-making ability, it retains power to make emergency orders if necessary (if the test for the making of an emergency order is met);
- it is more appropriate that a person is offered support to make their own supported decision. Complementary reforms giving power to the Public Guardian to negotiate or mediate a matter may assist; \(^{446}\) and
- at a practical level, it may be difficult to undertake an assessment of a person’s decision-making ability where they refuse to participate in an assessment.

### Third parties obstructing assessments

6.11.17 Of greater concern to the Institute are circumstances where third parties, for example family members or others close to a person, may obstruct or prevent an assessment of a person’s decision-making abilities from taking place. This might be for a range of reasons, but at worst, might be used as a deliberate attempt to thwart the Board’s ability to intervene and make orders to further an individual’s personal interests.

6.11.18 There is no specific provision within the Act dealing with these circumstances. Potentially, the conduct might amount to hindering any proceedings under the Act which is an offence under s 87. \(^ {447}\) If the Board has made a lawful order or direction requiring a representative to facilitate a capacity assessment, then this might amount to contempt of the Board. \(^ {448}\)

6.11.19 The Institute asked for views about whether the Act should create penalties for third parties who prevent or obstruct a capacity assessment.

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\(^{446}\) Refer to Part 16.

\(^{447}\) Guardianship and Administration Act 1995 (Tas) s 87(ba).

\(^{448}\) Ibid s 74A(e).
Should there be any consequences for people who prevent or obstruct a capacity assessment? 449

6.11.20 There were five responses to this question. Four indicated that there ought to be penalties imposed in certain circumstances where individuals obstruct a capacity assessment. The fifth respondent did not specifically indicate a preference.

6.11.21 The OPMHS commented that there should be criminal penalties available for individuals who obstruct a capacity assessment. This was supported on the basis that failure to complete a capacity assessment ‘is likely a step leaving people in a vulnerable situation and potentially enabling elder abuse in the long run, even if initially well meant.’ Members of the Elder Law Committee instead considered that moderate civil penalties ought to be imposed where the Board determines that a person’s conduct is unreasonable or inappropriate. Dr Elizabeth Pickup 450 commented that the consequence should be that the person not be able to act as the person’s representative.

6.11.22 As already commented, the assessment of a person’s decision-making abilities is fundamental to the operation of the Act. This creates a risk of people intentionally withholding or obstructing the collation of medical evidence as a strategic tool to avoid the Board’s jurisdiction. The Institute is concerned that this activity might be intended to conceal potential abuse or neglect.

6.11.23 The Institute does not propose that penalties be imposed where a person has a reasonable excuse for attempting to prevent an assessment being conducted. It should be a matter for the Board to consider, at its discretion, what amounts to a reasonable excuse. This might, for example, include where a person has the interests of a proposed represented person as paramount and is seeking to uphold the wishes of the person who may themselves object to the assessment. But, to effectively respond to circumstances where a person seeks to obstruct the obtaining of information relevant to a hearing, the Institute considers it appropriate that an offence be created.

6.11.24 Effectively, this is an extension of existing provisions that create offences for those who fail to assist the Board to obtain evidence. These include offences for failing to comply with a summons to appear before the Board or produce documents, 451 and for refusing to be sworn or to answer any relevant question when required to do so by the Board. 452 As already noted, the Act also provides an overarching offence for those who hinder any proceedings under the Act. 453

6.11.25 Ultimately, penalties should only be imposed in exceptional of cases, with mediation being attempted first. The use of alternative dispute resolution is discussed further in Part 12. 454

Recommendation 6.11

That the Act create an offence where a person intentionally or recklessly obstructs another person undergoing an assessment of their decision-making ability for the purpose of the Act, without reasonable excuse.

449 TLRI, above n 69, Question 3.7(ii).
450 A general practitioner in the ACT.
451 Guardianship and Administration Act 1995 (Tas) ss 87(a)–(b).
452 Ibid s 87(d).
453 Ibid s 87(ba).
454 See [12.4.37]–[12.4.48]. See also Recommendation 12.3.
6.12 Safeguards in relation to assessments

6.12.1 The Issues Paper observed that there are no offences imposed within the Act for failing to properly conduct an assessment of a person’s abilities. It might, however, have implications under other laws or result in a breach of professional or ethical standards.

6.12.2 In South Australia, guardianship legislation creates a specific offence for a medical practitioner, psychologist or member of the health profession to:

- sign any certificate or report without having personally examined the person;\(^{455}\) or
- wilfully certify that a person has a mental incapacity, not believing that to be the case, or making any other false or misleading statement.\(^{456}\)

It is also an offence to purport to be a medical practitioner, psychologist or member of the health profession.\(^{457}\)

6.12.3 The Issues Paper asked whether there ought to be consequences where a person fails to adequately assess a person’s capacity for the purposes of the Act.

Should there be consequences for failing to properly conduct a capacity assessment? What might this include?\(^{458}\)

6.12.4 Eleven respondents answered this question. Three respondents suggested that there should be consequences where a medical practitioner does not properly complete an assessment, with one commenting that fines ought to be able to be imposed. Six respondents asserted that the Act should not impose specific penalties, with the majority commenting that inappropriate or negligent conduct would already be covered under other regulatory schemes, including the Australian Health Practitioner Regulation Agency (AHPRA), the Tasmanian Health Complaints Commissioner, or Health Practitioner Regulation National Law (Tasmania) Act 2010 (Tas), in addition to potential consequences for the individual’s employment. The other two responses stated that consequences for failing to properly conduct an assessment should include having the individual reassessed, with two suggesting re-training for the individual.

6.12.5 The Institute agrees that other regulatory schemes address inappropriate conduct by health practitioners broadly and that this extends to conducting a capacity assessment for the purposes of the Act. The Institute notes, however, the OPG’s suggestion that a medical practitioner should be required to record in a patient’s records the fact that they assessed the individual as lacking decision-making capacity, and any substitute consent sought. This matter is addressed in Part 14.\(^{459}\) Social Work Services RHH also submitted that the Act should specifically require an assessor to have met with the individual. This is similar to the position in South Australia (outlined above), where guardianship legislation creates a specific offence for an assessor to sign any certificate or report without having personally examined the person.\(^{460}\) The Institute does not make recommendations for

\(^{455}\) Guardianship and Administration Act 1993 (SA) s 77(1).

\(^{456}\) Ibid s 77(2).

\(^{457}\) Ibid s 77(3).

\(^{458}\) TLRI, above n 69, Question 3.8.

\(^{459}\) Sec [13.4.28]–[13.4.32].

\(^{460}\) Guardianship and Administration Act 1993 (SA) s 77(1).
reform to adopt this proposal on the basis that it does not have sufficient evidence of the need for such reform.
Part 7

Informal and Formal Supported Decision-Making Frameworks

7.1 Introduction

7.1.1 The Institute’s Terms of Reference required analysis of how both informal and formal assisted or supported decision-making frameworks are working for Tasmanians with impaired capacity, having regard to national and international trends.

7.1.2 Parts 2 and 3 outlined what the Convention and ALRC say about providing support for decision-making. In its simplest form, the Convention mandates that supports must be available for people to make their own decisions about matters affecting their lives. This Part reviews and makes several recommendations to reform the Act to better recognise and strengthen the provision of support for decision-making.

7.2 The Convention and ALRC recommendations

7.2.1 Fundamental to the Convention is that people who require decision-making support must have access to support to make their own decisions. Article 12(3) of the Convention requires State parties to ‘take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.’

7.2.2 The ALRC has developed guidelines about providing support to people to make decisions that are intended to reflect the principles and obligations under the Convention:

<table>
<thead>
<tr>
<th>ALRC Support Guidelines</th>
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<tbody>
<tr>
<td>(1) <strong>General</strong></td>
</tr>
<tr>
<td>(a) Persons who require decision-making support should be supported to participate in and contribute to all aspects of life.</td>
</tr>
<tr>
<td>(b) Persons who require decision-making support should be supported in making decisions.</td>
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<tr>
<td>(c) The role of persons who provide decision-making support should be acknowledged and respected — including family members, carers or other significant people chosen to provide support.</td>
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<tr>
<td>(d) Persons who may require decision-making support may chose not to be supported.</td>
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461 ALRC, above n 3, Recommendation 3-2, see [3.29].
Assessing support needs

In assessing what support is required in decision-making, the following must be considered:

(a) All adults must be presumed to have ability to make decisions that affect their lives.
(b) A person must not be assessed to lack decision-making ability on the basis of having a disability.
(c) A person’s decision making ability must be considered in the context of available supports.
(d) A person’s decision-making ability is to be assessed, not the outcome of the decision they want to make.
(e) A person’s decision-making ability will depend on the kind of decisions to be made.
(f) A person’s decision-making ability may evolve or fluctuate over time.

7.2.3 A number of these principles were considered and addressed in Part 6 in relation to how a person’s decision-making ability is assessed under the Act.

7.3 How current support arrangements are working

7.3.1 As discussed in Part 3, the Act implicitly recognises and endorses the use of informal support by requiring that the Act be applied in a way that is least restrictive of a person’s freedom of decision and action as is possible. Representatives may only be appointed if there is a need for their appointment which cannot be met by less restrictive alternatives.

7.3.2 The Issues Paper gave examples of how current support arrangements are being used in Tasmania. These arrangements occur informally within families and broader social networks and, more formally, through advocacy groups and other service providers.

7.3.3 The Institute asked for feedback about the effectiveness of current informal and formal support arrangements.

| What informal support arrangements are working well and what is not working well |

7.3.4 There were 17 responses addressing this question. Examples given of commonly used decision-making supports included informal support provided by family, friends, general practitioners and advocates. It is apparent that informal supports are utilised frequently. The Board commented that ‘[i]nformal supported decision making is not new. Much support for decision making happens informally without the sanction of a legal framework.’ TasCOSS noted that:

462 Guardianship and Administration Act 1995 (Tas) s 6(a).
463 Ibid ss 20, 51.
464 TLRI, above n 69, [13.3].
466 Thirteen written, four verbal submissions.
Most of us draw on formal or informal supports for making decisions at different points in our lives—we turn to our partner, friends, financial and other professional advisors, life coaches and psychologists. For many of us, our largest financial asset—our superannuation—is usually managed by someone else because of their expertise. In these cases our decision-making capacity is not assumed to be absent. Rather, it is simply recognised that supported decision-making can enhance the outcomes we seek.

7.3.5 Some respondents stated that current informal support arrangements are working well. The Board, for example, commented that:

The relatively low number of applications contrasted with the number of people in Tasmania estimated as having a disability that affects cognition suggests:

- informal supported decision making is already extensively and effectively operating for many people in the Tasmanian community
- the ‘person responsible’ scheme in Part 6 of the Act is working effectively. This scheme provides for the automatic substitute decision making hierarchy of ‘person responsible’ for consent to medical and dental treatment where the patient does not have capacity to provide or withhold his or her own consent
- the appointment of enduring guardians and attorneys pursuant to enduring powers of attorney is meeting the needs of many people
- informal decision makers may be acting as substitute decision makers

Given the relatively low number of appointments of substitute decision makers compared with the high number of people accessing services and support, an inference may be drawn that informal supported decision making arrangements are currently being used for the majority of people with cognitive disability in Tasmania.

7.3.6 The Public Trustee’s submission echoed these views, stating that it considers that current informal support arrangements are working well. MIGA and the OPG also submitted that informal support arrangements are generally working well in relation to health care. MIGA commented that ‘[i]t is important not to impose additional, unnecessary requirements which could hinder these arrangements.’

7.3.7 Other submissions endorsed reform to the Act to formally recognise the use of decision-making support. This reform was supported as a way of acknowledging and legitimising the range of ways in which people make decisions. EOT commented that ‘[i]t is imperative that Tasmania’s guardianship laws cover all circumstances where a person’s legal capacity is challenged.’ The Institute notes that Recommendation 6.4(1) proposes that the Act provide that a person has decision-making ability if they can make a decision with practicable and appropriate support. This approach provides one strategy to formally recognise and legitimise decision-making utilising support.

7.3.8 Some respondents that raised issues with current informal support arrangements highlighted the lack of independent oversight and safeguards. The Board commented in its submission that:

467 Adopting the same reasoning put forward by New South Wales Civil and Administrative Tribunal in relation to the NSWLRRC recent review into the Guardianship Act in New South Wales.

468 TasCROSS and EOT. This is consistent with observations made by the Office of the Public Advocate in Victoria that ‘interdependent decision-making is the way in which most of us operate.’; Barbara Carter, Supported Decision-making Background and Discussion Paper, Office of the Public Advocate (November 2009) 3–4.
A person with disability can vest a significant level of trust, reliance and responsibility in their informal supports. The negative side of informal support is that people can, consciously or unconsciously, exercise enormous influence on people with disabilities during the process of decision making and can essentially end up acting like a guardian but without the accountability and lawfulness of a formal order, or worst still, apply undue influence for their own benefit. It is therefore critically important that an informal supporter has a clear understanding of the role they play.

7.3.9 Some members who attended meetings at Carers Tasmania indicated support for independent monitoring of informal support arrangements to identify situations where informal supporters are acting improperly. It was suggested that this could be achieved similar to the way in which a person’s residence is assessed for suitability and their need for in-home care or assistance evaluated.

7.3.10 The Institute requested specific advice about barriers that exist when utilising informal decision-making support.

Are there barriers to informal support arrangements working effectively? How could these be resolved?

7.3.11 There were 15 submissions addressing this question. Along with the potential for abuse, barriers identified typically fell under two themes: lack of formal recognition and the need for capacity building. These are discussed below.

Lack of formal recognition

7.3.12 One of the critical barriers impacting the effectiveness of informal arrangements was stated as being a lack of recognition. Several respondents commented that informal supporters may at times not be recognised without the supporter’s formal appointment as a representative. The OPG summarised some examples of this occurring:

The biggest barrier to informal supports for decision-making is lack of recognition for the ‘authority’ of the supporter to provide support, and for the ‘validity’ of a decision made by someone who has impaired capacity for decision-making and has required support to make the decision. The OPG is concerned about the propensity of organisations to ‘require’ formal substitute decision-making for their own peace of mind to avoid perceived risk. We see this with some residential aged care facilities ‘demanding’ that a new resident has an enduring or Board-appointed guardian and/or power of attorney. The NDIS (paradoxically) is resulting in an increase in guardianship appointments for the express purpose of someone with authority to sign service agreements between the provider and the participant — the NDIS itself doesn’t require these agreements to be signed, but service providers sometimes do. At least part of the reason Roy Fagan Centre staff insist on the consent of a guardian rather than a person responsible for admissions to that facility is a fear of legal ramifications associated with false imprisonment.

7.3.13 Carers Tasmania also commented about the lack of recognition that informal supporters are given:

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469 TLRI, above n 69, Question 13.1(ii).
470 Ten written, five verbal.
Carers Tasmania’s members often speak of not being recognised or included in decision making processes, in spite of a current Tasmanian policy that encourages this to be the case. There is change required to build a culture of carer inclusion. While this is the case, carers continue navigate and advocate for the needs of the person they care for, but are sometimes blocked by service providers who state they are unable to engage with them due to privacy and confidentiality.

7.3.14 At an individual level, the Institute heard several examples during facilitated consultation meetings where carers and family members had encountered difficulties accessing information that they stated they needed in order to perform their role as a supporter or carer.

7.3.15 The Issues Paper asked how informal support arrangements could be better recognised.

**How can we improve how informal support arrangements are recognised?**

7.3.16 There were 11 submissions that addressed this question. Two respondents highlighted the need to educate the community about the role of informal supporters. Several responses suggested that the Act should play a role in improving the recognition of informal support arrangements. Suggestions included:

- requiring a person’s capacity to be assessed based on an ability to make decisions with support. This suggestion aligns with Recommendation 6.4(1);
- requiring that all reasonable support options be exhausted before a substitute decision-maker can be appointed. This is the effect of Recommendation 6.4(2);
- that the Act could explicitly state the importance of informal supports. This suggestion is included within Recommendation 3.3;
- by clarifying the role and duties of informal supporters. The Board suggested that the Act could include key concepts and principles of informal support arrangements:

  ‘For example, it could be legislated that an informal supporter’s role is to recognise the rights of the person to participate in decision making and to make their own decision wherever possible and to being directed by their will and preferences when providing support. Further it could be legislated that informal support arrangements take priority over substitute decision making.’

Recommendation 3.4 aligns with this proposal. It provides that any person assisting someone or making a decision for a person informally must apply the Act’s guiding principles. The reformed guiding principles would require decision-making support to be made available, and decisions to reflect a person’s will, preferences and rights;

- inclusion of an acknowledgement about the role of carers, a definition of ‘carers,’ and a statement regarding their inclusion, drawing upon the *Tasmanian Carer Policy*.

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471 TLRI, above n 69, Question 13.1(iii).
472 Seven written, four verbal.
473 OPG.
474 OPG.
475 The Board.
476 Members, COTA and Dementia Australia (Tas).
477 Carers Tas.
Recommendation 3.3 includes a proposal to include as one of the guiding principles of the Act the importance of respecting and acknowledging the role of families, carers, and other significant persons in an adult’s life; and

- possibly some form of central registration.\footnote{Members of the Elder Law Committee.}

In summary, other than the suggestion of a registration process for informal supporters, all alternatives for legislative reform presented have been adopted as recommendations within this Report.

**Building the capacity of decision-making support**

7.3.17 Some responses highlighted the need for cultural change and education to maximise the effectiveness of informal supported decision-making arrangements. Carers Tasmania noted that, when supporters are themselves not supported, this affects the quality of support they provide:

Providing good support takes time, patience and skill. Identifying and responding to changing capacity can be complex; carers may be over cautious when the decision making capacity of the person they care for has declined, unnecessarily limiting their input.

7.3.18 Speak Out advocates also commented on the importance of capacity building. They suggested that training and education should be available to build decision-making skills and confidence. They noted that this is particularly important where a person has previously had a representative acting and has not had opportunity to practice decision-making.

7.3.19 The Board commented that education is required both at an individual and broader systemic level:

Barriers to informal support arrangements working effectively can be reduced by investment in training and skills development for decision makers and education and skills development for informal supporters.

Further education in the broader community and systemic advocacy is considered appropriate to emphasise the need to support people to make their own decisions, and what this means in practical terms.

7.3.20 EOT made similar comments:

At a policy level efforts should continue to improve education and awareness of the rights of people who may require decision making support and support principles should be widely promoted throughout the community.

**Availability of supports**

7.3.21 Another barrier identified was the availability of support, particularly for those who are socially isolated or do not have available informal supporters within their existing networks.

7.3.22 EOT highlighted the need to ensure that decision-making support is made available to individuals in the community who require it:
the State also has a role to play in enabling those with decision-making capacity to exercise choice by making available the sorts of services that will help vulnerable individuals to maintain their independence and structure their lives in ways that are consistent with their views and preferences. This is to acknowledge that rights can also be denied in circumstances where individuals lack access to most basic needs such as shelter or appropriate health services.

Ensuring everyone has access to a minimum level of high-quality service provides an important platform from which human rights can be met and the needs and preferences of individuals can be realised.

7.3.23 The Issues Paper asked how people who are socially isolated could be better supported to make decisions.

| How could we better support people who do not have family or other networks of support? |

7.3.24 There were a range of suggestions made to improve the availability of decision-making support for those who are socially isolated. A number of responses highlighted the importance of developing advocacy supports that are readily available and properly resourced. Another submission referred more broadly to the development of adequately funded decision support programs as a means of ensuring that decision-making support is available for those who require or request it.

7.3.25 The OPG’s submission made two practical suggestions to improve the provision of decision-making support. Firstly, it commented that:

The onus should be on the professional involved in significant decisions (e.g. doctor, support provider, social worker), to ensure advocacy/decision making support has been discussed and offered to the person. This may also have overall safeguarding implications.

7.3.26 Secondly, it suggested that:

Prior to making an application to the Board for appointment of a guardian or administrator, the applicant should be required to thoroughly explore whether all supported decision-making options have been attempted. There should be a requirement for the applicant to document the process and outcome of such investigations. As noted, the Board should only proceed to make an appointment of a substitute decision-maker if it is satisfied that all other reasonable options have been tried and failed. The OPG considers such requirements would be a significant move towards recognition of informal supports, and much stronger and more concrete than the current Act’s requirement that the principle of the least restrictive alternative is observed.

7.3.27 Education can play an important role in improving recognition of informal support arrangements. Information should be readily available in a variety of formats and easily accessible. Educational materials should explain the role and duties of informal supporters and the importance of offering decision-making support so that, wherever possible, individuals make their own decisions. More broadly, there must be community education explaining the rights of people with disability to equality and non-discrimination as articulated in the Convention.

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479 TLRI, above n 69, Question 13.1(iv).
480 The Board, OPG.
481 TasCOSS.
Recommendation 7.1
That an adequately funded public education program be developed and delivered to ensure that Tasmanians understand the rights of people with disability articulated in the *Convention on the Rights of Persons with Disabilities*, including the need to provide adults requiring support with decision-making with access to the support they may require to make and implement decisions about matters affecting their lives and the duties of individuals who provide that support.

7.3.28 The Institute emphasises the importance of ensuring that decision-making supports are equally available to all members of the community. Support must be available in a variety of formats, accessible to people living in rural, regional and remote areas, and culturally appropriate. Decision-making supports must be able to be utilised at low or no cost to ensure that an individual’s financial position does not preclude equal access to support.

7.3.29 These recommendations are fundamental to the Convention which requires State parties to ensure that people with disabilities have access to the support they require to exercise their legal capacity.\(^{482}\)

Recommendation 7.2
That adequately funded decision-making support programs be developed, ensuring equity of access.

7.3.30 The Institute proposes that revisions be made to the Board’s application forms to signify the importance of first attempting informal support options before applying to the Board for more formal intervention. Currently, the Board’s forms require an applicant to give details of lesser restrictive alternatives that have been considered, and describe why those methods are not sufficient.\(^{483}\) Implicitly, this involves an applicant describing informal supports have been considered and/or provided. It is suggested that the need to consider and attempt informal support arrangements be an explicit component of the Board’s application forms. This could be achieved by revising the existing questions asking about lesser restrictive alternatives attempted to explicitly reference informal decision-making support as being a less restrictive alternative. Alternatively, a separate question could be added to require an applicant to describe the informal supports offered to a proposed represented person or attempted prior to making an application.

Recommendation 7.3
That the standard Board application forms ask specifically about the informal decision-making supports that have been offered to a proposed represented person and/or attempted prior to the making of the application.

7.4 The role of legislation

7.4.1 Many responses to the Issues Paper highlighted the need for policy reform to better recognise and facilitate the use of informal support arrangements. These were explained and discussed earlier in this Part.

\(^{482}\) *Convention on the Rights of Persons with Disabilities* art 12(2).

Several of the recommendations already made in this Report contain suggestions for legislative reform to ensure that the Act recognises and endorses the use of informal decision-making support. The question is whether there is any need to introduce a formal legislated supported decision-making scheme within Tasmania’s legal framework.

**Legislated assisted decision-making schemes**

Some guardianship laws establish formal, legislated assisted decision-making arrangements that formally recognise an ‘in between’ between a person making their own decision and the making of a representative decision. This approach provides legislative recognition that ‘no person should have another person appointed to make a decision on their behalf, if they could make the decision themselves with assistance and support.’

The Institute uses the term ‘assisted decision-making’ as an umbrella term to describe situations where a person makes their own decision with some level of assistance. Within assisted decision-making is both supported decision-making and co-decision-making. Supported decision-making describes decision-making where an individual makes their own decision but with support. Co-decision-making involves the making of a joint decision between two people — in other words, where decision-making is shared.

**Legislated supported decision-making** arrangements involve a person or group of people (a ‘supporter’) providing a person with support to make, communicate or implement a decision. The supporter cannot make a decision on behalf of a supported person. Their role includes to:

- access, collect or obtain relevant information, or assist a person to do so;
- communicate information about the person which is necessary or relevant to a supported decision;
- explain relevant information and considerations;
- help a person understand options, responsibilities and consequences of a decision;
- assist a person to ascertain their will and preferences;
- communicate a person’s supported decision;


Sources:


486 *Powers of Attorney Act 2014* (Vic) s 87(1).


488 Ibid s 14.

7.4.6 **Co-decision-making** is similar to supported decision-making except that, instead of the supported person making their own decision, they make a joint decision with another person.

7.4.7 The Issues Paper provided examples of legislated supported decision-making and co-decision-making models in other jurisdictions.\(^{491}\) Several bodies have recommended the development of legislated supported decision-making schemes in other jurisdictions.\(^{492}\) Others express concern that legislated supported decision-making has a theoretical basis and that it has not been sufficiently tested through empirical evidence.\(^{493}\) The South Australian Office of the Public Advocate has commented, however, that lack of empirical evidence should not be a barrier to legislative reform.\(^{494}\)

7.4.8 The Institute called for submissions to ascertain what level of support exists for a legislated supported decision-making scheme in Tasmania.

Do you support legislation in Tasmania enabling the formal appointment of supporters to support people with decision-making impairments, and/or co-decision-makers to make joint decisions?\(^{495}\)

7.4.9 There were 14 responses to this question. Nine submissions expressed support for introduction of legislated supported decision-making in Tasmania.\(^{496}\) Three submissions expressed qualified support, or support in principle. One submission did not support a legislated supported decision-making scheme.

7.4.10 As it was considered a matter of policy, the Board did not express a position. The Board’s submission instead commented whether there is a need for legislated supported decision-making:

Given the relatively low number of appointments of substitute decision makers compared with the high number of people accessing services and support, an inference may be drawn that informal supported decision making arrangements are currently being used for the majority of people with cognitive disability in Tasmania. If this is the case, then it remains a significant question whether the likely consequences associated with the introduction of a formal appointment process, including significant workload and resourcing implications for the Board, are justified.

Further as soon as informal support is formalised and legislated it no longer is informal decision making, but becomes a statutory scheme with increased formality and complexity.

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\(^{490}\) Ibid s 89. The NSWLRC has recently made recommendations to this effect: NSWLRC, above n 24, Recommendation 7.12.

\(^{491}\) TLRI, above n 69, [13.4]–[13.7].


\(^{493}\) See for example, Evaluation Report of the Link and Learn Supported Decision Making Project, a Report made to the Community Services Directorate, Office for Disability, ACT (February 2018) 19.

\(^{494}\) Office of the Public Advocate (South Australia), Annual Report 2013 (2013) 58.

\(^{495}\) TLRI, above n 69, Question 13.2.

\(^{496}\) Attendees of a carers meeting convened by Carers Tasmania Devonport also suggested that carers should have an official role within the Act so that their roles as supporters can be recognised.
Support for a legislated supported decision-making scheme

7.4.11 Nine submissions supported introduction of legislated supported decision-making, with some expressing strong support.\footnote{Advocacy Tas, OPG.}

7.4.12 Some respondents stated that it is not possible for the Act to comply with the obligations of the Convention without formally recognising the role of supporters.\footnote{Advocacy Tas, TasCOSS.} TasCOSS commented:

It is of particular relevance to note that the current approach seems to preclude formal recognition of supported decision-making and those who are available to provide that support. Without a re-conception of guardianship and administration law to incorporate mechanisms for formal recognition of the continuum of decision-making capacity\footnote{Commentators have also referred to decision-making as a continuum ‘with the decision-making that best reflects usual decision-making processes in our society at one end and fully substituted decision-making at the other.’: Carter, above n 468, 15.} and the benefits of formal recognition of support, it is difficult to see how this area of legislation can be part of Australia’s compliance with its Convention obligations under Article 12. The legal and lay meaning of ‘guardianship’ in particular and the principle that it is a last-resort intervention need to be recognised and a broader schema for supported decision-making be established through legislation.

7.4.13 Others stated that legislated supported decision-making is an ‘essential part’ of ensuring that substitute decision-making is used only as a last resort.\footnote{Advocacy Tas, TasCOSS made similar observations.}

Issues raised in relation to a legislated supported decision-making scheme

7.4.14 Two submissions expressed support in principle for a legislated supported decision-making scheme, but noted that it would depend upon the detail and specifics of the scheme.\footnote{MIGA, Speak Out advocates.} MIGA, for example, commented that it supports developing understandings about supported decision making but commented that: ‘How a support person is appointed, the extent of their role and obligations, and issues which they should be required to give consideration to, are not clear.’

7.4.15 Speak Out advocates also commented that much would depend upon how the scheme was systematised. They noted, however, that a legislated supported decision-making framework may be beneficial if it builds people’s decision-making capacity and avoids guardianship orders.

7.4.16 Both the OPG and the Board stated that it is critical that a legislated supported decision-making scheme not adversely impact existing informal support arrangements. The OPG commented that ‘[w]e do not want to see such a scheme resulting in pressure to turn informal arrangements that are working satisfactorily into formal support appointments.’

7.4.17 EOT also emphasised the need to avoid unintended adverse consequences:

It is important however that the establishment of a formal category of supporters not deflect the need for meeting broader legal obligations to provide supports and adjustments where these are required. It is unlawful under the \textit{Anti-Discrimination Act 1998} (Tas), for example, not to make adjustments or other changes to ensure that people with
disability have the same access to goods and services as others unless it would cause unjustifiable hardship to do so. We would not wish to see increased calls for the appointment of formally appointed supporters in circumstances where the service or Agency would otherwise have a responsibility to make the relevant adjustment.

7.4.18 The OPG suggested that these issues could be reduced or avoided by ensuring that there is greater recognition of informal support arrangements.

7.4.19 Submissions emphasised that, for a legislated supported decision-making model to be successful, there would need to be:

- supports available in a variety of forms;
- capacity building for people with cognitive disability and those around them;
- adequate education about the role of a support person and the extent of their powers; and
- adequate resourcing.

**Concerns with legislated supported decision-making**

7.4.20 Members of the Elder Law Committee did not endorse supported decision-making arrangements being established as separate roles within legislation. They stated that existing substitute decision-makers can and should play a role in supporting a person to make their own decisions:

Developing the ability for substitute decision makers to assist with supported decision making (including through enhanced education around concepts such as will and preference, capacity and so on) is the best way to incorporate the principles from the UN Convention into our legislation. In reality this is, in our experience, what those same people, on the whole, already do in their role. It would add in the potential for confusion and dispute to have a supporter as a different person. Capacity to make decisions usually fluctuates and the complexity of different people needing to drop in and out (according to their role) is not in the best interests of a person with a disability.

**The Institute's view**

7.4.21 The Convention Committee has stated that the effect of the Convention is to require ‘both the abolition of substitute decision making regimes and the development of supported decision making alternatives.’

7.4.22 The main rationales given in support of introduction of a legislated supported decision-making scheme were:

- the lack of formal recognition of the legitimate role of decision-making support;
- the lack of oversight and other safeguarding mechanisms to avoid the potential abuse or undue influence of informal supporters;
- that it might improve the quality and availability of decision-making supports; and

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502 Convention Committee, above n 21, [28].
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- that it provides another strategy to ensure that a representative decision is only required as a last resort.

These are considered below:

Recognising the legitimate role that support plays in decision-making

7.4.23 Recommendation 6.4(1) proposes that the Act provide that a person has decision-making ability if they are able to make a decision with practicable and appropriate support. Recommendation 7.3 proposes that the standard Board application forms require applicants to outline what informal supports have been considered and attempted prior to making an application for the appointment of a representative. Recommendation 8.1(2) (discussed in the following Part) also proposes that, when considering the ‘need’ for a representative, the Board be required to consider whether the decision may be more suitably made by more informal means. These proposals complement the revised guiding principles of the Act outlined in Recommendation 3.3 which proposes that two of the guiding principles that all individuals must uphold and promote are:

- that people who require support in decision-making must be provided with access to the most effective support necessary for them to make, communicate and participate in decisions that affect their lives; and

- that the role of families, carers and other significant people in an adult’s life to support the adult to make decisions must be acknowledged and respected.

7.4.24 Four of the recommendations made in this Report thus propose legislative reform aimed at promoting and legitimising decision-making with support. These, combined with recommendations made in Part 18 about the need for community education, provide a range of strategies aimed at improving the way in which informal support arrangements are recognised and acknowledged as a decision-making tool.

7.4.25 The Institute notes observations that a culture of risk management and concern for legal liability is affecting the use of informal decision-making alternatives.\(^503\) The former President of the Board commented that '[f]inancial institutions are increasingly refusing to accept informal arrangements for management of funds, such as bank signatories, where the holder of the account is incapacitated for financial transactions.'\(^504\) Others have made similar observations.\(^505\)

7.4.26 The Powers of Attorney Act enables attorneys to act upon the instructions of the donor prior to any loss of ‘mental capacity’ of the donor. Conversely, the Act, which governs the role and powers of enduring guardians, does not provide for enduring guardians having authority prior to a donor losing the ability to make their own personal decisions. Section 32(5) of the Act provides that:

Subject to any conditions specified in the instrument, an instrument appointing an enduring guardian authorizes each appointee to exercise the powers of a guardian under section 25 if the appointor subsequently becomes unable by reason of a disability to make


\(^{504}\) Anita Smith, Management of a Resident’s Funds in a Supported Accommodation Facility – A Legal Perspective (July 2010) 3.

\(^{505}\) House of Representatives Standing Committee on Legal and Constitutional Affairs, above n 264, [3.117].
reasonable judgements in respect of matters relating to his or her personal circumstances.506

Section 32B then provides that:

An enduring guardian has a right to all the information to which the appointor is entitled … if the information is reasonably required for the purpose of exercising a power, or determining whether to exercise a power, of the enduring guardian.507

7.4.27 These sections have the effect of restricting an enduring guardian’s powers and rights in ways that attorney’s powers are not. Subject to the terms of an enduring power of attorney, the effect of the Powers of Attorney Act is to give attorneys rights and powers prior to the donor losing the ability to make their own financial decisions. This gives them authority to:

- access, collect or obtain relevant information, or assist the donor to do so;
- communicate information about the donor which is necessary or relevant to a decision;
- communicate a donor’s supported decision; and
- take any reasonable action or do anything reasonably necessary to give effect to a supported decision, subject to limits.

These are the same functions and powers as typically granted to supporters. Provided that an attorney understands the extent and scope of their authority whilst the donor retains the ability to make decisions with support, the appointment of an attorney facilitates that attorney informally supporting a donor prior to taking on a more formal representative role if required.

7.4.28 The Institute considers that there is merit to the Act providing the same approach in relation to enduring guardians. This would enable donors to grant powers to their enduring guardian to access and communicate information and implement decisions, as directed in their instrument. Having this option available may remove some of the barriers that presently hinder the provision of decision-making support.

7.4.29 It must remain possible (as is the case for attorneys) for a donor to limit their enduring guardian’s powers to times when they do not have the ability to make their own decisions. The standard form instrument should provide clear guidance about a donor’s options to elect when the powers of their enduring guardian commence.

7.4.30 An example of this approach is the Victorian legislation which provides:

39 When attorney’s power is exercisable

(1) A principal may specify, in an enduring power of attorney, a time from which, a circumstance in which or an occasion on which the power for all matters or the power for a specified matter under the power of attorney is exercisable, which may be—

(a) immediately on the making of the power; or

506 Guardianship and Administration Act 1995 (Tas) s 25(5).
507 Ibid s 32B(1).
508 Note that the Victorian Act deals collectively with attorneys for financial and personal matters — in other words, a fused model to Tasmania’s separate attorneys and enduring guardians.
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(b) when the principal ceases to have decision making capacity for the matters or matter; or

(c) any other time, circumstance or occasion

(2) If a specification is not made in an enduring power of attorney under subsection (1),
the power for all matters under the enduring power of attorney is exercisable on and from the making of the power of attorney.509

Recommendation 7.4

(1) That the Act provide that a donor may specify in an instrument a time from which, a circumstance in which or an occasion on which the authority for all matters or the authority for a specified matter under the instrument is exercisable, which may be:

- immediately on the making of the instrument; or
- when the donor ceases to have decision-making ability for the matters or matter; or
- any other time, circumstance or occasion.

(2) That the standard form instrument provide guidance to donors about their options to nominate when the authority of their enduring guardian is to commence.

7.4.31 One limitation of this approach is that it does not address circumstances where a donor does not wish to confer any decision-making powers upon a representative and only wishes to grant them authority to support them with decision-making.510 A person called an ‘enduring guardian’ might, for example, be assumed by third parties to have powers to make decisions, whilst the terms of their appointment may in fact only grant them powers to support the donor. Whilst Recommendation 7.4 will provide donors with greater options to enhance the provision of decision-making support, it would not address situations where a donor wishes to limit a person’s authority to only providing them with support. The Institute therefore concludes that additional legislative reforms are required, as outlined in the following paragraphs.

Lack of oversight and safeguards

7.4.32 One of the ALRC’s Safeguards Guidelines provides that ‘support in decision-making must be free of conflict of interests and undue influence.’511 Presently there is no structured oversight of the activities of informal supporters in the same way that there is structured, periodic monitoring and oversight over the activities of Board-appointed representatives. There is, however, also no periodic monitoring of attorneys or enduring guardians, a matter discussed further in Part 12.512 The Board does, however, have jurisdiction to hear applications for the review of enduring powers of attorneys and instruments, and thus still plays a role in supervising the activities of attorneys and enduring

509 Powers of Attorney Act 2014 (Vic) s 39. This approach is consistent with reforms suggested by the Office of the Public Advocate on the basis that it ‘would more readily enable enduring powers of attorney to exist as tools of supported decision-making’: see Office of the Public Advocate Victoria, Supported Decision-Making: Options for Legislative Recognition (January 2010) 6–7. The NSWLRC has also recently made recommendations to adopt the same approach: NSWLRC, above n 24, Recommendation 8.8(1).

510 The Office of the Public Advocate Victoria observed that Victoria’s previous legislation, which was broadly consistent with Tasmania’s in this context, is fundamentally different to supported decision-making arrangements which do not permit the support to substitute the donor’s decision: Office of the Public Advocate Victoria, above n 509, 8.

511 ALRC, above n 3, Recommendation 3-4.

512 See [12.6.19].
guardians. A similar situation also occurs in relation to informal supporters. Interested parties can apply to the Board for the appointment of a representative where they are concerned about existing informal support arrangements and consider that there is a need for a formal appointment of a representative. The Board is not, however, able to formally remove an informal supporter or penalise inappropriate conduct. A legislated supported decision-making scheme could give the Board specific powers to supervise, and if necessary, remove supporters who acted contrary to the Act.

**Improving the quality and availability of decision-making supports**

7.4.33 One potential benefit to introducing a formal legislated supported decision-making scheme is that it may trigger the development of a range of quality, accessible decision-making supports. This is particularly valuable for individuals who do not have people within their existing social networks from which to draw informal supporters. Recommendation 7.2 proposes that adequately funded decision-support programs be developed, ensuring equity of access. It is suggested that this priority can and should be developed irrespective of whether a formal, legislated supported decision-making scheme is established. Nevertheless, designating a role of supporter within statute mandates the need for decision-making supports to be made available. This is part of ensuring that there is equity of access to effective decision-making support for all members of the community, consistent with the Convention.\(^{513}\)

**Providing another strategy so that a representative decision is only made as a last resort**

7.4.34 A further reason that respondents expressed support for introduction of a legislated supported decision-making scheme was that it facilitates representative decision-making occurring as a last resort. The Institute observes the following benefits to a formal, legislated system of supported decision-making:

- having the option to formally grant authority to support decision-making, rather than make decisions, provides a further alternative to the making of a representative decision;
- whilst individuals can delegate authority to attorneys to support a person to make and implement their own decisions, and this Report recommends that this approach to be extended to enduring guardians,\(^{514}\) the Board does not have a corresponding ability to formally authorise a person to support another person with decision-making — it may only appoint a representative. The new approach advocated gives the Board more tools through which to tailor its orders as required; and
- it provides a less restrictive alternative to the appointment of a representative or the making of a representative decision.

7.4.35 Article 4 of the Convention requires State parties to adopt all appropriate legislative measures to implement the rights recognised in the Convention.\(^{515}\) The Convention Committee has stated that the Convention requires the development of supported decision-making regimes in place of substitute decision-making arrangements.\(^{516}\) It states that establishing a supported decision-making framework whilst maintaining substitute decision-making regimes does not comply with the Convention.\(^{517}\)

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513 *Convention on the Rights of Persons with Disabilities* art 12(2).
514 Recommendation 7.4.
516 Convention Committee, above 21, [28].
517 Ibid [24].
7.4.36 Some respondents raised concerns that introducing a formal legislated supported decision-making scheme would add complexity and formality to arrangements, with the risk that it could result in pressure being placed upon individuals to formalise informal arrangements. It is agreed that this risk needs to be mitigated, with it being suggested that this can be achieved via robust community education. The risk of it being used to abuse or exploit a supported person was also raised. This risk is acknowledged, whilst observing that this is the same risk that already exists in relation to the appointment of representatives. Both require legislative responses that safeguard the rights and interests of individuals requiring support.

7.4.37 Whilst other recommendations in this Report advance obligations under the Convention, the Institute concludes that a legislated supported decision-making scheme is necessary to establish a legislative framework for individuals to be supported with decision-making without affecting their decision-making rights. This reform is consistent with the views of the majority of respondents who addressed this question in the Issues Paper.

7.4.38 To the Institute’s knowledge, there have not been any formal trials of supported decision-making within Tasmania although there have been several within other jurisdictions and overseas. The Institute observes that public awareness and understanding of supported decision-making is limited. It therefore considers, consistent with recommendations of the ACTLRAC, that legislative reforms should be enhanced by an appropriate lead-time during which public education campaigns can ensure community understanding of the reforms and provide time for capacity building within the sector. As discussed earlier in this Part, public education must emphasise that legislated supported decision-making is intended to complement, not replace current informal support alternatives. This approach also enables Tasmania to develop a legislative framework that reflects best-practice approaches in other jurisdictions.

7.4.39 The Institute further recommends that, as part of enacting these reforms, the Act be renamed. This is because the Act will then no longer be limited to the appointment of guardians and administrators and the title of the Act needs to acknowledge and reflect the additional role of supporters within the legislative framework.

**Recommendation 7.5**

(1) That a legislated supported decision-making scheme be introduced in Tasmania.

(2) That, as part of introducing legislative reforms to establish a supported decision-making scheme, the Act be renamed to reflect the new framework.

(3) That legislative reform to establish a formal supported decision-making scheme be supported by an appropriate lead-time incorporating a comprehensive public education campaign explaining the reforms, emphasising that the scheme is intended to complement not replace existing informal support arrangements.


519 ACTLRAC, above n 24, Recommendation 11.
7.5 Elements of legislated supported decision-making

7.5.1 The Issues Paper asked a range of questions that would need to be resolved if legislation established a formal role of a supporter. This included:

- what types of decisions supporters should be able to provide support with;
- who should be able to appoint a supporter;
- who should be able to be a supporter;
- what role, duties and powers supporters should have;
- whether supporters should be formally supervised, and if so how and by whom; and
- other safeguards that would protect the rights and interests of people being supported.

7.5.2 These matters are addressed in the following paragraphs.

Types of decisions

7.5.3 The Issues Paper asked whether legislated supported decision-making should exist in relation to some or all decisions involving financial, personal and medical treatment matters.

If a supported decision-making model was incorporated into the Act, should supported decision-making be available for personal decisions? Financial decisions? Medical decisions? 520

7.5.4 There were six responses to this question. Three respondents expressed support for legislated supported decision-making to be available for personal, financial and medical treatment decisions. MIGA’s submission focussed on medical treatment decisions, agreeing that legislated supported decision-making should be available in this area. One submission expressed support for the scheme being available for personal decisions, without forming a confirmed view about financial and medical matters.

7.5.5 The Institute recommends that the legislated supported decision-making scheme be available for personal matters, including in relation to consent to health care and treatment. Further consultation is appropriate to decide whether and how legislated supported decision-making should be available for financial matters given that it would require reform to the Powers of Attorney Act and that review of that Act falls outside of the scope of the Institute’s reference for this project. Broader and targeted consultation with key stakeholders is needed, including the financial services industry. This should part of the proposed review of the Powers of Attorney Act, discussed in Part 17. 521

Recommendation 7.6

That a legislated supported decision-making scheme be available for personal matters, including consent to health care and treatment.

520 TLRI, above n 69, Question 13.3(i).
521 See [17.5], Recommendation 17.4.
Who should be able to appoint a supporter?

7.5.6 The Institute asked who should be able to appoint a supporter.

Who should be able to appoint a supporter?\textsuperscript{522}

7.5.7 There were five responses to this question, although some submissions addressing other questions in the Issues Paper were also relevant to this issue.

Own appointment of a supporter

7.5.8 Six submissions stated that an individual should be able to appoint their own supporter. EOT commented that: ‘For some, the ability to formally appoint a support responsible for assisting them to make decisions may provide an important avenue to continue to assert their legal authority.’

7.5.9 PCT submitted that it is important that young people be able to participate in decision-making, along with people with dementia and intellectual disability.

7.5.10 MIGA’s submission stated that a competent person should be able to appoint a supporter. This was the only submission that raised the issue of the level of ability that ought to be required for a person to appoint a supporter. The Institute notes that, in Victoria, a person must have ‘decision-making capacity’ to appoint a supporter.\textsuperscript{523} A similar test applies in the Irish Republic.\textsuperscript{524}

7.5.11 The Institute considers it fundamental to a legislated supported decision-making regime that individuals be able to appoint their own supporters. It enables a person to express their will and preference and exercise autonomy. It enables them to choose the level of support that they wish to have available to them. Enabling a person to appoint their own supporter has been described as: ‘The least invasive end of legislatively recognised supported decision-making.’\textsuperscript{525} On this basis, the Institute recommends that legislation permit an individual to appoint their own supporter for personal matters. Specific recommendations are not made about any formal requirements to appoint a supporter. It is recommended that these details adopt best practice models from other jurisdictions. Broad consistency with the appointment of enduring guardians and creation of ACDs is, however, endorsed.

Recommendation 7.7

(1) That legislation enable an individual to appoint their own supporter for personal matters including consent to health care and treatment.

(2) That, to appoint a supporter, an individual needs ‘decision-making ability’ to appoint a supporter.

Board appointed supporters

7.5.12 Three submissions expressed support for the Board being able to appoint supporters. The OPG commented that the Board should only be permitted to appoint a supporter where the

\textsuperscript{522} TLRI, above n 69, Question 13.3(ii).

\textsuperscript{523} Powers of Attorney Act 2014 (Vic) s 86(1).

\textsuperscript{524} Assisted Decision-Making (Capacity) Act 2015 (Ireland) s 3.

\textsuperscript{525} Office of the Public Advocate Victoria, above n 509, 7.
individual is unable to appoint their own supporter and the supported person agrees (or at least does not object) to the appointment. This approach is consistent with the previously expressed views of the Office of the Public Advocate in Victoria, which proposed, as part of the review of guardianship laws in Victoria, that ‘any supported decision-making arrangement must have the free agreement of the person and their supporters.’ It advocated an approach where the supported person could terminate the arrangement at any time.\textsuperscript{526}

7.5.13 Fundamental to the Convention is that people who require support with decision-making have access to the support they require. Support must be available on an equal basis. It follows that all individuals should have equal access to the formal appointment of a supporter as a means of offering decision-making support. It should not, however, be mandated where an individual chooses not to receive support.

7.5.14 Further consultation is desirable to decide upon the details of when and how the Board should be able to appoint supporters and the Institute has not made recommendations about these elements.

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<th>Recommendation 7.8</th>
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<td>(1) That legislation enable the Board to appoint supporters for personal matters, including consent to health care and treatment.</td>
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<td>(2) That the Board not be permitted to appoint a supporter where the proposed supported person objects to that appointment.</td>
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**Safeguards**

7.5.15 It is critical that a legislated supported decision-making regime provides appropriate safeguards to protect the rights and interests of those being supported to make decisions. The Institute asked for views about safeguards that ought to be built into legislation to ensure that supporters act properly.

| What safeguarding measures should be put in place to prevent abuse?\textsuperscript{527} |

7.5.16 Five submissions addressed this question. Safeguarding options that were put forward included:

- clearly defined duties, functions and responsibilities;\textsuperscript{528}
- safeguards that ensure that a supported person is not subject to undue influence in the making of a supported decision-making arrangement;\textsuperscript{529}
- the ability for a supported person to revoke a supported decision-making agreement and remove their supporter;\textsuperscript{530}
- the ability for the Board to revoke its own appointment of a supporter;\textsuperscript{531}

\textsuperscript{526} Carter, above n 468, 20.
\textsuperscript{527} TLRI, above n 69, Question 13.3(v).
\textsuperscript{528} OPG and MIGA.
\textsuperscript{529} Speak Out Advocates.
\textsuperscript{530} OPG.
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- regular reviews of appointments\textsuperscript{532} including the creation of a monitor role;\textsuperscript{533}
- power for the Public Guardian to receive and investigate complaints or concerns;\textsuperscript{534}
- a requirement for supporters to notify the Board if they consider that a supported person is unable to make decisions with support;\textsuperscript{535} and
- allocation of a role of a ‘coach’ to support and educate supporters.\textsuperscript{536}

7.5.17 The Board’s submission commented that: ‘As a general comment, if a formal supported decision making model is introduced, it should operate with as little formality and legal complexity as possible and appropriate safeguards for the supported person need to exist.’

7.5.18 The Institute makes the following recommendations in relation to safeguarding provisions to protect those with formally appointed supporters:

**Recommendation 7.9**

That legislation contain the following safeguarding provisions in relation to supporters:

(a) that there be a clear description of a supporter’s role. Subject to the terms of their appointment, and the directions of a supported person or the Board, a supporter’s role should include:

- to obtain and disclose personal and other information on behalf of the supported person relevant to a decision;
- to assist the supported person to understand information relevant to a decision;
- to provide advice to the supported person about a decision;
- to assist the supported person to communicate their decision; and
- to endeavour to ensure the decisions of the supported person are given effect.

(b) That legislation state explicitly that a supporter cannot make decisions on behalf of a supported person.

(c) That supporters only be permitted to act during periods in which the supported person has decision-making ability for the relevant matter.

(d) That supporters be required to comply with the duties outlined in Recommendation 8.3(2).

(e) That a supported person be able to direct their supporter to report to a person or body when they are acting as supporter.

(f) That a person be able to revoke their own appointment of a supporter.

(g) That the Board be able to revoke the appointment of a supporter in defined circumstances, broadly consistent with the test to revoke a representative.

\textsuperscript{531} OPG.

\textsuperscript{532} TasCoss.

\textsuperscript{533} TasCoss, referring to the ACT Spectrums of Support recommendations.

\textsuperscript{534} MIGA.

\textsuperscript{535} OPG.

\textsuperscript{536} TasCoss, referring to the ACT Spectrums of Support recommendations.
(h) That supporters have a duty to notify the Board if they consider that the test for the appointment of a representative may be satisfied.

Eligibility to be a supporter

7.5.19 Noting that the Act precludes certain classes of individuals from being appointed as an enduring guardian, the Issues Paper asked for views about who ought to be able to be a supporter and whether there should be any individuals or groups excluded from acting in the role.

If a supported decision-making model was incorporated into the Act, who should be able to be appointed as a supporter? Who should not be able to be appointed?

7.5.20 Seven submissions addressed this question. Answers typically endorsed supporters being someone with an existing relationship with the supported person. PCT commented that supporters should be a person who knows the supported person best. MIGA suggested that any person who falls within the definition of a person responsible ought to be eligible to be a supporter. It expressed support for children who are Gillick competent being able to act as supporters. One submission supported the Public Guardian being eligible to act in the role.

7.5.21 Two submissions commented about the question of assessing a person’s suitability. The OPG commented:

Tasmania is well on its way to establishing a ‘working with vulnerable people’ registration scheme — Board-appointed supporters should be eligible for registration. Someone should not be appointed as a supporter where there have been allegations of abuse or neglect, or where there is a conflict of interest that cannot be mitigated.

A supporter must be able and agree to act in accordance with principles as defined by the Act.

7.5.22 Speak Out advocates suggested that it would be inappropriate for support workers to act as formal supporters due to the conflict between their duty to support the development of decision-making skills and their personal interest in continuing to provide the person with care. The OPG, on the other hand, suggested that it might be appropriate to enable paid workers to act as supporters:

The OPG is not opposed to consideration of paid workers acting as supporters and being able to be appointed in that role. The OPG believes people with disabilities should be able to choose who they seek support from and we understand that this might be a paid worker with whom they have a long-term close relationship. Obviously appropriate safeguards would need to be put in place, and appointments should be precluded where there is the possibility of a supporter obtaining personal gain.

7.5.23 The Institute considers that whether any classes of individuals ought to be ineligible to act as a supporter be further evaluated. The Institute takes this opportunity to note that previous supported decision-making trials have observed difficulties in recruiting volunteers to provide decision-making support, finding that training individuals within a person’s existing social network can provide a better alternative.

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537 Refer to [4.3.17]–[4.3.25].
538 TLRI, above n 69, Question 13.3(iii).
539 Evaluation Report of the Link and Learn Supported Decision Making Project, above n 493, 4, 5.
Oversight of supporters

7.5.24 The Issues Paper asked for views about who ought to supervise the activities of supporters.

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7.5.25 There were six responses to this question. The OPG suggested that the Board be responsible for overseeing any register of supported decision-making arrangements and reporting requirements. The OPG would then provide education and support to supporters, have responsibility for conducting investigations in relation to allegations of misconduct and have powers in relation to dispute resolution. MIGA's submission also supported this type of division of functions between the Board and the OPG, consistent with the existing arrangements in relation to the oversight of representatives.

7.5.26 Two submissions stated that the Board should be responsible for oversight of the activities of supporters, whilst TasCOSs suggested that this function could be allocated to a new Office of the Public Advocate. One submission did not refer to the specific body that ought to oversee supporters, but commented that it is appropriate that there be some assessment of the quality of supporters.

7.5.27 The Institute agrees with the submissions of MIGA and the OPG that the oversight of supporters should align with the provisions governing oversight of representatives.

**Recommendation 7.10**

That Recommendation 5.7 (providing a mediation role for the Public Guardian) be extended to supporters.

### 7.6 A legislated co-decision-making scheme

7.6.1 The Issues Paper explained the use of co-decision-making models in other jurisdictions. Co-decision-making involves the appointment of a ‘co-decision-maker’ whose role it is to make a joint decision with the person requiring that level of support. In Canada, both Alberta and Saskatchewan have legislation providing for co-decision-makers, as does the Irish Republic. Hybrid models exist in Japan, Norway and Denmark. There is no legislated model of co-decision-making in Australia. Both the VLRC and the ACTLRAC have recommended that there is a place for co-decision-making as part of a ‘suite’ of decision-making alternatives. They recommend that co-decision-making be available where there is an unreasonable risk of substantial harm if a person were to make a decision alone.

7.6.2 The Institute's consultation considered whether there is merit to the establishment of a co-decision-making model in Tasmania.

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540 TLRI, above n 69, Question 13.3(iv).
541 Ibid [13.6].
542 See Then, above n 503, 151.
If a co-decision-making model were incorporated into the Act, should it be available for personal decisions? Financial decisions? Medical decisions?  

7.6.3 Two submissions supported the introduction of co-decision-making. Four respondents did not support this reform including the OPG which commented that:

If the Act is flexible in allowing room for the role, function and definition of supported decision making to evolve as suitable models are developed, then it would not be necessary to incorporate a co-decision-making model into the Act. Further, we see the role of education and advocacy as key in assisting our community to move towards supported decision-making. The OPG does not support a co-decision-making model and holds the view that co-decision making models adopted in other jurisdictions have inherent challenges and short-falls. We see this as a lesser alternative to supported decision making.

7.6.4 Several submissions expressed concerns about the lack of compelling evidence supporting introduction of a co-decision-making model. EOT commented:

Whilst we appreciate that for some people it may provide a degree of flexibility without the need to resort to a substitute decision maker. However, in circumstances where the principal decision maker retains the capacity to make their own decisions we would expect that there would be a preference to respect that ability. This will, however, depend on exact circumstances and it is difficult to be entirely prescriptive regarding this approach. It could be useful mechanism in circumstances where the principal decision maker requires assistance in particular areas of life (for example with regard to financial decisions) but retains capacity to exercise their will and preferences in other areas of decision making. We would, however, wish to see more detail about how the model would be applied prior to finalising our views and would, in any event, wish to ensure that any decisions made represented the will and preference of the person or what the person would likely want based on all available information. We would not wish to see this model used as a mechanism to reintroduce a ‘best interests’ model of decision making.

7.6.5 The Board stated:

The Board notes the detail and reasoning behind co-decision making is not clearly established and safeguards have not yet been demonstrated.

7.6.6 Similarly, MIGA commented:

Co-decision making is a new model, which requires significant research and trials before it could be considered for use in a broader healthcare context or recognised under legislation.

There is not presently any compelling case for co-decision making, it is potentially confusing and differs from supported decision-making where that model already reflects the realities of informal relationships.

7.6.7 Consistent with these views, the Institute has not made recommendations for the introduction of a legislated co-decision-making scheme in Tasmania at this time. The State

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544 TLRI, above n 69, Question 13.4(i).
545 PCT, Wallace.
546 Elder Law Committee, National Seniors Australia, Tasmanian Policy Advisory Group, OPG.
Government should maintain a watching brief in relation to the development and evaluation of co-decision-making models in other jurisdictions.

### 7.7 Other matters

7.7.1 Members of the Elder Law Committee’s submission raised specific recommendations in relation to improving recognition of the role of parents in supporting children with disability upon that child attaining the age of 18 years. Their submission made the following observations and recommendations:

The Committee suggests for consideration a process by which parents and other long term full time carers for persons with disability have a clear entitlement to be appointed by the Board as Administrator and Guardian for the person who they care for …

The Committee feels that a formal appointment giving clear and defined legal authority to the parent/carer may often be appropriate, and in the best interests of the person with a disability. A parent or other carer who always has, and likely always will, provide daily personal care for a person should be given the clearest possible formal legal authority to act for that person in their best interests. They should also have the ability to plan for and put in place arrangements for their own replacement/succession in advance of that need arising.

The Committee suggests that a model that could achieve this would be the Act giving parents/carers who meet stated objective criteria a statutory right to apply and be appointed as Administrator and Guardian, with appointments being longer and reporting requirements less than other types of appointments. The existing requirement for a ‘need’ for the appointment should not apply in the same way in these cases. For example, the criteria could include being a parent with the full time care for a person who lacks capacity to live independently. It is felt that having a clear statutory right to an appointment is an appropriate starting point, both to encourage applications by reducing the fear of unnecessary intervention of the Public Trustee in appropriate close family arrangements, and to reflect the reality that the parent/carer will otherwise most likely act informally anyway.

The parent/carer so appointed should otherwise be subject to the same duties, and apply the same considerations when making decisions, as any other appointed Administrator and Guardian. Whilst reporting and review should in the Committee’s view be at a low level, the Board would nevertheless have oversight and a protective role where appropriate that does not presently exist for ‘informal’ arrangements. The Board should retain the power in exceptional cases not to appoint the parent/carer, and the power to shape the terms of the appointment to the needs and circumstances of the individual person.

It should be recognised that parents/carers who live with the person long term are different to adult children or others who take on decision making roles for a person later in that person’s life. Parents/carers should be more strongly recognised and supported by the Act, to make their (often very difficult) role as long term carer easier when it comes to the legalities around decision making.

The Committee feels that facilitating these types of appointments within the existing Administrator/Guardian framework is preferable to creating a separate ‘co-decision maker’ or ‘assisted decision maker’ role, whilst being likely to facilitate and advance the public policy/intent behind those ideas being to involve the person themselves in their own decision making as far as possible and appropriate.
7.7.2 Carers Tasmania made similar observations in relation to difficulties faced by parents of children with profound disability upon that child attaining the age of 18 years:

Some Carers Tasmania members have shared experiences of confusion, distress and practical inconvenience when their child with a profound intellectual disability becomes legally independent, aged 18. The implications of this change are not well communicated, and can result in substantial adverse changes to care arrangements. Carers Tasmania believes a more streamlined approach should be introduced to facilitate the appointment of the guardian, wherever appropriate.

7.7.3 Both the VLRC and NSWLRC’s reviews considered the issue of whether parents of adult children with severe disability should involve any different treatment in relation to their appointment as a representative upon their child attaining the age of 18 years. The NSWLRC’s recent Question Paper summarised this issue:

2.64 Currently, many relatives and friends provide informal support to people who require decision-making assistance. Others act as formal guardians or financial managers. They may understandably have concerns about who will take on these roles if they are unable to do so in the future. As the VLRC observed, ‘[t]his matter is of particular concern to ageing parents and carers of people with lifetime disabilities’.

2.65 The *Guardianship Act* already allows for some forms of succession planning. The Tribunal can appoint a person to act as an alternative guardian under a continuing guardianship order. The alternative guardian takes on the guardianship role if the original guardian is absent or becomes incapacitated. The alternative guardian also acts as a person’s guardian if the original guardian dies and there is no surviving joint guardian to take over the original guardian’s functions.

2.66 The VLRC recommended that the Victorian guardianship legislation should contain another form of succession planning. Under the VLRC’s proposal, family members, carers and decision-makers for a person with ‘ongoing impaired decision-making capacity’ could file a ‘succession document’ with the Victorian tribunal. In this document, they could state their wishes about what the person’s future decision-making arrangements should be.

2.67 However, the VLRC believed that the legislation should not require the Victorian tribunal to give effect to these wishes. Instead, the VLRC recommended that the tribunal should simply be required to consider them. This is because the tribunal’s ‘decisions must be made in the light of current circumstances’.

2.68 The Victorian Bill proposed a similar arrangement. This would have allowed relatives, primary carers, guardians and administrators (among others) to state who should be appointed as a guardian or administrator in the future.

2.69 The Bill proposed to require the Victorian tribunal to consider such a statement when deciding if a person is suitable to act as a guardian or an administrator. In contrast to the VLRC’s proposal, the Victorian Bill stated that the Victorian tribunal would have to appoint the nominated person if:

- the statement was made by the current guardian or administrator
- the nominated person is over 18 and consents to act as guardian or administrator, and
- the nominated person meets other applicable eligibility criteria.\(^\text{547}\)

\(^{547}\) NSWLRC, above n 518, [2.64]–[2.69].
7.7.4 The NSWLRC’s draft recommendations did not make recommendations for reform to deal specially with parents’ appointment as representative upon their child becoming an adult.548

7.7.5 This matter has not been the specific subject of public consultation as part of this review. Further consultation would be necessary to ascertain the degree of support for this reform. As the matter falls outside of the Institute’s Terms of Reference, specific recommendations are not made. The Institute observes, however, that fundamental to the recommendations made in this Report is that the appointment of a representative should be a last resort. It is important that this remain a critical consideration when considering a parent’s appointment as representative for their adult child. Any appointment of a representative should also reflect the proposed represented person’s will and preference. A proposed representative’s suitability remains an important consideration to safeguard to promote the rights and interests of a represented person. For these reasons, the Institute considers that there remains an important role for the Board to play in assessing the need for, and suitability of proposed representatives including in relation to a parent’s application to be appointed as representative for their adult child.

548 NSWLRC, above n 543.
8.1 Introduction

8.1.1 The Terms of Reference asked the Institute to report on the role of guardians and administrators in advancing the interests of people with decision-making impairments and to consider these provisions in light of the overarching principles and rights articulated in the Convention and developments in other jurisdictions.

8.1.2 Part 7 of this Report reviewed how support can be provided to enable a person to make their own decisions. This Part reviews and makes recommendations about the appointment of representatives for individuals who are unable to make their own decisions or their own decisions with support. Parts 9 and 10 then consider the role and powers of guardians and administrators respectively.

8.2 When a representative may be appointed

8.2.1 To appoint an administrator or guardian for a person, the Board must be satisfied that:

- the person has a disability;
- the person is unable, by reason of that disability, to make a reasonable judgment about their personal or financial affairs;
- the person is in need of an administrator or guardian;\(^{549}\) and
- it is in the person’s best interests.\(^{550}\)

The Board must also consider whether the person’s needs could be met by less restrictive means.\(^{551}\)

8.2.2 The need for a disability and the assessment of a person’s ability to make a ‘reasonable judgment’ were discussed in Part 6.\(^{552}\) This Part reviews the other elements of the existing test to appoint a representative.

**Best Interests**

8.2.3 A representative may only be appointed if the Board considers that it is in the person’s best interests.\(^{553}\) As discussed in Part 3, the need to uphold a person’s ‘best interests’ is an overriding

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\(^{549}\) Guardianship and Administration Act 1995 (Tas) ss 20(2), 51(2).

\(^{550}\) Ibid ss 20(3), 51(3).

\(^{551}\) Ibid ss 20(5), 51(4).

\(^{552}\) Refer to [6.2], [6.4] and Recommendations 6.1, 6.3.

\(^{553}\) Guardianship and Administration Act 1995 (Tas) ss 20(3), 51(3).
Part 8: Representative Decision-Making

principle governing the Act. Part 3 considered whether the term ‘best interests’ ought to remain within the Act, concluding that, where it is appropriate to continue to assess whether a course of action is in a person’s best interests, the term ‘personal and social wellbeing’ be used.

‘Need’

8.2.4 For the Board to appoint a representative, there must be a need for that appointment. Requiring there to be a need for a representative is consistent with the overriding principle of the Act of adopting a course of action that is least restrictive of a person’s freedom of decision and action as possible. This principle was discussed in Part 3.

8.2.5 The Act does not define or further explain what is meant by there being a ‘need’ for a representative. It is a matter that the Board determines based on the circumstances. An issue raised in the Issues Paper was that if ‘need’ is interpreted to mean an immediate, present need, then applicants may be unsuccessful if they seek to be appointed as a representative in anticipation of a likely future need. This can impact the ability of families to plan and put in place arrangements to minimise disruption and delay. The Issues Paper explained that the VLRC made recommendations to define what is meant by the ‘need’ for a representative within legislation. Subsequent reforms that have been proposed to the Victorian legislation (in cl 31 of the Victorian Guardianship and Administration Bill 2018) would require VCAT to consider the following factors in determining whether there is a need for an appointment:

- the will and preferences of the proposed represented person (so far as they can be ascertained);
- whether decisions in relation to the personal or financial matter for which the order is sought:
  - may more suitably be made by informal means; or
  - may reasonably be made through negotiation, mediation or similar means;
- the wishes of any primary carer or relative of the proposed represented person or other person with a direct interest in the application; and
- the desirability of preserving existing relationships that are important to the proposed represented person.

8.2.6 The ‘need’ for a representative is explained in the ACT and Queensland, with inclusion of such guidance endorsed by the QLRC. Factors for the tribunal to consider when assessing the ‘need’ for a representative are also outlined in the Northern Territory. That section provides that ‘need’ is to be assessed taking into account:

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554 Ibid s 6(b).
555 Ibid s 6(a).
556 VLRC, above n 24, [12.120].
557 Guardianship and Management of Property Act 1991 (ACT) s 7(1); Guardianship and Administration Act 2000 (Qld) s 12(1).
558 QLRC, above n 25, Recommendation 14-1.
559 Guardianship of Adults Act 2016 (NT) s 11(2).
• the nature and extent of the decision-making impairment including:
  o whether it is continuous or episodic;
  o whether it is likely to be permanent or, if not, the likely duration; and
  o the matters for which the adult’s decision-making capacity is impaired;
• whether the adult already has an agent with authority for the matters for which the adult’s
decision-making capacity is impaired;
• any views and wishes stated by an interested person;
• the desirability of preserving existing family relationships and other relationships that are
important to the adult; and
• whether the adult’s needs could be adequately provided for in a way that is less restrictive
of the adult’s freedom of decision and action than appointing a guardian.560

8.2.7 The NSWLRC’s recent recommendations propose that in considering whether there is a
need for an order, the Tribunal should take into account, where relevant:
• the adequacy of existing or available formal or informal arrangements in meeting the
person’s decision-making needs; and
• the availability and suitability of less restrictive and intrusive measures to meet the person’s
needs, including but not limited to a support order or support agreement.561

Public Consultation

8.2.8 The Issues Paper asked what test should apply to appoint a representative.

| What test should apply to appoint a guardian or administrator?562 |

8.2.9 There were 13 submissions addressing this question. Five referred to the importance of
ensuring that the appointment of a representative is only made as a last resort. Advocacy Tasmania
commented, for example, that:

We do not believe that the ‘need’ test is a necessary aspect of the Act. This wording does
not reflect a rights-based understanding of substitute decision making, similar to language
around best interests. The appointment of a guardian or administrator should be legal
appointment of last resort, after all decision support options have been undertaken and
where it is not possible to ascertain a person’s will and preferences in relation to
decisions.

8.2.10 Another submission stated that a representative should only be appointed if it is established
that the proposed represented person is completely unable to function, for example, where they are
in a coma. The Public Trustee suggested that it should be a capacity test that determines whether a
representative is appointed.

560 Ibid s 11(2).
561 NSWLRC, above n 24, Recommendation 9.3(2).
562 TLRI, above n 69, Question 4.1.
8.2.11 Members of the Elder Law Committee supported retention of the current test to appoint a representative. PCT also supported continuation of the existing test, but removing the requirement for the appointment to be in a person’s ‘best interests’.

8.2.12 Responses demonstrated the need to balance competing considerations. On one hand, respondents stated that representatives should not be appointed for the sake of mere convenience. On the other hand, it was explained that not appointing representatives as part of forward planning can create inconvenience, delay and the potential for harm to the person involved. Some respondents stated that they had observed that aged care facilities may require their residents to have an appointed representative. Associate Professor Wallace commented that:

A common sense approach should apply. The moving of a family member into a nursing home is often a stressful time, and the extra paperwork involved in making an application, attending a hearing (which may be in another location) is additive in stress — if it could be avoided the better.

8.2.13 The OPMHS, however, commented about the practical difficulties that can arise where an appointment is not made because the test of ‘need’ is not met:

The necessity to have a ‘need’ prior to appointment of a guardian or administrator is problematic as this does can lead to significant delays due to not being able to appoint a guardian before the need arises even when it is clear it will at some stage. The other issue is that it is debatable whether having a guardian/administrator is really more restrictive than not having one if the latter means that different people take over functions without proper appointment or scrutiny and without clear rules of engaging/consulting the person affected. A formal guardian or administrator with defined role and duties can in fact safeguard a person’s voice being heard and their rights being protected. A best interest concept would be more suitable than having to prove a current need for a specific decision.

8.2.14 The Institute asked specifically whether the test to appoint a representative should continue to require assessment of the ‘need’ for a representative and, if so, whether the term ‘need’ should be defined.

(i) If the ‘need’ to have a representative remains part of the test to appoint a representative, should it be defined?

(ii) If so, what should ‘need’ mean?\(^{563}\)

8.2.15 There were 14 responses to this question. The Board considered that there was no need to revise the existing test. The majority of submissions supported the test continuing to require a ‘need’ for a representative.

8.2.16 Seven responses stated that the term ‘need’ could usefully be defined or explained. The OPG stated that:

The OPG believes the ‘need’ for a guardian or administrator should remain part of the test and should be strengthened and clarified. The need should be current and demonstrated and relate to substitute decision/s required to be made.

\(^{563}\) TLRI, above n 69, Question 4.2.
Ordinarily, when a person is not objecting to a proposed course of action, if there is no question as to coercion and if there is no contention about the options at hand, there should not be a need for substitute decision-making. There may well be, however, a need for an advocate or a supporter to properly explore wishes/lack of objection, ensure the provision of services and to look into broader alternatives or options. The need for a representative should only be established when all such options for informal supports and advocacy have been exhausted.

‘Need’ should not be confused with ‘risk’: it is common for risks to arise from poor judgement and risk-taking behaviour of a person with a disability — as for any person — and/or from a lack of appropriate resources or services. But the presence of risk does not necessarily mean substitute decisions need to be made. For example, a person with a disability may face risks associated with being homeless, but if they would clearly accept an offer of housing, the appointment of a guardian to make a substitute decision as to where the person is to live is not needed. Or a person with a disability may make poor decisions regarding intimate relationships with associated risks of exploitation, emotional hurt or sexually transmitted disease — substitute decision-making is often not viable in such circumstances, whereas support, counselling and education can be beneficial and empowering.

The OPG believes consideration should be given to adopting the approaches of the new Victorian legislation and the Northern Territory.

8.2.17 Two other submissions also supported the term ‘need’ being defined consistently with the approach in the Northern Territory. Members of the Elder Law Committee preferred the Queensland approach, whilst PCT did not support the Queensland example.

8.2.18 Two responses observed difficulties with the test requiring a ‘need’ for a representative. Carers Tasmania submitted that the test should be revised to consider a carer’s perspective, including:

- While not having a representative appointed may be the least restrictive option, it may be important to closely assess exactly how significant the caring role is, and to consider how difficult it currently is for the carer to advocate on behalf of a person without a formal decision making role, and the dilemmas and consequences this creates for both parties.

- If a family member is not able to be appointed in anticipation of a future need, what impact will this have on the person and the carer if an unexpected need arises needing urgent attention.

- The family or friend in a caring role’s capacity (ie time, emotional resilience, skills, support) to perform these decision making responsibilities, and associated requirements if appointed.

8.2.19 The OPMHS commented that the appointment of a representative can act as a safeguard:

The current provision that there needs to be a need for a guardian often leads to people clearly lacking capacity not having a guardian. This can lead to others making decisions for a person without authority, scrutiny and often not very aware of the principles of alternative decision making. This is particularly a risk for dementia patients in nursing homes and given the aging population, this vulnerable group will increase over time … It would be good if guardians could be appointed for those people, preferably family or friends unless there is a conflict of interest. The guardian would then be clear as the decision maker around life style decisions, when restrictions of movement are put in place.
due to safety issues, how personal funds are spent etc. Often this is just done by nursing
home staff and mostly with good intentions, but staff often focus on safety rather than
personal preferences and individual freedoms and the fact remains that there is little
scrutiny and support for the person if they disagree with decisions.

8.2.20 The Institute also asked whether the test to appoint a representative ought to have regard
to the extent to which decision-making support has been attempted and failed.

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8.2.21 There were 11 submissions addressing this question, seven of which supported the Act
explicitly stating that the Board should need to be satisfied that all reasonable support options have
been attempted before a representative is appointed. Some submissions expressed strong support,
with others commenting that it was critical and part of ensuring that the appointment of a
representative is a last resort.

8.2.22 The Board and the Public Trustee did not support the Act explicitly stating that a
representative may only be appointed if all reasonable support options have been attempted. The
Board commented that this requirement is implicit in upholding the guiding principles of the Act
which require the least restrictive alternative to be adopted. The Board noted that, as part of
upholding this principle, it enquires about other options attempted to satisfy itself that the
appointment of a representative is the least restrictive alternative.

8.2.23 Social Work Services RHH made the following observations, without explicitly supporting
or rejecting this potential reform:

In many cases, ensuring that all reasonable support options have been attempted before a
representative is appointed will be appropriate. However there are many times with
clients who have a significant decision-making-impairment can’t trial the least restrictive
option without a Guardian or Administrator.

Example: A represented person is unsafe at home and refuses support services which
would enable them to remain at home. There are times a Guardian is required to consider
the risks of whether a person can return home with enforced support services (sometimes
requiring the financial support of the administrator or Enduring power of attorney)
versus needing to move to permanent residential aged care. A Guardian is often required
to consent to implementing support services with an overarching consideration for the
persons’ wishes, what is in their best interests and considering at what point living at
home is no longer sustainable. Therefore a Guardian is sometimes required to promote
the least restrictive option.

The Institute’s view

8.2.24 The Institute proposes that the test to appoint a representative remain substantially the
same. Minor revisions are, however, recommended in response to feedback received. The proposed
revisions are as follows:

564 TLRI, above n 69, Question 4.3.
8.2.25 Firstly, it is recommended that the Act provide a single test for the Board to apply when determining whether to make an order appointing a representative. Currently, whilst the tests are the same, the Act outlines them within separate sections in relation to the appointment of a guardian and administrator.\textsuperscript{565} Consistent with comments made elsewhere in this Report, the Institute promotes reforms that assist to simplify and shorten the Act, so that it is accessible as possible.

8.2.26 Secondly, the Institute recommends that, instead of assessing whether the appointment of a representative is in a proposed represented person’s best interests, the test require consideration of whether the appointment promotes their ‘personal and social wellbeing’. The rationale for this reform is discussed in Part 11.\textsuperscript{566}

8.2.27 The final revision proposed is to outline what must be considered when assessing the need for a representative, consistent with the approach in Victoria. Most respondents supported the Act clarifying what is meant by the ‘need’ for a representative. The proposed Victorian approach is endorsed because:

- it requires consideration of the will and preference of the person;
- it explicitly requires an assessment of the availability and suitability of other informal means. Whilst it is acknowledged that this may already be implicit, this reform is consistent with responses that it should only be possible to appoint a representative if other alternatives have been unsuccessful and a representative is needed as a last resort;
- consistent with submissions made by Carers Tasmania, it requires consideration of the views of those close to a proposed represented person; and
- it calls for an evaluation of what impact the appointment of a representative may have on existing support relationships. This consideration promotes the rights and interests of the proposed represented person. It is not dissimilar to the existing requirement that the Board consider the desirability of preserving existing family relationships when considering the suitability of a guardian.\textsuperscript{567}

8.2.28 These reforms complement other proposals made in Part 6 which would require the Board to only determine that a proposed represented person does not have the decision-making ability in relation to a personal or financial matter (the first limb of the test) if it is satisfied that they are unable to make a decision with support.\textsuperscript{568}

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<td>(1) That the test to appoint a representative require the Board to be satisfied that:</td>
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<tr>
<td>(a) the proposed represented person does not have decision-making ability in relation to one or more personal matters (in the case of a guardianship order) or financial matters (in the case of an administration order);</td>
</tr>
<tr>
<td>(b) the proposed represented person is in need of a guardian or administrator; and</td>
</tr>
</tbody>
</table>

\textsuperscript{565} Guardianship and Administration Act 1995 (Tas) ss 20, 51.
\textsuperscript{566} Refer to [11.4.27]–[11.4.28].
\textsuperscript{567} See Guardianship and Administration Act 1995 (Tas) s 21(2)(b).
\textsuperscript{568} See Recommendation 6.4.
(c) the guardianship order or administration order will promote the proposed represented person’s personal and social wellbeing.

(2) That, when considering whether there is a need for a representative, the Board be required to consider:

(a) the values, wishes and preferences of the proposed represented person;

(b) whether the needs of the proposed represented person could be met by other means less restrictive of that person’s freedom of decision and action, including whether the need could be met by informal means, through negotiation, mediation or similar means, or in the case of a guardianship order, through the appointment of a supporter;

(c) the wishes of any primary carer or close relative of the proposed represented person or other person with a direct interest in the application; and

(d) the desirability of preserving existing relationships that are important to the proposed represented person.

### 8.3 Plenary orders

8.3.1 Representatives may be given authority over all of a person’s personal or financial matters. The Act calls this a ‘full’ appointment. It is often also called a ‘plenary’ appointment. Alternatively, the Board may give representatives powers over only some matters. The Act calls this a ‘limited’ appointment.

8.3.2 The Act provides that the Board must not appoint a full guardian unless satisfied that a limited appointment would be insufficient to meet the person’s needs. An equivalent statement is not included in relation to administrators, although it confirms that: ‘Where the Board makes an order appointing an administrator of a person’s estate, the order is to be that which is the least restrictive of that person’s freedom of decision and action as is possible in the circumstances.’ This is also one of the overriding governing principles of the Act, as discussed in Part 3.

8.3.3 The Convention provides that safeguards for decision-making must be proportional and tailored to a person’s circumstances. In light of the Convention, the ALRC recommended that any appointment of a representative must be limited in scope and proportionate. The VLRC recommended that plenary guardianship be abolished. The Northern Territory has adopted this approach. The revised Victorian Bill also provides that VCAT may only appoint a representative if satisfied that a person does not have the decision-making capacity in relation to the personal/financial matter in relation to which the order is sought. Effectively, this will require the tribunal to tailor its orders. The NSWLRC’s recent recommendations also implicitly require abolition

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569 Guardianship and Administration Act 1995 (Tas) s 20(4).
570 See ibid s 51.
571 Ibid s 51(4); see also Guardianship and Administration Act 1995 (Tas) s 20(5) in relation to guardianship orders.
573 ALRC, above n 3, Recommendation 3-4.
574 VLRC, above n 24, Recommendation 182.
575 Guardianship of Adults Act 2016 (NT) s 16(1).
576 Guardianship and Administration Bill 2018 (Vic) cl 30(2).
of plenary orders by proposing that the tribunal be required to specify the decisions that the appointed representative may make.\textsuperscript{577}

8.3.4 The Issues Paper commented that full orders provide flexibility and may reduce the need for multiple applications to the Board if a representative requires extended powers. On the other hand, requiring the Board to consider and then list the powers given to a representative ensures that orders are tailored and that a person’s freedom of decision and action is only restricted to the extent that it is necessary.

8.3.5 The Public Guardian reports that 32 (15 per cent) of the orders appointing the Public Guardian as guardian as at 30 June 2017 were plenary orders.\textsuperscript{578} This compared to 16 plenary guardianship orders appointing the Public Guardian as at 30 June 2016 (or 9.5 per cent of orders appointing the Public Guardian).\textsuperscript{579} In 2016–2017, 46 (21 per cent) of orders appointing the Public Guardian were limited to a single power. This compares to 27 per cent as at 30 June 2016.\textsuperscript{580}

8.3.6 The Issues Paper asked for stakeholder’s views about whether full guardianship orders ought to continue.

\begin{center}
\textbf{Should plenary (full) guardianship Orders continue, and if so, in what circumstances?} \textsuperscript{581}
\end{center}

8.3.7 Seven respondents addressed this question. Two submissions stated that the Board should not be permitted to make plenary orders and should need to tailor its orders according to an individual’s circumstances. Social Work Services RHH, for example, commented that: ‘Abolishing plenary orders makes a Board consider the powers given and ensures that members must deliberate over least restrictive practices by only giving powers for necessary areas.’

8.3.8 Both the OPG and the Board observed that it is difficult to see how plenary orders are a least restrictive alternative. Both stated that, if the ability to make plenary orders did continue, then such orders should be reserved for the most exceptional circumstances. The Board submitted:

\begin{quote}
Generally speaking it is difficult to see how plenary guardianship orders are ‘the least restrictive of a person’s freedom of decision and action’ (s 6 of the Act). Further, it is arguable that plenary guardianship orders appear contrary to Article 12 of the UN Convention on the Rights of Persons with Disabilities.

If plenary guardianship orders are retained then it would appear that such orders should only be made in exceptional circumstances.
\end{quote}

8.3.9 The OPG made similar comments:

\begin{quote}
On balance, the OPG leans towardsabolishing plenary orders. It is extremely difficult to envisage a plenary order being the least restrictive option, and it is never the case that the full range of powers possible under a plenary order would be required for one represented person. It is almost unheard of, for example, for a guardian to be required to make decisions about whether and where a person should work. The OPG believes plenary orders are often made where there are multiple areas of decision-making and it
\end{quote}

\textsuperscript{577} NSWLRC, above n 24, Recommendation 9.1.
\textsuperscript{578} OPG, \textit{Annual Report 2016–2017}, 12.
\textsuperscript{579} Ibid.
\textsuperscript{580} Ibid.
\textsuperscript{581} TLRI, above n 69, Question 5.6.
seems more expedient to confer full powers rather than to consider and specify a list of powers. Orders should be tailored to the decisions needing to be made in the circumstances of the case. Even a person with profound impairments resulting in an inability to make any decisions is unlikely to need decisions to be made across all lifestyle/personal domains.

The circumstances in which a plenary order might be justifiable include extremely complex cases where there are multiple risks, no clear solutions at the time of the hearing and a high degree of problem solving required to arrive at protective measures for which a guardian’s decisions are needed. The OPG is not completely opposed to the option of plenary orders continuing, but if it is to be retained, the law should make it available only in exceptional circumstances, for a short term (perhaps 6 or 12 months) limited period and reviewable.

8.3.10 One submission\textsuperscript{582} supported retaining the Board’s ability to make full guardianship orders in appropriate circumstances. Sandra Taglieri SC commented that in cases of severe and permanent disability a full guardianship order can promote a person’s best interests by giving flexibility to deal with the likelihood of circumstances eventuating where the person’s needs may be fluctuating and variable. In these cases, it was commented that a full order would avoid the need for multiple applications to the Board. This was a particular concern in relation to consent to medical treatment in cases where:

- there was a potential for conflict between a limited guardian and the person’s represented person;
- there is confusion on the part of a limited guardian about what power he/she has; or
- where a limited guardian was concerned about acting outside of their power (so refuses or delays in giving consent) or the medical professional involved in the anticipated treatment will not provide treatment because of fear of committing an offence (s 39, despite the terms of s 40).

In cases referred to above, it was submitted that there is a risk that if a guardian is given powers that are too limited (for example, to consent to only one particular type of treatment), this can lead to difficulties if the patient’s medical condition changes or a medical practitioner recommends a supplementary investigation or treatment (for example, due to complications arising) that were not anticipated at the time of the Board’s hearing. It was noted that the patient may have already been on a wait list for treatment for some time and an order that is too limited may not be flexible enough to deal with all circumstances that arise whilst a represented person is receiving professional care. If substitute consent is unable to be provided at that time because the limited guardian believes they do not have power to give consent to that intervention, or there is conflict between the limited guardian and a person responsible, there can be resulting delay whilst a guardian applies to the Board for enlarged powers, with the potential need to then have to join a further wait list to receive the treatment. Ms Taglieri commented that this could potentially result in significant adverse consequences for a represented person and those close to them. At worst, it was noted that this could create the potential for allegations against carers or service providers in circumstances where they were aware that treatment was required but were unable to facilitate treatment due to these constraints. Ms Taglieri did observe that an application for an emergency order may be open to

\textsuperscript{582} Sandra Taglieri SC.
hopefully avoid or alleviate adverse outcomes, it is by no means certain that the application would be made and determined to ensure the represented person’s best interest.

8.3.11 Ms Taglieri further submitted that constraining the Board by removing its ability to make plenary orders comprises an interference with the function and duty of a statutory decision-maker, whose role it is to make appropriate orders based on the evidence at the hearing. It was commented that the appeals system permits scrutiny of the Board’s decisions and that this is the appropriate forum to address any grievance relating to excess power being granted in any given case. Further, Ms Taglieri commented that the making of a plenary order does not prevent a guardian from engaging in consultation and co-operative decision making with a represented person if that is possible, but it will promote the best interests of represented persons in cases of severe disability.

8.3.12 The Institute accepts these concerns but considers that, reflecting on the rights of individuals articulated in the Convention and the need to adopt the least restrictive alternative, the Board should be required to tailor its orders and only confer powers upon a representative to the extent that is necessary. This would complement Recommendation 8.1(2) which emphasises the importance of considering the ‘need’ for a representative. The intention is to ensure focus upon a proposed represented person’s circumstances and that the appointment of a representative is a last resort and only permitted where less restrictive alternatives (for example the provision of decision-making support) have been unsuccessful.

8.3.13 This reform would not eliminate the Board’s ability to make orders granting powers in relation to multiple or even all aspects of a represented person’s personal affairs if satisfied that powers in each of those areas is necessary and the least restrictive alternative to meet the represented person’s needs in the circumstances. It might be, for example, that the Board considers it appropriate to grant powers in relation to all consent to health care and treatment matters to provide a degree of flexibility where appropriate. But, for that same individual, it might be unnecessary to grant their guardian powers in relation to work, or restricting visits because of a lack of need. The Victorian Bill provides a useful example of this approach.

Recommendation 8.2

That, when conferring authority upon a representative, the Board need to be satisfied that the test for the appointment of a representative is satisfied in relation to each function conferred.

8.4 Duties of representatives

8.4.1 The Issues Paper outlined the duties of administrators and guardians separately. It asked what ought to be included within with scope of duties of each separately. Responses were broadly consistent, indicating that respondents viewed the duties of both administrators and guardians as being equivalent. The Institute proposes reform to provide a separate section within the Act articulating the duties of all representatives. This ensures that the duties of representatives are explicit and easily located. The Board’s submission also commented that the difference between a duty and a power should be made distinct. Outlining the duties of representatives within a separate section achieves this. The following paragraphs outline proposals for what should be included within the

583 Guardianship and Administration Bill 2018 (Vic) cl 30(2).
scope of a representative’s duty. Recommendation 7.9 proposes that these duties also apply to formally appointed supporters.

**Current duties of representatives**

8.4.2 The Act provides that representatives must act in accordance with the guiding principles of the Act.\(^{585}\) They are required to act at all times in accordance with a represented person’s best interests.\(^{586}\) The Act explains that this means that representatives must act as far as possible:

- in consultation with the person, taking into account their wishes, as far as possible;
- as an advocate for the person; and
- in a way that encourages the person to participate in the life of the community as much as possible.\(^{587}\)

8.4.3 The Act then separately provides that, for guardians, it also means acting as much as possible in a way that:

- encourages and assists the person to become capable of caring for themselves and making reasonable judgments; and
- protects them from neglect, abuse or exploitation.\(^{588}\)

8.4.4 The Institute notes that the National Standards for Financial Managers outline the need for administrators to:

- keep people informed about all aspects of their financial affairs in a format that is best for the person; and
- provide a represented person with every opportunity appropriate and possible to take back control of managing some or all of their financial affairs.\(^{589}\)

8.4.5 The Institute enquired what stakeholders considered ought to be included within the scope of duties of representatives.

<table>
<thead>
<tr>
<th>What duties should a guardian have? (^{590})</th>
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<tr>
<td>What duties should an administrator have? (^{591})</td>
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Answers are outlined below.

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586 Ibid ss 57(1), 27(1).
587 Ibid ss 27(2), 58(2)(b).
588 Ibid s 27(2).
590 TLRI, above n 69, Question 5.1.
591 Ibid Question 6.1.
Duty to apply the guiding principles of the Act

8.4.6 The most common response was that representatives should continue to be required to apply the Act’s guiding principles. The Institute agrees that this is fundamental to ensuring that the guiding principles govern all activities under the Act. Revised guiding principles are outlined in Recommendation 3.3.

Involving those close to the represented person

8.4.7 The second most common response was that representatives should have a duty to include those close to a represented person in decision-making. Several attendees of consultation sessions convened by Carers Tasmania expressed frustration that they felt they are at times excluded from decisions where another person is acting as a representative. Some commented that it can make it difficult to carry out their role as primary carer if they are not included in the decision-making process or kept informed of matters relevant to their role. Speak Out’s submission observed that speaking with family or someone who knows a represented person well can help to ascertain the person’s wishes.

8.4.8 This issue was also discussed in Part 3 when considering reform to the guiding principles of the Act. One of the proposed new guiding principles is that the role of families, carers and other significant persons in an adult’s life to support the adult to make decisions must be acknowledged and respected. As it is proposed that representatives have a duty to uphold the guiding principles, they would be required to act in accordance with this principle.

Duty to act with reasonable diligence

8.4.9 Three submissions referred to and supported reform to include an explicit duty upon representatives to act with reasonable diligence. The Institute supports this reform as it promotes the rights and interests of a represented person. This reform is consistent with legislative provisions in Queensland and the Northern Territory.

Duty to treat the represented person with respect and dignity

8.4.10 Three respondents supported an express duty to treat a represented person with respect and dignity. This reform is endorsed on the basis that it promotes the rights of represented people and is consistent with the principles of the Convention.

Duty to protect the represented person from violence, abuse, neglect and exploitation

8.4.11 Three respondents endorsed a duty upon representatives to protect a represented person from violence, abuse, neglect and exploitation. One of the existing elements of a guardian acting in accordance with a represented person’s best interests is protecting them from neglect, abuse or exploitation. The Institute recommends that this remain, and that it also extend to administrators.

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592 Six responses raised this.
593 Four responses raised this.
594 Guardianship and Administration Act 2000 (Qld) ss 35, 36. See also Guardianship of Adults Act 2016 (NT) s 22(1)(d).
595 Guardianship and Administration Act 1995 (Tas) s 27(2).
8.4.12 Four responses supported a duty for representatives to build a represented person’s skills and abilities. Speak Out advocates highlighted the need for capacity building and the importance of building a person’s skills and confidence so that a person can make decisions for themselves. Speak Out’s submission stated that: ‘Teaching should be part of the representative’s job and role.’

8.4.13 Currently, the Act provides that, for guardians, acting in accordance with a represented person’s best interests means encouraging and assisting them to become capable of caring for themselves and making reasonable judgments. For administrators, it means encouraging and assisting a represented person to become capable of administering his or her estate. It is proposed that the duty to build the skills and ability of a represented person remain in the Act. It ensures that representatives have an active duty to assist to improve the decision-making abilities of a represented person, with the aim of no longer needing a representative. This is one component of providing people with decision-making support.

8.4.14 Three responses stated that representatives should have a duty to keep a represented person informed about decisions and actions taken. Speak Out Advocacy also commented that ‘the Act should be clear that people need to be told if they have a guardian or administrator and who it is.’ The Institute heard many examples where people felt that a represented person was not kept adequately informed of a representative’s decisions and actions. One example shared included funds being transferred between accounts without notifying the represented person, causing them distress when later viewing their bank account summary to find funds withdrawn.

8.4.15 One of the existing components of acting in accordance with a represented person’s best interests is acting ‘in consultation with the person, taking into account their wishes, as far as possible.’ It is proposed that representatives have a duty to keep a represented person informed. This proposal strengthens the existing requirement of acting ‘in consultation’ with the person — which may be interpreted to relate primarily to a need for consultation before making a decision, without adequately signifying the importance of keeping a person informed as a decision is implemented. Ensuring that a represented person is kept informed is a critical element of treating a person with respect. Providing information is also critical to supporting a person to make their own decisions and capacity building. A duty to this effect is already captured in the National Standards for Financial Managers.

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596 By implication, this duty is also supported by the Public Trustee who submitted that it did not have any issues with the existing duties of representatives included in the Act.

597 Guardianship and Administration Act 1995 (Tas) s 27(2).

598 Ibid s 57(2)(a).

599 By implication, the Public Trustee also supported maintenance of this duty, noting in its submission that it did not have any issues with the existing duties of administrators.

600 Guardianship and Administration Act 1995 (Tas) ss 27(2)(a), 57(2)(b).

601 T Lester, above n 589.
Duty to act honestly and in good faith

8.4.16 Two responses suggested a duty upon representatives to act honestly and in good faith.602 Consistent with the VLRC’s recommendations and subsequent legislative reform proposed in Victoria,603 and statutory provisions in Queensland and the Northern Territory,604 a duty upon representatives to act honestly and in good faith is endorsed.

Duty to build a relationship with the represented person

8.4.17 Two respondents suggested that representatives should have a duty to build a relationship with the represented person. The Institute agrees, noting that, to uphold and promote a person’s will and preferences, the first step is to ascertain the person’s will and preference — a strong relationship may assist with this.605 An effective relationship may also assist with the provision of support. The Institute has not, however, recommended that this be included as a separate duty. This is because it forms an essential component of other duties proposed — notably, duties to uphold the Act’s guiding principles, to act with reasonable diligence, treat a person with respect and dignity, build their skills and abilities and keep a represented person informed.

Duty to communicate with the represented person in a way that they understand

8.4.18 Three responses supported a duty upon representatives to communicate with a represented person in a way that they understand. It is proposed that this be included as one of the duties of representatives. The intention is to promote respect, and comprises one means of supporting a represented person to make and participate in decisions.

Duty to uphold the represented person’s wishes

8.4.19 Two respondents commented upon the role of representatives in ensuring that a represented person’s wishes are upheld.

8.4.20 The Institute notes that the revised guiding principles of the Act provide that ‘the will, preferences and rights of persons who may require decision-making support must direct decisions that affect their lives.’606 The enactment of Recommendations in Part 11 would also require representatives to adopt a particular ‘decision-making process’, developed with the need to uphold and promote a person’s will and preferences as a paramount consideration.607 Part 5 also considered specific duties upon guardians to uphold a person’s wishes as conveyed in an advance care directive.608 This duty is therefore captured elsewhere.

602 The OPG’s submission (one of the two responses listed) stated that it did not object to this reform.
603 Guardianship and Administration Bill 2018 (Vic) cl 41(1)(e).
604 Guardianship and Administration Act 2000 (Qld) ss 35, 36. See also Guardianship of Adults Act 2016 (NT) s 22(1)(d).
605 Refer to the Decision-Making Process detailed at Recommendation 11.2.
606 Recommendation 3.3.
607 Recommendation 11.2.
608 Recommendation 5.8.
The Institute’s view

8.4.21 In addition to those duties identified in responses, the Institute considers it appropriate to maintain the existing requirement for representatives to act as an advocate for a represented person. One example of this was discussed in Part 5 in relation to the requirement for guardians to advocate for a person’s views and wishes contained in their advance care directive.609 The duty to act as an advocate for a represented person is also conferred in the Northern Territory.610

8.4.22 The Institute also proposes that representatives have a duty to consult with each other in circumstances where there is more than one representative appointed. This might occur where both an administrator and guardian are appointed, or where there are joint representatives appointed (for example, joint guardians). Presently the Act does not impose any obligations upon jointly appointed representatives about how they must fulfil the role jointly. In Queensland and South Australia, jointly appointed representatives are required to regularly consult and keep each other informed about substantial decisions or actions.611 Giving representatives a duty to consult with each other encourages strong communication to assist them to effectively perform their roles.

8.4.23 The Institute further proposes that the Act provide a duty upon representatives to respect a represented person’s right to privacy. Maintenance of a person’s right to privacy is an obligation under the Convention. Article 22 provides:

Article 22 – Respect for privacy

1. No person with disabilities, regardless of place of residence or living arrangements, shall be subjected to arbitrary or unlawful interference with his or her privacy, family, or correspondence or other types of communication or to unlawful attacks on his or her honour and reputation. Persons with disabilities have the right to the protection of the law against such interference or attacks.

2. States Parties shall protect the privacy of personal, health and rehabilitation information of persons with disabilities on an equal basis with others.

8.4.24 Draft legislation in Queensland provides the right to privacy as one of the general principles of its Act.612 In making suggestions for improvements to the safeguarding components of the Act, the Board submitted that:

There is often a misunderstanding from a family member or other interested person that they are entitled to information, documentation including a financial statement relating to a person’s estate from an administrator. Usually a request is made informally to the Board or Public Trustee rather than a request by virtue of section 86 of the Act. Such a request does not accord with a person’s right to privacy and the principles set out in the UN Convention. This common misunderstanding could be assisted by a reference in the Act to a person’s right to privacy.

8.4.25 Privacy considerations are addressed further in Part 12 as part of a broader discussion about safeguards for representative decision-making. As part of considering improvements to the

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609 Ibid.
610 Guardianship of Adults Act 2016 (NT) s 21(1)(b).
611 Guardianship and Administration Act 1993 (SA) s 72. See also Advance Care Directives Act 2013 (SA) s 25.
612 Guardianship and Administration and other Legislative Amendment Bill 2018 (Queensland) cl 11B, general principle 6.
Act to reflect an individual’s right to privacy, it is proposed that respecting a person’s right to privacy be one of the duties of representatives.

**Recommendation 8.3**

1. That the duties of representatives be outlined in a separate section of the Act.
2. That the duties of representatives include the following:
   a. to uphold the guiding principles of the Act;
   b. to act honestly, diligently and in good faith;
   c. to treat the represented person (the ‘person’) with respect and dignity;
   d. to communicate with the person by any means that they consider the person will be best able to understand;
   e. to keep the person informed about decisions made and steps taken by the representative as appropriate in the circumstances;
   f. to regularly consult with any other appointed representative of the person and then keep informed about substantial decisions or actions, subject to the terms of their appointment;
   g. to act as an advocate for the person;
   h. to encourage and support the person to develop their decision-making abilities where possible;
   i. to act in such a way so as to protect the person from violence, neglect, abuse or exploitation; and
   j. to respect the person’s right to privacy.

**8.5 Ending of the powers of representatives**

8.5.1 Representatives may only be appointed if a person does not have the ability to make a decision about their personal or financial circumstances. It follows that a representative’s power should end upon a represented person gaining the ability to make their own decision. The Act does not state that representatives have a duty to monitor a represented person’s ability to make their own decisions or require them to report improvements.

8.5.2 In the UK, the *Mental Capacity Act 2005* confirms that a representative does not have power to make decisions if they know or have reasonable grounds to believe that a represented person has capacity in relation to that matter. In the Irish Republic, representatives have a duty to monitor and report improvements to a person’s capacity. The Northern Territory makes it an offence for representatives to intentionally exercise their authority when the represented person does not have

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613 *Mental Capacity Act 2005* (UK) s 20(1). The NSWLRC has recently recommended a similar approach in New South Wales, proposing that legislation provide that a tribunal order appointing a representative only have effect when the represented person does not have decision-making ability for that decision: NSWLRC, above n 24, Recommendation 9.8(2).

614 Co-decision-makers, in this instance.

impaired decision-making and they are reckless about this.\footnote{Advance Personal Planning Act 2016 (NT) s 78(2).} Higher penalties apply if this conduct is undertaken with the intention of obtaining a benefit for themselves or another person.\footnote{Ibid ss 76(2), 78(4); Guardianship of Adults Act 2016 (NT) s 86(2).} The QLRC supported this approach.\footnote{QLRC, above n 25, Recommendation 15-1.}

8.5.3 The Issues Paper asked stakeholders the extent to which the Act should outline obligations and duties upon representatives to monitor a represented person’s decision-making abilities during the course of their appointment.

| (i) Should representatives have a duty to monitor a represented person’s capacity whilst they are acting? | (ii) Should the Act state that representatives may only make decisions when a represented person does not have decision-making capacity?\footnote{TLRI, above n 69, Question 4.4.} |

**Duty to monitor a represented person’s abilities**

8.5.4 Most respondents\footnote{Ten out of 14 responses.} supported introduction of a duty upon representatives to monitor a represented person’s decision-making ability whilst acting or appointed to the role. The Board stated that this requirement is already implicit in the Act. Speak Out submitted ‘[p]eople shouldn’t make decisions if they think the person can make them.’

8.5.5 The OPMHS commented that it did not consider that the need for representatives to monitor a represented person’s capacity is consistent with the position that assessment of a person’s abilities is a matter for professional assessment. Advocacy Tasmania also expressed concern about the potential need for a represented person to then regularly submit to a capacity assessment:

> A representative should have a duty to continue to support a person to make decisions and to give effect to the person’s will and preferences. We do not believe an ongoing capacity assessment is an appropriate way to undertake this.

8.5.6 Social Work Services RHH also raised the question of what is meant by ‘monitoring’ a person’s capacity and the frequency with which this should be required.

8.5.7 The proposed Decision-Making Process outlined at Recommendation 11.2 addresses this issue. It requires representatives to consider whether there is a need for a representative decision which involves consideration of a represented person’s own ability to make a decision. It also requires a representative to consider the person’s ability to make their own decision with support, including offering the person that support. The Decision-Making Process then requires a representative to consider whether they believe that the represented person may be able to make their own decision in the future and if so, whether there would be any detriment caused in deferring a decision until that point. Each of these stages of the Decision-Making Process involves consideration of the represented person’s ability to make their own decision.
Duty to report to the Board about a represented person’s decision-making ability

8.5.8 Some respondents suggested that Board-appointed representatives should have a duty to advise the Board if they consider that a represented person’s decision-making ability has improved and they are able to make their own decisions. The Board informed that it advises representatives that they should apply for the review of an order if they believe that a represented person is able to make their own decisions.

8.5.9 The OPG submitted that, in addition to a requirement to advise the Board when a person’s decision-making ability has improved, a representative should need to do so if they consider that there is no longer a need for an appointment — as the test to appoint a representative involves other factors in addition to assessment of the person’s abilities.

8.5.10 The Institute agrees with the OPG’s submission to ensure that orders appointing representatives do not last any longer than necessary. A decision or series of decisions taken by a representative following their appointment may satisfactorily address the relevant need. For example, a representative might establish direct debit payment arrangements, or make a decision in relation to a represented person’s move to alternative accommodation. Once those decisions have been implemented, there may no longer be a need for a representative. Whilst Recommendation 12.15 proposes that the Board be required to take this matter into account when determining the duration of an order, this further measure promotes orders appointing representatives only lasting for as short a duration as possible.

Recommendation 8.4
That the Act require Board-appointed representatives to apply to the Board for the review of an order if they consider that the test for the appointment of a representative would no longer be met.

8.6 Death of a representative

8.6.1 The Institute asked for views about whether the Act needs to be revised to deal with what happens when a representative dies. The Issues Paper commented that the death of a representative could create a situation where the represented person does not have a representative available to make decisions. Where a decision needed to be made urgently, this could result in a need to apply to the Board for an emergency order.

Should the Public Trustee or Public Guardian be automatically appointed as a temporary representative upon the death of a representative?621

8.6.2 The Institute understands that this situation is rare and was not informed of any examples where this had caused a problem. The matter can already be resolved urgently if required, by making an emergency order appointing the Public Trustee or Public Guardian. Having a default but temporary appointment of the Public Trustee or Public Guardian would not, therefore, have any meaningful benefit, other than avoiding an application to the Board. The Board commented that:

It appears a cumbersome process that on the death of a guardian or an administrator appropriate records need to be provided to the Public Guardian and/or Public Trustee for a short period of time and then returned to another family member who satisfies the

621 TLRI, above n 69, Question 4.5.
eligibility test for appointment in the Act (section 54), just in case decisions may need to be made.

8.6.3 The situation can be mitigated by the Board making flexible orders, for example, by appointing joint or substitute representatives to act where a representative dies or is otherwise unable to act. The default appointment of a temporary representative is contrary to the principle that a representative should only be appointed for a person if there is a need. The appointment of a representative should also consider the views, wishes and preferences of the represented person — a default appointment would not achieve this. As the Public Trustee observed in its submission, these circumstances justify a fresh look at the order.

8.7 Rights of representatives

8.7.1 Parts 9 and 10 deal separately with the rights of guardians and administrators. One matter that is relevant to both is their right to access information. The right to access a represented person’s Will is also relevant to both, but is considered in Part 12 in relation to safeguards more broadly.

8.7.2 As noted in the Issues Paper, the Act sets out explicitly the rights of enduring guardians to access information. An equivalent provision is not included in relation to Board-appointed guardians or administrators. The Powers of Attorney Act includes an equivalent section dealing with the rights of an attorney to access information. The OPG’s submission stated that equivalent provisions should be included in legislation in relation to representatives’ rights to information however appointed (ie, whether by the Board or an individual). The Institute agrees that it is appropriate that the Act provide representatives with equivalent powers and rights in relation to accessing information.

Recommendation 8.5

That the rights of enduring guardians to access information in s 32B(1) of the Act also be included for Board-appointed guardians and administrators.

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622 Refer to [12.9.22]–[12.9.27].
623 TLRI, above n 69, [5.5.2].
624 Guardianship and Administration Act 1995 (Tas) s 32B.
625 Powers of Attorney Act 2000 (Tas) s 32AA.
Part 9

Functions and Powers of Guardians

9.1 Introduction

9.1.1 The Terms of Reference asked the Institute to consider:

- how the role of guardians advances the interests of people with impaired capacity; and
- the need to ensure that the powers and duties of guardians are effective, appropriate, and advance the interests of people with impaired capacity.

9.1.2 This Part reviews the powers given to guardians in the Act and proposes reform to these provisions in light of the Convention and developments in policy, law and practice.

9.2 Powers of guardians

9.2.1 Currently, guardians are appointed if a person is unable to make a reasonable judgment about their ‘person or circumstances’. The Act does not define ‘person or circumstances’. Other jurisdictions describe the role of a guardian as relating to a person’s personal or lifestyle affairs, care and welfare. The Institute considers that, to better describe the role using plain English, the role be described as relating to a person’s ‘personal matters’. This is also the term that the Powers of Attorney Act uses.

Recommendation 9.1

That the Act describe the scope of a guardian’s role as relating to ‘personal matters’.

9.2.2 The Act describes the powers of full guardians as being consistent with the powers that a parent has in relation to their child. The VLRC described this as an outdated description and recommended it be removed. It does not appear in the revised Victorian Bill.

9.2.3 The Institute sought views about whether the description of the role of a guardian being akin to that of a parent ought to be removed from the Act.

626 Guardianship and Administration Act 1995 (Tas) s 20(1)(b).
627 See for example Powers of Attorney Act 2014 (Vic) s 3(1).
628 Advance Personal Planning Act 2016 (NT) s 16(2). The NSWLRC has recommended that the term ‘personal decision’ be used: NSWLRC, above n 24, Recommendation 4.4.
629 Powers of Attorney Act 2000 (Tas) s 31(2C).
630 Guardianship and Administration Act 1995 (Tas) s 25(1). The VLRC commented in relation to this expression that: ‘This characterisation is both demeaning and unhelpful. It arguably perpetuates the ‘eternal child’ image of a person whose decision-making capacity is severely impaired. In addition, the description of a plenary guardian as a person who has the same powers as those that they would have if the represented person were their child is unhelpful given the fluid nature of the powers that a parent may exercise in relation to a child who has not yet reached maturity’: VLRC, above n 24, [12.154].
631 VLRC, above n 24, [12.16].
Part 9: Functions and Powers of Guardians

Should the description that a guardian’s powers and duties are akin to those ‘that a parent has over a child’ be removed? 632

9.2.4 There was overwhelming support for this reform. Respondents commented that, apart from perpetuating paternalistic notions of guardianship, it also does not in fact assist to explain the role. It was observed that the role that a parent plays in relation to decision-making for their child depends, amongst other things, upon the particular relationship and the child’s age. It was considered unhelpful to make broad generalisations about the role that a parent has in relation to a child.

9.2.5 The Institute considers that the description of having authority over ‘personal matters’, along with inclusion of a non-exhaustive list of powers of guardians, adequately describes the role and that this description does not add to public understanding.

**Recommendation 9.2**

That the description in the Act that a guardian has a role akin to that of a parent in relation to a child be removed.

**List of powers of guardians**

9.2.6 The Act lists the powers of a full guardian as including:

- deciding where a person lives whether permanently or temporarily;
- deciding with whom a person lives;
- deciding whether a person should work and related matters;
- restricting visits on behalf of a represented person where it is in their best interests, and prohibiting visits where the guardian reasonably believes that they would have an adverse effect on the person; and
- consenting to health care that is in the best interests of the person, or refusing or withdrawing consent to any such treatment. 633

9.2.7 The *Powers of Attorney Act* defines a ‘personal matter’ as also including:

- education or training;
- applications for a licence or permit, other than for business or commercial reasons; and
- day to day matters relating to diet, recreation, hobbies, companions, pet ownership, sexual expression, dress, hairstyle, with whom a person associates, or clubs, associations or political parties the person may join. 634

9.2.8 The Issues Paper gave examples of other functions of guardians conferred in other jurisdictions, including:

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632 TLRI, above n 69, Question 5.3.
633 Guardianship and Administration Act 1995 (Tas) s 25(2).
634 Powers of Attorney Act 2000 (Tas) s 31(2C).
9.2.9 The Act does not presently refer to litigation as one of the roles of a guardian. The Board’s guidelines, however, note that it may be within the scope of a guardian’s power to conduct litigation where legal proceedings relate to non-financial matters. Non-financial matters might include applications for restraint orders, Family Court children’s matters or child protection matters.

9.2.10 The Institute asked whether the list of powers of a guardian needs to be revised, and if so, how. It also asked specifically about reform in relation to guardians’ powers to conduct litigation.

(i) Does the list of powers of a guardian need to be revised, and if so, how?
(ii) Should the list confirm guardians’ powers to conduct litigation?

9.2.11 There were 10 responses to the first question. Some responses indicated that there is no need to revise the existing list of powers. Two submissions raised the issue of guardians’ powers to access a represented person’s Will. This is addressed in Part 12.

9.2.12 Suggestions to revise to the list of powers of guardians included:

- making the list clearer;
- reducing the powers of guardians;
- clarifying powers in relation to restricting a person’s travel and movement, for example, by removing passports; and
- confirming the extent and scope of guardians’ powers in relation to detention and other restrictive practices. (These matters are addressed in Parts 13 and 17).

The OPG commented:

Guardians can also be requested to make decisions on day-to-day matters which would normally be minor and not require a substitute decision. Such matters might include the person’s diet and smoking (although such decisions might fall under health care consent); recreational pursuits; dress; hairstyle; access to the phone and internet; and pet ownership or relinquishment … We do not advocate that these types of decisions should be included in the list as they are only very rarely required, but consideration could be given...

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635 Guardianship and Administration Act 2000 (Qld) sch 2 s 2.
636 Guardianship of Adults Act 2016 (NT) s 16(2).
638 TLRI, above n 69, Question 5.4.
639 Refer to [12.9.22]–[12.9.27].
to the need for the Board, on occasion, to give a very specific power in relation to one (or more) of these daily living issues.

Subsection 25(2)(c) rather prominently sets out various decisions a guardian could make in relation to a represented person’s work. These powers are rarely (almost never) granted and consideration should be given to removing them from the list, or at the very least distilling them into single line.

9.2.13 There were six responses to the second question asking whether the Act should explicitly provide a power for guardians to conduct litigation. All endorsed this reform, with the Board noting that provisions to this effect are included in the ACT and WA legislation.

9.2.14 The Institute proposes revisions to the existing list of powers of guardians reflecting submissions received. To clarify what is meant by a ‘legal matter’, it is proposed that the Act define the term to include retaining legal services and bringing and defending a legal proceeding or hearing in a court, tribunal or other body, consistent with the recent Victorian Bill.  

Recommendation 9.3

(1) That ‘personal matters’ be defined to include:

- deciding where and with whom a represented person lives whether permanently or temporarily;
- restricting visits on behalf of a represented person where it promotes their personal and social wellbeing, and prohibiting visits where the guardian reasonably believes that it would have an adverse effect on the person;
- consenting to, or refusing or withdrawing consent to health care and treatment other than special treatment;
- deciding upon education, training, and work arrangements of a represented person; and
- legal matters that relate to personal matters.

(2) That ‘legal matter’ be defined to include:

- the use of legal services for a represented person’s benefit; or
- bringing or defending a legal proceeding or hearing in a court, tribunal or other body on behalf of the person.

Meaning of ‘health care’

9.2.15 The Act gives powers to guardians to consent to ‘health care’. The term is not defined. The same sub-section then goes on to provide that guardians may also refuse or withdraw consent to ‘any such treatment’. This language creates ambiguity about what comprises ‘medical treatment’ and what comprises ‘health care’ and the extent to which these terms differ.

9.2.16 In South Australia, the term ‘health care’ is used and is defined as follows:

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Guardianship and Administration Bill 2018 (Vic) cl 3.
‘health care’ means any care, service, procedure or treatment (including medical treatment) provided by, or under the supervision of, a health practitioner for the purpose of diagnosing, maintaining or treating a physical or mental condition of a person;\(^{642}\)

‘health practitioner’ means a person who practises 1 or more of the following:

(a) a health profession (within the meaning of the Health Practitioner Regulation National Law (South Australia));

(b) any other profession or practice declared by the regulations to be included in the ambit of this definition.\(^{643}\)

9.2.17 In Queensland, the term ‘health care’ is used and is defined as follows:

(1) Health care, of an adult, is care or treatment of, or a service or a procedure for, the adult:

(a) to diagnose, maintain, or treat the adult’s physical or mental condition; and

(b) carried out by, or under the direction or supervision of, a health provider.\(^{544}\)

9.2.18 In the Northern Territory, ‘health care’ is defined as follows:

‘health care’ means health care of any kind, including:

(a) anything that is part of a health service, as defined in section 5 of the Health Practitioner Regulation National Law; and

(b) the removal of tissue from a person’s body in accordance with Part 2 of the Transplantation and Anatomy Act.\(^{645}\)

9.2.19 The NSWLRC recommend the following revised definition of ‘health care’:

(1) ‘Healthcare’ includes

(a) any care, service, procedure or treatment provided by, or under the supervision of, a registered health practitioner for the purpose of diagnosing, maintaining or treating a physical or mental condition of a person

(b) in the case of healthcare in the course of a medical research procedure – the giving of placebos, and

(c) any other act declared by the regulations to be healthcare.


(3) ‘Registered health practitioner’ means a person who practises in:

(a) a health profession within the meaning of the Health Practitioner Regulation National Law (NSW), and/or

(b) any other profession or practice as declared by the regulations.\(^{646}\)
9.2.20 In Victoria, the term ‘medical treatment’ is used but is defined to include treatments performed by health practitioners:

medical treatment means any of the following treatments of a person by a health practitioner for the purposes of diagnosing a physical or mental condition, preventing disease, restoring or replacing bodily function in the face of disease or injury or improving comfort and quality of life—

(a) treatment with physical or surgical therapy;
(b) treatment for mental illness;
(c) treatment with—
   (i) prescription pharmaceuticals; or
   (ii) an approved medicinal cannabis product within the meaning of the Access to Medicinal Cannabis Act 2016;
(d) dental treatment;
(e) palliative care— but does not include a medical research procedure.

9.2.21 Presently, under the Act, for the purpose of confirming who may complete a Health Care Professional Report for the Board, the Act defines ‘Registered practitioner’ as ‘a person who is a medical practitioner or person registered under the Health Practitioner Regulation National Law (Tasmania) in the dental profession as a dentist.’

9.2.22 The Institute sought feedback about whether, and how, the phrase ‘health care’ ought to be defined.

(i) Does the term ‘health care’ need to be defined?

(ii) If so, how should it be defined?

9.2.23 There were 12 responses to this question with a range of responses received. It was generally considered that the current approach of using both terms ‘health care’ and ‘medical treatment’ without defining what ‘health care’ is creates confusion and that it would be beneficial to provide clarity. The Board commented that, if both terms remain, then the distinction should be made clear.

9.2.24 Seven respondents supported the term ‘health care’ being used and defined. The OPG instead suggested that the phrase ‘health care and medical treatment’ be used, to capture both matters and removing the distinction between the terms. COTA considered that the term health care should not be used, and that ‘medical treatment’ should be used as a more precise term.

9.2.25 Answers to the following question in Part 10 also contained statements about the distinction between health care and medical treatment:

647 ‘Health practitioner’ is defined to include ‘a registered health practitioner’, with this term defined as follows: ‘registered health practitioner has the same meaning as it has in the Health Practitioner Regulation National Law: Medical Treatment Planning and Decision Act 2016 (Vic) s 3.
648 Medical Treatment Planning and Decision Act 2016 (Vic) s 3.
649 Guardianship and Administration Act 1995 (Tas) s 3.
650 TLRI, above n 69, Question 5.5.
9.2.26 In response to this question, the Board submitted that:

The Board’s view is that clarification is required of the meaning of ‘medical treatment’ to include ‘matters relating to health care’ more broadly, as has been adopted in the Guardianship and Administration Act 2000 (Qld) schedule 2 para 5(1). This proposal for redefining ‘medical treatment to include ‘health care’ is being considered by other jurisdictions. It recognises the need for clarification and, if necessary, regulation of what is commonly occurring in practice in the decision making of persons responsible.

9.2.27 The MHT instead submitted that the Act should not adopt the Queensland definition of health care:

The definition of medical treatment is limited to procedures, operations and examinations carried out by a medical practitioner. The Act requires a definition of examination and should exclude procedures, operations, examinations and assessments relating to the treatment of mental illness.

It is noted at [10.2.10] (page 112) that other jurisdictions have differing definitions of medical treatment. For example, in Queensland, ‘the phrase “matters relating to health care” is used. Health care is defined broadly to mean care or treatment of, or a service or a procedure for an adult to diagnose, maintain, or treat a person’s physical or mental condition’ …

The adoption of this definition in Tasmania would not be supported by the Mental Health Tribunal as it includes the treatment of an adult with a mental condition. This should be excluded under any definition of health care.

9.2.28 The OPG submitted that:

The OPG has a firm view that the definition of medical treatment should be termed ‘health care and treatment’ and broadened to include other health care provided by or under the supervision of a health practitioner as defined by the Health Practitioner Regulation National Law. This includes dental practitioners so dental treatment would not, then, require a separate definition…

The OPG believes the definition of health care and treatment should refer to the assessment, diagnosis, treatment, management and prevention of physical and mental conditions, and should specifically include the admission to and discharge from treatment facilities and hospitals.

To avoid the potential for any confusion or overlap, the Act needs to be explicit that treatment covered under the Mental Health Act is precluded.

9.2.29 Dr Lisa Eckstein commented:

The term ‘medical and dental treatment’ is currently unclear and warrants definition. I support including a relatively broad statutory definition for the term, including expressly extending it to cover matters that are incidental to treatments. Guardians also need a clear power to consent to health care that goes beyond treatment and matters incidental to treatment. This could include, for example, nursing care—such as tooth brushing and other hygiene interventions.

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651 Ibid Question 10.3.
652 This matter is addressed in Part 14.
9.2.30 Based on a majority of submissions received, the Institute considers it both appropriate and necessary to redefine the powers of guardians (and persons responsible) to clarify their powers in relation to what has been termed ‘medical treatment’ and ‘health care’. Consistent with the OPG’s submission, it is proposed that the term ‘health care and treatment’ be used, and that the term be defined. It is suggested that the single term ‘health care and treatment’ be used to describe the powers of both guardians and persons responsible. This ensures that guardians and persons responsible have complementary powers, enabling a person or the Board to appoint a guardian to avoid the otherwise default powers of persons responsible and removing the current gap in relation to ‘health care’.

9.2.31 Several submissions provided suggestions about what ought to be included within the definition of ‘health care’. The OPMHS submitted that:

it needs to be clarified whether it [health care] includes decisions around attending healthcare appointments, spending time in a hospital, including whether the guardian can consent to a stay in a secure unit (either hospital or e.g. residential aged care facility) for care and treatment.

9.2.32 PCT submitted that:

For people with life limiting illnesses, the definition in the Act should incorporate the following:

Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual – World Health Organization.

9.2.33 MIGA commented that ‘[i]t is important to develop a definition which reflects the variety of actions which constitute healthcare, including assessment, investigation, care and treatment.’ It supported the Northern Territory approach of defining health care by reference to s 5 of the Health Practitioner Regulation National Law (Queensland), being services provided by registered health practitioners. As noted above, the OPG also endorsed this approach. Under the Health Practitioner Regulation National Law, ‘health practitioner’ means an individual who practices a ‘health profession’. Health profession is defined to mean the following professions, including a recognised specialty in any of the following professions:

- Aboriginal and Torres Strait Islander health practice;
- Chinese medicine;
- chiropractic;
- dental (including the profession of a dentist, dental therapist, dental hygienist, dental prosthetist and oral health therapist);
- medical;
- medical radiation practice;

653 Health Practitioner Regulation National Law (Queensland) s 5 definition of ‘health practitioner’, incorporated by reference in the Health Practitioner Regulation National Law (Tasmania) Act 2010 (Tas) s 3(2).
• nursing and midwifery;
• occupational therapy;
• optometry;
• osteopathy;
• pharmacy;
• physiotherapy;
• podiatry; and
• psychology.\(^{654}\)

9.2.34 ‘Health service’ is defined as follows:

\textit{health service} includes the following services, whether provided as public or private services:

(a) services provided by registered health practitioners;
(b) hospital services;
(c) mental health services;
(d) pharmaceutical services;
(e) ambulance services;
(f) community health services;
(g) health education services;
(h) welfare services necessary to implement any services referred to in paragraphs (a) to (g);
(i) services provided by dietitians, masseurs, naturopaths, social workers, speech pathologists, audiologists or audiometrists;
(j) pathology services.\(^{655}\)

9.2.35 Consistent with approaches in other jurisdictions, and as supported by respondents to the Issues Paper, the Institute proposes that the term ‘health care and treatment’ be defined by reference to the Health Practitioner Regulation National Law. Consistent with the MHT’s submission, assessment and treatment for mental illnesses covered by the \textit{Mental Health Act} is excluded from the proposed definition. Discussion about whether consent to admission in a secure facility should be included within the definition is addressed separately in Part 14.\(^{656}\)

\(^{654}\) Ibid, definition of ‘health profession’.
\(^{655}\) Ibid, definition of ‘health service’.
\(^{656}\) Refer to [14.6].
Recommendation 9.4

(1) That the terms ‘medical treatment’ and ‘health care’ as used in the Act be replaced with the single term ‘health care and treatment’.

(2) That ‘health care and treatment’ be defined to include ‘health care’ of any kind, including:
   (a) anything that is part of a health service within the meaning of the Health Practitioner Regulation National Law;
   (b) an intimate forensic procedure and a non-intimate forensic procedure normally carried out by a person authorised to carry out the procedure under s 40 of the Forensic Procedures Act 2000 (Tas); and
   (c) any other act declared by the Regulations to be health care and treatment for the purposes of the Act.

(3) That the term ‘health care and treatment’ exclude the assessment and treatment of mental illness given to a patient under the Mental Health Act 2013 (Tas) and any other matter that is declared by the Regulations to not be health care and treatment.

(4) That the term ‘health practitioner’ be defined to mean a health practitioner within the meaning of the Health Practitioner Regulation National Law, and any other profession prescribed in the Act’s Regulations.

9.3 Matters outside of a guardian’s authority

9.3.1 The Act does not list matters that fall outside of a guardian’s authority. A list may help individuals to understand the limits of the powers of representatives.657 Some jurisdictions list matters that fall outside of a guardian’s power.658 This includes, most recently, amendments proposed in Victoria under the Guardianship and Administration Bill.659

9.3.2 The Institute asked whether it would be beneficial for the Act to provide a list of matters that fall outside of the powers of a guardian.

Should the Act list matters that a guardian does not have power over?660

9.3.3 Most respondents endorsed the Act containing a list of matters that are excluded from a guardian’s power. This was supported on the basis that it gives clarity to the role and provides consistency with other jurisdictions. The OPG stated that the list should include decisions about marriage and divorce, voting, care of a represented person’s children, making, revoking or amending Wills, powers of attorney and advance care directives.

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657 ALRC, above n 66, [5.73], Recommendation 5-1(f).
658 Powers of Attorney Act 2014 (Vic) s 26; Guardianship and Administration Act 2000 (Qld) pt 2 sch 2; Guardianship and Management of Property Act 1991 (ACT) s 7B; Guardianship and Administration Act 1990 (WA) s 45(3); Guardianship of Adults Act 2016 (NT) s 24.
659 Guardianship and Administration Bill 2018 (Vic) cl 39. The NSWLRC has also recently recommended that legislation confirm those matters falling outside the scope of a representative’s authority: NSWLRC, above n 24, Recommendation 8.6(4).
660 TLRI, above n 69, Question 5.8.
9.3.4 Two submissions did not support the Act containing a list of excluded matters. Members of the Elder Law Committee considered that it would be difficult for this list to be exhaustive and that a guidebook for guardians would be the better forum to include a list. Another respondent considered the reform unnecessary.

9.3.5 The Institute is of the view that providing lists of matters that fall outside of the powers of a representative can assist to promote understanding of the nature and extent of the role. It may avoid a representative inadvertently acting outside of their powers due to a lack of understanding. It also ensures that members of the public understand those powers that are outside of the authority of a guardian. The Institute endorses examples of excluded matters articulated in other jurisdictions’ legislation and in Tasmania within the *Powers of Attorney Act*. It is proposed that the list explicitly confirm, to avoid confusion, that a representative does not have power to act following the death of a represented person.

9.3.6 In light of the comments of members of the Elder Law Committee, it is suggested that the statutory list be expressed as being non-exhaustive.

**Recommendation 9.5**

That the Act provide a non-exhaustive list of matters that fall outside the authority of a guardian, including:

- those matters within the scope of an administrator’s authority;
- consenting to, or refusing or withdrawing consent to special treatment (unless giving consent to the continuation of special treatment is approved by the Board);
- consenting to assessment and treatment for mental illness covered by the *Mental Health Act 2013* (Tas);
- making, revoking, or amending a represented person’s Will, enduring power of attorney, instrument, or advance care directive;
- voting on behalf of a represented person;
- consenting to marriage or the dissolution of marriage or significant relationship, or a sexual relationship of the represented person;
- making decisions about the care and wellbeing of a represented person’s child;
- consenting to the adoption of children, surrogacy arrangements and parenting orders;
- acting after the death of the represented person;
- disciplining, chastising or punishing the represented person; or
- consenting to an unlawful act.

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661 *Powers of Attorney Act 2000* (Tas) ss 31(2B), 31(2C).
9.4 Rights of guardians

9.4.1 The Issues Paper asked whether there needs to be any other reform to the rights of guardians contained in the Act.

<table>
<thead>
<tr>
<th>Should guardians have any other or different rights?</th>
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</table>

9.4.2 Submissions addressing this question raised representatives’ access to a represented person’s Will (addressed in Part 12\(^663\)), and rights in relation to information (addressed in Part 8\(^664\)).

9.5 Other reforms?

9.5.1 The Issues Paper asked whether there are any other ways that provisions governing the powers and duties of guardians could be improved.

<table>
<thead>
<tr>
<th>How else could the Act be improved in relation to the powers and duties of guardians?</th>
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9.5.2 Responses received have been captured elsewhere in this Report as follows:

- that legislation should confirm whether an enduring guardian or guardian has priority in circumstances where both are appointed.\(^666\) This matter was addressed in Part 4\(^667\).
- that the Act confirm the priority of an ACD over the decisions of a representative.\(^668\) This matter is addressed in Parts 5 and 11\(^669\).
- that a guardian should be able to withdraw from the position.\(^670\) This matter was addressed in Part 4 in relation to enduring guardians.\(^671\) Board-appointed guardians are already able to resign by applying to the Board for the review of an order on the basis that they are unwilling to act.\(^672\)
- that the identification, inclusion, support and education of carers when someone else is required to make decisions on behalf of a person would improve outcomes.\(^673\) Recommendation 3.3 proposes reform to the Act to provide as one of its guiding principles the importance of acknowledging the role of carers and others significant in a person’s life;
- that advice, information and support should be provided for private representatives to develop their skills.\(^674\) Maintaining documentation and providing reports, and to confidently

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\(^{662}\) TLRI, above n 69, Question 5.7.
\(^{663}\) See [12.9.22]–[12.9.27].
\(^{664}\) See [8.7].
\(^{665}\) TLRI, above n 69, Question 5.9.
\(^{666}\) OPG.
\(^{667}\) See Recommendation 4.18.
\(^{668}\) COTA.
\(^{669}\) See Recommendations 5.6 and 11.2.
\(^{670}\) PCT.
\(^{671}\) See Recommendation 4.15. See also Guardianship and Administration Act 1995 (Tas) s 34(1)(a).
\(^{672}\) Guardianship and Administration Act 1995 (Tas) ss 67, 68.
\(^{673}\) Carers Tasmania.
\(^{674}\) Carers Tasmania, with other submissions also raising this matter.
interact with review processes were given as examples. Education, the use of guidebooks and plain English were also suggested as means to assist representatives. The need for education is addressed in Part 18;\textsuperscript{675} and

- the Board raised the issue of consent to restrictive practices,\textsuperscript{676} which is addressed in Part 17.\textsuperscript{677}

9.5.3 EOT stated that:

Whilst much of the detail with regard to these issues is more relevant to those with direct responsibility for the appointment and management of representative decision makers, we are strongly supportive of transparent procedures for determining whether a representative should be appointed, the terms of that appointment and arrangements for review of that appointment.

This matter is addressed throughout this Report.\textsuperscript{678}

\textsuperscript{675} See [18.2.9]–[18.2.20].
\textsuperscript{676} Including, for example, removing a person’s passport or mobile phone — matters that the OPG also raised in its submission.
\textsuperscript{677} See [17.4].
\textsuperscript{678} See Parts 8, Part 12.
Part 10

Functions and Powers of Administrators

10.1 Introduction

10.1.1 The Institute’s Terms of Reference asked for consideration of:

- how the role of administrators advances the interests of people with impaired capacity; and
- the need to ensure that the powers and duties of administrators are effective, appropriate and advance the interests of people with impaired capacity.

10.1.2 Part 8 reviewed and made recommendations about the duties of representatives. This Part reviews the powers given to administrators in the Act and makes recommendations for reform.

10.2 Powers of administrators

10.2.1 An administrator has power to do anything that a represented person could have done in relation to their ‘estate’ if not under a legal disability.679 The term ‘estate’ is not defined.680 The term ‘property and affairs’ is used in the Powers of Attorney Act. Feedback to the Institute commented that the term ‘estate’ does not clearly describe the powers of an administrator, particularly because the term ‘estate’ is often used in reference to a person’s assets after death. The Board endorsed use of plain English and terms that are likely to be broadly understood within the community. Members of the Elder Law Committee submitted that ‘[a] definition of ‘estate’ should be included and use terms such as financial affairs to create clarity of role.’

10.2.2 The Institute proposes that the Act use the term ‘financial and property matters’, and that an equivalent reform is made to the Powers of Attorney Act to provide consistency. The term ‘financial and property matters’ adopts commonly used language and avoids ambiguity or uncertainty.681 It clarifies that it encompasses financial transactions as well as dealings with real property. The term ‘matters’ provides consistency with proposed reforms in relation to the powers of guardians which would be described as ‘personal matters’.682

Recommendation 10.1

That the authority of administrators be described in the Act as relating to ‘financial and property matters’.

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679 Guardianship and Administration Act 1995 (Tas) s 56(1)(c).
680 See ibid s 3.
681 This proposal is linked to Recommendation 18.2, proposing that the Act be made as accessible as possible, including through use of plain English.
682 See Recommendation 9.1.
List of powers

10.2.3 The Act provides a non-exhaustive list of the powers of administrators. There are differences between this list and the powers of an attorney listed in the Powers of Attorney Act. These include:

- an attorney may enter into a lease with unlimited duration. An administrator may only enter into a lease for a maximum of five years;
- the list of attorneys’ powers includes power to renounce a person’s rights to apply for a grant of probate or grant of letters of administration; and
- the list of attorneys’ powers includes powers in respect of superannuation.

10.2.4 The Issues Paper also listed other powers included in other jurisdictions, including:

- holding a licence or permit;
- obtaining or surrendering insurance for the adult (in addition to their property);
- continuing investments, including taking up rights to issues of new shares or options for new shares to which the person becomes entitled by their existing shareholding;
- retaining any existing investments that are not authorised trustee investments;
- purchasing or retaining property as a joint tenant or tenant in common;
- granting powers of attorney to another person to do any act or thing that the administrator has power to do;
- suffering judgment or consenting to any judgment or order in an action or proceedings;
- surrendering, assigning, or otherwise disposing of onerous property, without consideration;
- lodging caveats over land; and
- applying for a grant of letters of administration or probate and acting as an administrator or executor.

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683 Guardianship and Administration Act 1995 (Tas) s 56(2).
684 Powers of Attorney Act 2000 (Tas) s 31(2A)(c); cf Guardianship and Administration Act 1995 (Tas) s 56(2)(c).
685 Powers of Attorney Act 2000 (Tas) ss 31(2A)(k), (l).
686 Ibid s 31(2A)(j).
687 Advance Personal Planning Act 2016 (NT) s 16(2).
688 Ibid s 16(2); Powers of Attorney Act 2014 (Vic) s 3(1); Guardianship and Administration Act 1993 (SA) s 39(2)(b).
689 Powers of Attorney Act 2014 (Vic) s 3(1); Guardianship and Administration Act 1993 (SA) s 39(2)(s).
690 Guardianship and Administration Act 1993 (SA) ss 39(5), (4); Guardianship and Administration Act 2000 (Qld) s 51.
691 Guardianship and Administration Act 1993 (SA) s 39(2)(b); Guardianship of Adults Act 2016 (NT) s 29(3).
693 Ibid s 39(2)(j).
694 Ibid s 39(2)(q).
695 Ibid s 39(2)(v).
10.2.5 The House of Representatives also endorsed representatives having power to renew, or make, binding death benefit nominations in relation to a person’s superannuation.  

10.2.6 The Issues Paper asked whether the list of powers of an administrator needs to be revised.  

**Does the list of powers of an administrator need to be revised and if so how?**

10.2.7 The Board submitted:

A revision of the list of powers could consider the language used in section 56 of the Act, ensuring it is clear and not legalistic and could include more everyday financial functions such as insuring the person’s property; withdrawing money from, or depositing money into a person’s account with a financial institution.

10.2.8 Both the Board and Social Work Services RHH raised the need for clarity between the respective roles of administrators and guardians in relation to litigation. This was addressed in Part 9.  

Recommendation 9.3 proposes that a guardian’s role may include participating in legal proceedings involving non-financial matters on behalf of a represented person. It is proposed that a complementary reform be made to the list of powers of administrators, confirming that their powers extend to litigation involving financial and property matters.

10.2.9 Other responses endorsed consistency between the provisions of the *Powers of Attorney Act* and the Act to provide mirror powers for attorneys and administrators.

10.2.10 Speak Out members submitted that ‘[a]n administrator shouldn’t be allowed to sell things you own without your permission while you are alive.’

10.2.11 The Institute agrees with these submissions and proposes reform to provide clarity and consistency with other jurisdictions. As a non-exhaustive list, there may be additional matters conferred upon administrators despite not being included in this list.

### Recommendation 10.2

1. That the existing non-exhaustive lists of powers of administrators in s 56(2) of the Act and powers of attorneys in s 31(2A) of the *Powers of Attorney Act 2000* (Tas) be made consistent.

2. That both the Act and the *Powers of Attorney Act 2000* (Tas) clarify that administrators and attorneys’ powers extend to legal matters relating to financial and property matters.

3. That the lists of matters falling within the scope of an attorney’s and administrator’s authority be revised to avoid use of legalistic terms and to include:
   - description of more day-to-day financial transactions for example, insuring a person’s property, withdrawing money from, or depositing money into a represented person’s account with a financial institution;
   - power to apply for and hold a license or permit;

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697 House of Representatives Standing Committee on Legal and Constitutional Affairs, above n 264, Recommendation 15.

698 TLRI, above n 69, Question 6.3.

699 See [9.2.6]–[9.2.14].

700 Five submissions were received in response to this question.
obtaining or surrendering insurance for the represented person;  
as exceptions to the power to invest money in any manner in which a trustee may invest,  
power to:  
  ○ retain any of the represented person’s existing investments that are not authorised trustee investments, including taking up rights to issues of new shares or options for new shares to which the person becomes entitled by their existing shareholding; and  
  ○ retain property owned by the represented person as a joint tenant or tenant in common;  
• lodging and removing caveats over land; and  
• lodging and removing caveats against the issue of a grant of probate or administration in an estate.

10.2.12 The NSWLRC is presently reviewing laws that apply to accessing and controlling a person’s digital assets upon their incapacity. This review may make recommendations for reform to NSW guardianship laws dealing with the powers (if any) of representatives in relation to a represented person’s ‘digital estate’, meaning a person’s digital property and electronic communications, including photographs, videos, emails, online banking accounts, cryptocurrency, domain names, blogs and online gaming accounts. The NSWLRC notes that:

Digital assets can have significant personal, sentimental and even financial value. Permitting access to these assets after the person’s death or incapacity is therefore essential. However, family members and fiduciaries can encounter significant barriers in acquiring access, largely due to the terms of service agreements between users and service providers.

10.2.13 This is an important matter but falls outside of the scope of the Institute’s Terms of Reference for this project. It is appropriate that this matter be dealt with separately, taking into account developments in other jurisdictions.

Recommendation 10.3
That the State Government review pending recommendations of the NSWLRC dealing with the rights and powers of representatives in relation to a person’s digital estate and consider any need for legislative reform.

10.3 Excluded matters

10.3.1 The Act does not list matters that fall outside of the powers of an administrator. The Powers of Attorney Act lists matters over which an attorney does not have power. The Institute sought feedback about whether there is any utility in the Act containing a list of matters over which an administrator does not have power.

701 See NSWLRC, Access to digital assets upon death or incapacity, Consultation Paper 20 (August 2018) [3.22]–[3.25].
703 Ibid.
704 See Powers of Attorney Act 2000 (Tas) ss 31(2B), (2C).
10.3.2 There were seven responses to this question, with five endorsing the Act containing a list of excluded powers. As explained in Part 9, members of the Elder Law Committee considered that a guidebook is a more appropriate mechanism to clarify matters excluded from an administrator’s power.

10.3.3 Consistent with Recommendation 9.5, for reasons articulated in Part 9, it is recommended that the Act also contain a list of matters excluded from the powers of an administrator. The proposed list effectively adopts the list in the *Powers of Attorney Act*. It explicitly confirms, to avoid confusion, that a representative does not have power to act following the death of a represented person.

**Recommendation 10.4**

That the Act provide a non-exhaustive list of matters that fall outside the authority of an administrator, including:

- personal matters included within the scope of a guardian’s authority;
- making, revoking or amending a represented person’s Will, enduring power of attorney, instrument or advance care directive;
- voting on behalf of a represented person;
- consenting to marriage or the dissolution of marriage or significant relationship, or a sexual relationship of the represented person;
- making decisions about the care and wellbeing of a represented person’s child;
- consenting to the adoption of children, surrogacy arrangements and parenting orders;
- acting after the death of the represented person;
- disciplining, chastising or punishing the represented person; and
- consenting to an unlawful act.

### 10.4 Rights of administrators

10.4.1 An administrator has power to do anything that a represented person could have done in relation to their estate if not under a legal disability. The Issues Paper asked whether there needs to be reform to the rights of administrators contained in the Act.

**Should administrators have any other or different rights?**

10.4.2 Submissions addressing this question raised representatives’ access to a represented person’s Will (addressed in Part 12), and rights in relation to information (addressed in Part 8).

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705 TLRI, above n 69, Question 6.4.
706 See [9.3].
707 *Guardianship and Administration Act 1995* (Tas) s 56(1)(c).
708 TLRI, above n 69, Question 6.5.
10.5 Other reforms?

10.5.1 The Institute requested comments about any other changes needed in relation to the powers, rights and duties of administrators.

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<thead>
<tr>
<th>How else could the Act be improved in relation to the powers and duties of administrators?</th>
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<tr>
<td>10.5.2 Most observations were consistent with suggestions made in relation to the powers and duties of guardians. Several responses indicated a need to improve implementation of the legislative framework rather than a need for legislative reform. Responses addressed elsewhere in this Report included:</td>
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<tr>
<td>• the need for education, advice and support for representatives. This matter is addressed in Part 18;</td>
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<tr>
<td>• the need for people to be able to be spontaneous, and to have access to financial resources outside of business hours (particularly where a public representative is appointed). This issue is addressed throughout this Report; and</td>
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<tr>
<td>• providing greater choice or rights for a represented person to decide how funds are spent, a matter also addressed throughout this Report.</td>
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10.5.3 In addressing this question, the OPG suggested that reform could be made to require an administrator to be monitored or supervised by the Public Trustee or another professional trustee. This suggestion is considered in Part 12 as part of examination of safeguards for representative decision-making.

Statutory protections for representatives acting as a litigation guardian

10.5.4 The Public Trustee submitted that ‘[s]tatutory protections when acting as litigation guardian continue to be an issue both in the State Courts and Federal Court (Family Law Court).’ One respondent observed that the need for adequate protection arises particularly in the context of acting as a person’s litigation guardian in appealing a Board decision to the Supreme Court.

10.5.5 This is an important matter that must be appropriately addressed given that conducting litigation on behalf of a represented person falls within the scope of both a guardian and administrator’s power. To promote representatives performing their role in the interests of a represented person, it is appropriate to ensure adequate protections for representatives who participate in legal proceedings on behalf of, and in the interests of, a represented person. There ought to be appropriate protections for representatives who participate in that process in good faith.

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709 Two submissions received.
710 See [12.9.22]–[12.9.27].
711 See [8.7].
712 TLRI, above n 69, Question 6.6.
713 See Part 9.
714 See [18.2.9]–[18.2.20].
715 See [12.11.6].
716 Appeals are discussed further in Part 13. Recommendation 12.1 proposes that there be no adverse costs orders for a person in respect of whom a decision relates who appeals a decision of the Board to the Supreme Court.
and without personal gain so that they not be subject to adverse personal costs orders if unsuccessful. This involves reform to the respective Court rules rather than reform to the Act. It is recommended that this issue is the subject of a separate review.

**Recommendation 10.5**

That protections for representatives who enter into or participate in court proceedings on behalf of a represented person be reviewed.
Part 11

The Decision-Making Process

11.1 Introduction

11.1.1 Part 3 considered reform to the Act’s guiding principles. Presently, when making decisions for a person, decision-makers must consider not only the Act’s guiding principles, but also other matters outlined within separate sections. Different considerations apply depending on who is making the decision and the subject matter.

11.1.2 This Part deals collectively with how all representative decision-makers ought to make decisions. It reviews the current provisions of the Act and makes proposals about how reform to the Act might provide greater clarity as well as more closely align with the Convention to reflect the rights and interests of people requiring decision-making support.

11.2 The current position

11.2.1 When performing a function or exercising a power, the Board and representatives must apply the Act’s general principles. Presently, this requires all functions and powers to be performed so that:

- the means which is the least restrictive of a person’s freedom of decision and action as is possible in the circumstances is adopted;
- the best interests of a person are promoted; and
- the wishes of a person with a disability, or in respect of whom an application is made under the Act, are, if possible, carried into effect.

11.2.2 There are then separate lists of relevant factors to consider for financial matters, personal matters and medical treatment decisions. There is, to a large degree, substantial overlap between these sections.

11.3 A proposed ‘Decision-Making Process’

11.3.1 It is suggested that there be a single reference point in the Act for all representative decision-makers to refer to when making decisions, called ‘the Decision-Making Process’. A single reference point provides ease of reference, ensures consistency and avoids unnecessary duplication.

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717 In this context, representatives, the Board, and persons responsible.
718 Factors that administrators must consider are outlined in Guardianship and Administration Act 1995 (Tas) s 57, factors that guardians must consider are contained in s 27, factors that persons responsible must consider are outlined in s 43, and factors that the Board must consider in relation to consent to medical treatment are contained in s 45.
719 Guardianship and Administration Act 1995 (Tas) s 6.
Some attendees at a meeting facilitated by COTA and Dementia Australia (Tasmania) endorsed the Act outlining a simple, structured decision-making process for representatives to follow.

11.3.2 The proposal outlines a clear process to assist decision-makers to understand and uphold their duties. The process assists decision-makers to understand when it is appropriate for decisions to be made and when a decision ought to be deferred. It outlines a logical step-by-step approach to facilitate decisions being made in accordance with an individual’s will, preferences and rights. It serves as a tool to support representatives acting in the role.

<table>
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<th>Recommendation 11.1</th>
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<tr>
<td>That the Act contain a separate section headed ‘the Decision-Making Process’ that outlines when and how representatives and the Board are to make decisions for a person.</td>
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### 11.4 The Decision-Making Process

11.4.1 The ALRC suggested the following approach to give effect to a person’s will, preferences and rights in accordance with the Convention:

**ALRC Rights, Will and Preference Guidelines**

Where a representative is appointed to make decisions for a person who require decision-making support:

(a) The person’s will and preferences must be given effect.

(b) Where the person’s current will and preferences cannot be determined, the representative must give effect to what the person would likely want, based on all the information available, including by consulting with family members, carers, and other significant people in their life.

(c) If it is not possible to determine what the person would likely want, the representative must act to promote and uphold the person’s human rights and act in the way least restrictive of those rights.

(d) A representative may override the person’s will and preferences only where necessary to prevent harm.\(^{720}\)

This approach broadly aligns with the approach recently proposed in Victoria under the Guardianship and Administration Bill 2018 (Vic).\(^{721}\)

11.4.2 The Issues Paper sought to ascertain the degree of community support that exists to adopt the ALRC’s Guidelines as a means of advancing a ‘will, preferences and rights’ approach to decision-making.

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\(^{720}\) ALRC, above n 3, Recommendation 3-3(2). The NSWLRC has recently made recommendations consistent with this approach: NSWLRC, above n 24, Recommendation 5.4.

\(^{721}\) Guardianship and Administration Bill 2018 (Vic) cl 9.
Should the Act adopt the ALRC’s approach to giving effect to a person’s rights, will and preferences?

The ALRC provides:

Where a representative is appointed to make decisions for a person who requires decision-making support:

- The person’s will and preferences must be given effect
- Where the person’s current will and preferences cannot be determined, the representative must give effect to what the person would likely want, based on all the information available, including by consulting with family members, carers and other significant people in their life
- If it is not possible to determine what the person would likely want, the representative must act to promote and uphold the person’s human rights and act in the way least restrictive of those rights
- A representative may override the person’s will and preferences only where necessary to prevent harm.

11.4.3 There were 14 written submissions to this question, in addition to comments made during public consultation meetings that implicitly addressed this matter. There was broad support for the Guidelines, with 11 written responses expressing approval of the approach (some with minor variation, as discussed below).

11.4.4 Speak Out stated that its members and people from peer support networks that it consulted with all expressed support for decisions being based on a person’s rights and wishes. This was supported ‘[s]o you’ve got more control of your life and feel like you have some control.’ Speak Out submitted that ‘[p]eople should still think about your best interests but they need to listen to you.’ They suggested that the decision-making process should be as follows:

- Rights;
- Wishes;
- Listen;
- Decision.

11.4.5 As this was considered a matter of policy, the Board did not express a view. The Board acknowledged, however, that there is increasing support for a will, preferences and rights approach, with both the ACTLRAC and NSWLRAC having recently expressed support for the model. Similarly, it observed that legislation in Victoria also adopts a ‘right, will, and preferences’ approach.

11.4.6 Two written submissions did not expressly reject the ALRC’s Guidelines, but indicated some concern with this approach, or preference for an alternate model. National Seniors Australia, Tasmanian Policy Advisory Group, for example, suggested that the approach should be a

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722 TLRI, above n 69, Question 2.2.

723 The Institute notes that the Northern Territory legislation also adopts a will and preferences approach, although those terms are not used: see *Advance Personal Planning Act 2016* (NT) s 22; *Guardianship of Adults Act 2016* (NT) s 4.
combination of adopting a person’s wishes and their best interests. Effectively, this suggests support for continuation of the existing model. Associate Professor Wallace similarly commented about the importance of ensuring that a person’s rights are promoted and did not support decisions being made consistently with a person’s wishes without exception. For example, it was observed that a person’s diet ought not be solely guided by their wishes without regard to their right to a healthy diet.

11.4.7 A number of submissions highlighted the importance of considering safety, harm or damage before adopting a person’s will and preference. The OPG, for example, commented that a person’s will and preference ought to be adopted unless it would result in harm or detriment to the person. It reinforced, however, that the right of a person with a disability to make risky and unwise decisions must be respected. For this reason, it supported inclusion of a principle recognising this ‘dignity of risk’. Conversely, it was because of the importance of ensuring that people can make risky decisions that Advocacy Tasmania did not support a threshold of ‘preventing harm’ enabling decisions that are inconsistent with a person’s will and preference. Other submissions commented that assessment of harm is subjective, and that there needs to be consideration of the extent or level of harm.

The Institute’s view

11.4.8 The ALRC’s Guidelines enable a representative to override a person’s will and preferences where it is necessary to prevent harm. This is part of the ‘rights’ limb of the Convention paradigm as it enables decisions that are not in accordance with a person’s will and preferences where it might negatively impact their other human rights. The Institute considers that the Guidelines therefore adequately balance the issue of harm with a person’s right to have decisions about their life that are based on their will and preference.

11.4.9 Noting the broad support for the ALRC’s Guidelines, the Institute recommends that the proposed Decision-Making Process adopt, to a substantial degree, the ALRC’s Guidelines for giving effect to a person’s will, preferences and rights. In light of submissions received, however, the Institute proposes some subtle but important variations. These are discussed below.

The threshold question – does a decision need to be made?

11.4.10 The proposed Decision-Making Process requires decision-makers to first determine whether a representative decision needs to be made. This involves consideration of whether an immediate decision is required, or whether a decision could be deferred to a future time when the person would likely be able to make their own decision (including with support). This is consistent with adopting a least restrictive alternative and ensures that representatives only make decisions as a last resort, if there is no suitable alternative. Deferring a decision to a later time when a person could make their own decision may provide a suitable alternative.

11.4.11 A second step would require decision-makers to consider whether there is likely to be any detriment to a person if a decision were deferred. If there were the likelihood of detriment or harm, then it may not be a suitable alternative. This proposal aligns with the existing requirement in the Act that, before the Board may give substitute consent to medical treatment, it must consider whether the treatment is able to be postponed on the basis that the person might become able to consent to
the treatment.\textsuperscript{724} There appears to be no reason to not extend this requirement to other decision-makers and other types of decisions. The approach is consistent with the \textit{Mental Capacity Act 2005} in the UK and provisions in Victoria.\textsuperscript{725}

\textit{The phrase ‘will and preference’}

11.4.12 The Board commented that the words ‘will’ and ‘preference’ are open to interpretation, and that it would be useful for the Act to provide appropriate clarity if these terms are adopted.

11.4.13 The phrase ‘will and preference’ derives from the Convention. The Convention does not define or further explain those terms. The Convention Committee has similarly not provided specific guidance about what the terms are intended to mean.

11.4.14 Some jurisdictions, including the Irish Republic and Victoria, adopt the terms ‘will and preference’ within guardianship legislation. Neither the Irish Republic nor the Victorian Act define the terms. Other jurisdictions have not adopted the phrase, but use similar words. For example, the terms ‘views’ and ‘wishes’ are used in the Northern Territory.\textsuperscript{726} The recent Queensland Bill adopts the phrase ‘views, wishes, and preferences.’\textsuperscript{727} In the UK, a decision-maker must consider a person’s ‘wishes and feelings and their beliefs and values.’\textsuperscript{728} The terms ‘wishes’ and ‘values and beliefs’ are used in Alberta, Canada.\textsuperscript{729} The Act already uses the term ‘wishes’.

11.4.15 For consistency, it might be argued that the Act should adopt identical language to the Convention and use the phrase ‘will and preference’. Nevertheless, the Institute suggests that the phrase ‘views, wishes, and preferences’ be used instead, consistent with recent amendments proposed in Queensland. The phrase ‘views, wishes, and preferences’ is advocated for use in the Act on the basis that:

- one of the Institute’s fundamental objectives is for the law to be as clear, unambiguous and accessible as possible;
- the words ‘views’, ‘wishes’ and ‘preferences’ are more commonly used and therefore more likely to be understood by the broader community;
- aside from the Board, the Public Guardian, and Public Trustee, the largest group of stakeholders that will be called upon to apply the Act are members of the community — whether it is a person requiring decision-making support, or their family, carers or others close to the person. Adopting terms that these stakeholders are more likely to understand maximises the potential for a person’s will and preference to be promoted;
- the Board has itself raised issues about the meaning of the phrase ‘will and preference’ and sought clarity;
- one alternative to achieving clarity would be to define the terms within the Act’s definition section. It is considered unnecessarily cumbersome to define the term within the definition

\textsuperscript{724} See TLRI, above n 69, n 644.
\textsuperscript{725} \textit{Mental Capacity Act 2005} (UK) s 4; \textit{Medical Treatment Planning and Decision Act 2016} (Vic) s 59.
\textsuperscript{726} See for example \textit{Guardianship of Adults Act 2016} (NT) s 4.
\textsuperscript{727} For example, Guardianship and Administration and Other Legislation Amendment Bill 2018 (Qld) cl 8.
\textsuperscript{728} TLRI, above n 69, n 68.
\textsuperscript{729} \textit{see Adult Guardianship and Trusteeship Act 2008} (Alberta) s 2(d).
section given that is so commonly used, and fundamental, to the operation of the Act. A far easier approach is to adopt plain language in the first instance;

- the dictionary meaning of the term ‘will’ includes a person’s ‘wishes’. Revising the term used does not, therefore, depart from the rights recorded in the Convention; and
- the proposal continues to adopt language used in the current Act (‘wishes’) which individuals are already familiar with.

Giving ‘all practical and appropriate’ effect to a person’s will and preferences

11.4.16 The Institute recommends that a person’s will and preference be given ‘all practical and appropriate’ effect. The Board’s submission noted, in relation to the Victorian Act, that providing for decision-makers only needing to give effect to a person’s will and preference ‘whenever possible’, and similar phrases such as ‘as much as possible’ are open ended and subject to interpretation. In this way, it stated that they effectively allow ‘best interests’ principles to apply.

11.4.17 It is acknowledged that, in the absence of any further guidance, providing decision-makers with discretion could result in decisions continuing to adopt a default ‘best interests’ approach. To address this issue, it is proposed that the Act outline defined circumstances where a person’s will and preferences may be departed from. These circumstances include decisions that would be unlawful or result in unacceptable harm to the person or another person. This approach is consistent with laws in the Northern Territory and Irish Republic. Importantly, the approach does not require decisions that depart from a person’s will and preferences in these circumstances. Instead, it confirms that decision-makers may then adopt a different course. This permits decision-makers continuing to adopt decisions consistent with a person’s will and preference even where it could or would result in harm.

Confirming how a person’s will and preference can be communicated

11.4.18 Some submissions raised the issue of how a person’s will and preference is ascertained. Advocacy Tasmania commented that:

For many who are used to substitute and best interest decision making, their will and preferences may appear incapable of being determined at first. Lacking decision-making confidence and experiencing communication barriers are very different from not having a will or preferences.

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730 The Macquarie Dictionary defines ‘will’ as including: ‘1. The faculty of conscious and especially of deliberate actions. 2. The power of choosing one’s own actions. 3. The act of using this power. 4. The process of willing, or volition. 5. Wish or desire. 6. Purpose or determination, often hearty determination. 7. The wish or purpose as carried out, or to be carried out. 8. Disposition (good or ill) towards another…. 12. To wish or desire. …’ It provides that ‘preference’ includes: ‘1. The act of preferring; estimation of one thing above another; prior favour or choice. 2. The state of being preferred. 3. That which is preferred; the object of prior favour or choice. 4. A practical advantage given to one over others: Macquarie Dictionary (Macmillan, 2013) 1687 (definition of ‘will’), 1158 (definition of ‘preference’).


732 The NSWLRC has also recommended that decisions be made in accordance with a person’s will and preference ‘whenever possible’, similar to Victoria: NSWLRC above n 24, Recommendation 5.4(a).

733 See Point 5 of the Decision-Making Process.

734 Advance Personal Planning Act 2016 (NT) s 23(2).
11.4.19 The ALRC recommends that a person be entitled to communicate their will and preferences by any means that enables them to be understood. It also notes that cultural and linguistic circumstances must be recognised and respected.\textsuperscript{735} Many guardianship laws confirm the right of people to communicate their wishes by any means.\textsuperscript{736} The Institute proposes that the Decision-Making Process confirm that a person can communicate their views, wishes and preferences by any means. In effect, this is not a variation of the ALRC’s Rights, Will and Preferences Guidelines, the only difference is incorporating this as part of the Decision-Making Process.

\textit{Not restricting the relevance of a person’s prior communicated will and preference}

11.4.20 The ALRC’s Guidelines require that decisions give effect to a person’s will and preferences. The Guidelines do not refer to whether this requires decisions in accordance with a person’s \textit{current} will and preference, or their previously communicated will and preference. The Guidelines do, however, go on to explain what should occur when a person’s \textit{current} will and preference cannot be determined (emphasis added). This would suggest, although it is not explicit, that it is a person’s \textit{current} will and preference that must be given effect to.

11.4.21 Some submissions challenged whether it is appropriate to base decisions solely upon a person’s \textit{current} will and preference. This concern was raised particularly in relation to situations where a person’s \textit{current} will and preference may conflict with their prior will and preference, and where that change has occurred because of a decision-making disability. The OPMHS, for example, observed that:

\begin{quote}
Dementia presents a very different scenario to intellectual disability. In many cases of dementia, there can be alterations in personality and behaviour, and the reputation and relationships of a person with a disability can be jeopardised if the will and preferences, driven by dementia, are followed. Sufficient safeguards in the decision making are needed to protect such people from damage to their dignity, reputation, and relationships.
\end{quote}

11.4.22 Other respondents made similar comments.\textsuperscript{737}

11.4.23 In light of these submissions, the proposed Decision-Making Process does not refer to a person’s ‘current’ will and preference. This provides scope for decision-makers to balance relevant considerations. A possible criticism is that this continues to provide decision-makers with a degree of discretion to decide the point in time that a person’s will and preference should be ascertained. The Institute considers that it is appropriate to provide some flexibility as the approach may itself depend upon the individual’s values or the decision in question and the Act should not be overly prescriptive. Legislation in the Irish Republic and UK adopts a similar approach. Both Acts require consideration of a person’s ‘past and present’ will and preference (however described).\textsuperscript{738}

\textsuperscript{735} ALRC, above n 3, Recommendation 3-3.

\textsuperscript{736} See for example \textit{Guardianship and Administration Act 1993} (SA) s 3(1); \textit{Medical Treatment Planning and Decision Act 2016} (Vic) s 4(1)(d); \textit{Mental Capacity Act 2005} (UK) s 3(1)(d); \textit{Assisted Decision-Making (Capacity) Act 2015} (Ireland) s 3(2)(d).

\textsuperscript{737} Some attendees at facilitated consultation meetings convened by COTA and Dementia Australia (Tasmania), and Sandra Taglieri SC.

\textsuperscript{738} TLRI, above n 69, n 68.
11.4.24 It is noted that the Powers of Attorney Act limits the time in which a person’s wishes must be ascertained. It requires consideration of what a person would likely have wanted ‘if he or she were not subject to a mental incapacity’ (in other words, their prior will and preference).\textsuperscript{739}

Default ‘substituted judgment’ approach to be subjective

11.4.25 The ALRC’s Guidelines provide that ‘[w]here the person’s current will and preferences cannot be determined, the representative must give effect to what the person would likely want …’ (emphasis added). The Institute recommends a minor revision to provide that decisions should be based upon ‘what the decision-maker reasonably believes the represented person would likely want’ (emphasis added).\textsuperscript{740} Inclusion of these additional words confirms that this is a matter for the decision-maker to determine. It is intended to provide decision-makers with some degree of protection from criticism if they adopt an approach that they believe is consistent with a represented person’s likely will and preferences, even though their assessment might differ from another person’s interpretation or understanding. This approach is consistent with the law in Victoria.\textsuperscript{741}

11.4.26 The Powers of Attorney Act already adopts a ‘substituted judgment’ approach to decision-making.\textsuperscript{742} It requires attorneys to take into account what would be reasonably likely to be the wishes of the donor, if he or she were not subject to a mental incapacity.\textsuperscript{743} It goes on to confirm that an attorney complies with their duties in acting in the donor’s best interests if they exercise their powers in a way the donor would have been likely to if he or she were not subject to a mental incapacity.\textsuperscript{744} The Decision-Making Process also adopts a ‘substituted judgment’ approach, where a person’s will and preference cannot be ascertained.\textsuperscript{745} The major variation is requiring decision-makers to make a decision that is consistent with the person’s wishes (unless one of the permitted exceptions applies), rather than their wishes being a factor taken into account.

Adopt a ‘personal and social wellbeing’ approach where a person’s actual or likely will and preference cannot be ascertained

11.4.27 The ALRC’s Guidelines provide that: ‘If it is not possible to determine what the person would likely want, the representative must act to promote and uphold the person’s human rights and act in a way least restrictive of their human rights.’ Step 6 of the Institute’s proposed Decision-Making Process replaces the first reference to a person’s ‘human rights’ with the phrase ‘personal and social wellbeing’.

11.4.28 This variation is not intended to result in any significant departure from the ALRC’s Guidelines. Instead, it is intended as a means of providing clarity. Some members of the community may not understand what is meant by a person’s ‘human rights’. Requiring consideration of a person’s ‘personal and social wellbeing’ adopts more commonly used language that may be more

\textsuperscript{739} Powers of Attorney Act 2000 (Tas) s 32(1A)(c)(iii).
\textsuperscript{741} Medical Treatment Planning and Decision Act 2016 (Vic) s 61(1). See also Guardianship and Administration Bill 2018 (Vic) cl 9(1)(b).
\textsuperscript{742} Powers of Attorney Act 2000 (Tas) s 32(1B).
\textsuperscript{743} Ibid s 32(1A)(c)(iii).
\textsuperscript{744} Ibid s 32(1B)(a).
\textsuperscript{745} See Step 3.
easily understood. This phrase promotes a rights-based approach, is used in Victoria and is endorsed by the NSWLRC.\textsuperscript{746}

\textit{Considering ‘unacceptable’ harm}

11.4.29 The ALRC’s Guidelines do not set a threshold at which harm may justify decisions contrary to a person’s will and preference. Consistent with responses received, it is suggested that only ‘unacceptable’ harm permit decisions that are inconsistent with a person’s will and preference. Addition of the term ‘unacceptable’ is aimed at ensuring that decision-makers are not too risk averse.

11.4.30 In Victoria, it is proposed that only ‘serious’ harm may justify departure from a person’s will and preference.\textsuperscript{747} The National Standards of Public Guardianship similarly provide that a person’s will and preference should only be overridden where it is necessary to protect them from ‘significant’ risk.\textsuperscript{748} This proposal is consistent with the NSWLRC’s recommendation.\textsuperscript{749}

\textit{Considering harm to others}

11.4.31 Some submissions commented about the extent to which harm to another person should be a relevant consideration when making representative decisions. The OPMHS commented that:

Unlike the \textit{Mental Health Act}, the GAA does not have provisions for the management of risk, to others, from the represented person (RP). Avoiding harm to others may not clearly be in the RP’s best interests, as it may require restriction of their autonomy. Risk to others is hence often managed by using the avoidance of legal ramifications toward the represented person as being in their best interest. For example a man with dementia assaulting his wife might lead to police charges which would not be in his best interest. This is not only indirect, but is not necessarily valid as they would be unlikely to be held responsible. It would be preferable to simply and honestly recognise when risk to others is unacceptable and when it can be considered in decision making.

11.4.32 The Board made a similar observation in the context of giving approval to the use of restrictive practices:

a separate issue … which has arisen in practice is if the person’s behaviour is likely to cause harm to another person and whether this can be taken into account when making orders, particularly when detaining a person with impaired decision making disability. By way of example, a person is detained but not for treatment at a secure mental health facility and not within the ambit of the \textit{Mental Health Act 2013}, but serious concern is held by a treating medical practitioner that the release of the person may result in serious harm to another person. It is noted in the Queensland \textit{Guardianship and Administration Act 2000} in Chapter 5B Restrictive Practices, the Tribunal is to consider whether the ‘adult’s behaviour has previously resulted in harm to the adult or others; and there is reasonable likelihood that the adult’s behaviour will cause harm to the adult or others.’ Consideration of this issue would be of benefit.\textsuperscript{750}

\textsuperscript{746} See for example NSWLRC above n 24, Recommendation 5.4(d).
\textsuperscript{747} Guardianship and Administration Bill 2018 (Vic) cl 9(1)(d).
\textsuperscript{748} Australian Guardianship and Administration Council (AGAC), \textit{National Standards of Guardianship} (3\textsuperscript{rd} ed, 2016) Standard 3.
\textsuperscript{749} NSWLRC, above n 24, Recommendation 5.4.
\textsuperscript{750} The recent Review Committee report following the review of the \textit{Disability Services Act} notes that the Board also raised this issue as part of that review in relation to a guardian’s consent to the use of restrictive practices.
11.4.33 The ALRC’s Guidelines do not specify whether harm to another person is an appropriate consideration that would permit departure from a person’s will and preference. It only speaks to the possibility of considering ‘harm’. Arguably this contemplates harm to another person as being a relevant consideration. To avoid uncertainty or ambiguity, it is suggested that ‘harm’ include harm to the person, or to another person. This provides consistency with the approach under the Mental Health Act, which also permits consideration of harm to others.\(^751\)

*What if a person’s will and preference are in conflict?*

11.4.34 The Board’s submission raised the issue of how decision-makers should resolve situations where a person’s will and preference are in conflict. It commented that:

> the Issues Paper identifies some of the difficulties that may arise when attempting to ascertain a person’s will and preferences, including when a person’s will and preferences may conflict with each other and when there is very little evidence to determine what a person’s will and preferences are. In practice, the meaning of these terms ‘rights, will and preferences’ will be open to interpretation by a tribunal, as will the question of how they should be weighted when there is a conflict with each other.

11.4.35 The Institute agrees that there may be times when a person’s will and preference are in conflict and considers that the ALRC’s Guidelines provide appropriate guidance in these circumstances. For similar reasons to those articulated above, the Institute does not consider that legislation should be overly prescriptive. It would seem inappropriate to provide a default position that it is either a person’s wishes, or their preference that should take precedence. The appropriate resolution would likely depend on the matter in question and how strong a person’s respective wishes and preferences were. Decision-makers should be guided by the person themselves to assist them to formulate a view about which way to proceed. Where this is unable to be done, then Step 4 of the Decision-Making Process requires decision-makers to proceed in accordance with what they consider the person would likely want. This necessitates decision-makers forming a view about whether a person would want their will or their preference upheld (where they conflict) in relation to any particular matter.

*Upholding a person’s will and preference as much as possible*

11.4.36 Whilst the proposed Decision-Making Process permits departure from a person’s will and preference in exceptional circumstances,\(^752\) it is also proposed that the process confirm that decision-makers must in any event continue to give as much effect as possible to a person’s will and preference. This ensures that any departure from a person’s will and preferences is limited to the greatest extent possible, and that decision-makers continue to attempt to find ways to give effect to a person’s will and preferences in these circumstances. Smith and Rigby characterise this approach as consistent with the concept of making ‘reasonable adjustments’, adopting the language of anti-discrimination law.\(^753\) They propose that representatives powers ‘be limited to that required to make a reasonable adjustment for the represented person’s disability.’ They endorse appointed

\(^{751}\) See for example *Mental Health Act 2013 (Tas)* ss 25(a)(ii), 40(b)(ii).

\(^{752}\) See step 5.

\(^{753}\) Smith and Rigby, above n 433, advocate the benefits of alcohol and drug dependencies falling within the guardianship jurisdiction: at 185.
if the agent is able to make and enforce appropriate decisions merely through ‘assisted decision making’ then that is the level of adjustment required. However if ‘substituted decision making’ is required then it ought to be used only to the extent required to make a reasonable adjustment for the represented person’s disability.\(^{754}\)

**Recommendation 11.2**

That the Decision-Making Process require the Board and representatives (the decision-maker) to adopt the following process when making any decision on behalf of a person who does not have decision-making ability to make their own decision about the matter:

1. First, the decision-maker must consider whether there is a need for a decision. There is no need for them to make a decision where the person has made a binding direction in advance that applies to the circumstances, including in a valid advance care directive.

2. Second, the decision-maker must consider whether the person is likely to become able to make their own decision, and if so, when. If the decision-maker considers that a decision can be delayed until the person gains the ability to make the decision, without that delay causing harm, then the decision should be delayed.

3. If the decision-maker considers that a decision needs to be made, then the person’s views, wishes and preferences must be given all practical and appropriate effect. A person may communicate their views, wishes and preferences by any means.

4. Where the person’s views, wishes, and preferences cannot be determined, the decision-maker must give all practical and appropriate effect to what the decision-maker reasonably believes the person’s likely views, wishes and preferences are, based on all the information available, including by consulting with family, carers and other significant people in the person’s life that the decision-maker reasonably believes the person would want to be consulted.

5. A decision-maker may not give all practical and appropriate effect to the person’s views, wishes and preferences only where:
   
   (a) it is necessary to prevent unacceptable harm to the person or another person; or
   
   (b) it would be unlawful.

   In any of these cases, a representative must adopt Step 6 whilst continuing to give as much effect as possible to the person’s views, wishes and preference.

6. If it is not possible to determine or apply the person’s views, wishes and preferences, a decision-maker must act to promote and uphold the person’s personal and social wellbeing and act in a way least restrictive of their human rights.
Figure 11.1 illustrates the proposed Decision-Making Process:

**Does the person have the ability to make a decision or consent?**

Yes  
No  

**OWN DECISION** 

Has the person been offered support to make a decision/give consent?

Yes  
No  

Yes  

Can they make a decision with support?  

Yes 

Offer support 

No 

Is the person likely to gain the ability to make a decision/consent (including with support)?

No  
Yes  

Would there be harm in waiting?

Yes  

Has the person made a clear, relevant direction?  

Yes  
No  

Decision that gives all practical and appropriate effect to the person’s views, wishes, and preferences* (communicated by any means).

*The person’s actual or likely views, wishes, and preferences may not be given all practical and appropriate effect where:
- it is necessary to prevent unacceptable harm to the person or another person; or
- it would be unlawful.

But: must continue to adopt as much of the person’s views, wishes, and preferences as possible.
Part 12

Safeguards for Representative Decision-Making

12.1 Introduction

12.1.1 Safeguards promote the rights and interests of individuals. Safeguards within guardianship legislation primarily address the need to protect the interests of people requiring support with decision-making by preventing abuse, neglect or exploitation and adequately responding where it occurs. However, making laws easy to understand, accessible and responsive are other ways that the law can protect and promote the interests of individuals, as well as serving a broader community benefit. These strategies are considered later in this Report at Part 18. The Board and Public Guardian are themselves safeguarding bodies. Their powers and functions are considered separately in Parts 15 and 16.

12.1.2 The Convention confirms the rights of people with disability to be free from exploitation, violence and abuse. Recommendation 3.1 of this Report endorsed reform to the Act being guided by the ALRC’s National Decision-Making Principles. Principle 4 provides that ‘laws and legal frameworks must contain appropriate and effective safeguards in relation to interventions for people who may require decision-making support, including to prevent abuse and undue influence’. This Part evaluates and makes recommendations for reform to strengthen the safeguarding components of the Act. Part 14 deals specifically with safeguards for consent to medical treatment. Consideration of the merits of reform to the safeguarding provisions of the Act involves a balancing of the following:

- the need to not cause detriment to the substantial majority of families and friends who perform their support role appropriately and in the interests of the person they are supporting. These people are an essential component to the provision of decision-making support and are often strong advocates for the rights of individuals they are supporting;
- the need to encourage and support suitable people from within an individual’s existing network of support to accept and perform the more formal role of representative if required; and
- the need to prevent, detect and respond to abuse and other conduct that is contrary to the interests of people requiring decision-making support.

Convention on the Rights of Persons with Disabilities art 16.
12.2 The ALRC’s Safeguards Guidelines

12.2.1 The Convention requires State parties to ‘ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse.’ It goes on to provide that:

safeguards shall ensure that measures relating to the exercise of legal capacity … are free of conflict of interest and undue influence, are proportional and tailored to the person’s circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body.

12.2.2 The ALRC developed the following Safeguards Guidelines to complement and develop its National Decision-Making Principles, reflecting the principles of the Convention:

<table>
<thead>
<tr>
<th>ALRC Safeguards Guidelines</th>
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<tbody>
<tr>
<td>(1) General</td>
</tr>
<tr>
<td>Safeguards should ensure that interventions for persons who require decision-making support are:</td>
</tr>
<tr>
<td>(a) the least restrictive of a person’s human rights;</td>
</tr>
<tr>
<td>(b) subject to appeal; and</td>
</tr>
<tr>
<td>(c) subject to regular, independent and impartial monitoring and review.</td>
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<tr>
<td>(2) Support in decision-making</td>
</tr>
<tr>
<td>(a) Support in decision-making must be free of conflict of interests and undue influence.</td>
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<tr>
<td>(b) Any appointment of a representative decision-maker should be:</td>
</tr>
<tr>
<td>(i) a last resort and not an alternative to appropriate support;</td>
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<tr>
<td>(ii) limited in scope, proportionate, and apply for the shortest time possible; and</td>
</tr>
<tr>
<td>(iii) subject to review.</td>
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</table>

12.2.3 This Part evaluates current safeguarding provisions against the ALRC’s Safeguards Guidelines.

12.3 Least restrictive interventions

12.3.1 The first of the ALRC’s Safeguards Guidelines provides that safeguards should ensure that interventions for people who require decision-making support are the least restrictive of a person’s human rights. The need to adopt the least restrictive intervention has been considered throughout this Report, including Part 3 (Guiding Principles of the Act), Part 6 (Decision-Making Ability), and Part 8 (Representative Decision-Making).

756 Ibid art 12(4).
757 Ibid art 12.4
758 ALRC, above n 3, Recommendation 3-4.
12.4 Appeal Provisions

12.4.1 The second of the ALRC’s Safeguards Guidelines provides that safeguards must ensure that interventions for people who require decision-making support are subject to appeal. The Act’s appeal provisions are considered in the following paragraphs.

Appeals against the Board’s decisions

12.4.2 The Act provides the ability to appeal Board decisions. Appeals are lodged at the Supreme Court of Tasmania.759 A person who appeared before the Board, or who was entitled to appear,760 may appeal the Board’s decision. If the appeal relates to a question of law, then that appeal can be lodged as of right. If it relates to any other question, then it may only be appealed with leave of the Court.761 An appeal must be lodged within 28 days after the determination,762 or within 28 days after receipt of a statement of reasons.763 The Court can extend these time periods.764 At the time of writing, the filing fee on filing a notice of appeal of a decision of the Board is $916.40.765 An application can be made to the Supreme Court Registrar for the reduction or waiver of fees in cases of undue hardship.766

12.4.3 Statistics published in the Board’s annual reports demonstrate the rarity of people appealing decisions to the Supreme Court:767

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Appeals Lodged</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016–2017</td>
<td>1</td>
</tr>
<tr>
<td>2015–2016</td>
<td>0</td>
</tr>
<tr>
<td>2014–2015</td>
<td>0</td>
</tr>
<tr>
<td>2013–2014</td>
<td>1</td>
</tr>
<tr>
<td>2012–2013</td>
<td>0</td>
</tr>
</tbody>
</table>

12.4.4 The last reported Supreme Court decision was in 2011.768

12.4.5 It is unclear why there are so few appeals lodged. Anecdotally, the Institute understands that at least part of the reason may be because of the need to appeal to the Supreme Court. Proceedings in the Supreme Court are more expensive, complex and formal than hearings before the

759 Guardianship and Administration Act 1995 (Tas) s 76(1).
760 Including with leave.
761 Guardianship and Administration Act 1995 (Tas) s 76(2). Equivalent provisions apply in the Mental Health Act 2013 (Tas) s 174.
762 Guardianship and Administration Act 1995 (Tas) s 76(3)(a).
763 Ibid s 76(3)(c). Where the decision related to consent to terminate a pregnancy, then the appeal must be made within two days of the determination: s 76(3)(b). One respondent commented, in answering a separate question in the Issues Paper, that these appeal periods are too short.
764 Ibid s 76(3)(d).
765 Supreme Court (Fees) Rules 2017 (Tas), sch 1 pt 1.
766 Ibid r 8.
767 Data extracted from Guardianship and Administration Board Annual Reports.
Board. There is also the risk of adverse costs orders if unsuccessful.769 Some attendees of facilitated consultation meetings convened by Carers Tasmania raised these factors as reasons why individuals are deterred from lodging appeals. Carers Tasmania also noted in its submission that ‘Carers Tasmania members have expressed appealing via the Supreme Court is not an option for them, and both they and the person they represent would benefit from a more accessible appeal option.’ Another submission commented that:

It is too expensive for people to go to Court to appeal and the average person has no understanding of the Act and the procedure that give the Board so much power. …

It’s not in anyone’s interest to go to court, especially where there is elder abuse.770

12.4.6 Another response submitted that:

Some sort of review should be able to be done without it having to be reviewed by the Supreme Court. This is too expensive. …

There should be a way of reviewing their decisions which doesn’t cost thousands of dollars. The board has a large amount of power over people’s lives and it should have more scrutiny.771

12.4.7 The OPG submitted:

The number of appeals that are made to the Supreme Court is very low, particularly when we know many people feel aggrieved by decisions. This suggests that the process of lodging an appeal to the supreme Court is probably too onerous for people with decision-making impairments and their families, who may already be feeling disempowered.

12.4.8 One of the reasons the Board was established was to provide a more informal and cost-effective forum to facilitate the inclusion of people with disability.772

12.4.9 The ALRC’s Guidelines provide that the ability to appeal is an essential safeguarding component of guardianship legislation. It is concerning that actual or perceived complexities involved in appealing to the Supreme Court might create a barrier to people lodging an appeal, especially a represented person who the Board has determined has a need for decision-making support. Given these issues, the Issues Paper raised this as an area for potential reform. One option identified was the establishment of an internal review process.

Internal reviews of decisions

12.4.10 An internal review process enables the Board to review its decision internally in the first instance, avoiding the need to apply to the Supreme Court. Currently, the Act provides the ability for an applicant to request an internal review in relation to a decision of the Board rejecting an application.773

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769 Unless the Court orders otherwise, costs of an appeal follow the event: Supreme Court Rules 2000 (Tas) rr 701(1), 693(1), 672(6).
770 Dr Elizabeth Pickup.
771 Margaret Rolph.
772 Tasmania, Parliamentary Debates, House of Assembly, 6 April 1996, Second Reading Speech (Ron Cornish, Minister for Justice).
773 Guardianship and Administration Act 1995 (Tas) s 11(14).
12.4.11 The ability to apply for an internal review of a tribunal’s decision is a common feature of civil and administrative tribunal governing legislation in other jurisdictions. The South Australian Guardianship and Administration Act 1993 enables an applicant, person in respect of whom a hearing relates, the Public Guardian, any person who presented evidence or material before, or made submissions to the Board, or any other person that the Board considers has a proper interest in the matter, to apply for an internal review of a decision. It provides that, except in the case of a decision for or affirming the detention of a person or relating to the giving of consent to a sterilisation or a termination of pregnancy, an application for internal review may only be made with the permission of the Board. The Board can make a costs order against a party (other than the person in respect of whom a proceeding relates) if satisfied that the institution of the proceedings, or the party’s conduct in relation to the proceedings was frivolous, vexatious or calculated to cause delay.

12.4.12 The use of internal rights of appeal was considered as part of a separate review by the State Government into the establishment of a Civil and Administrative Tribunal for Tasmania (‘TASCAT’), amalgamating a number of tribunals (including the Board) within the Department of Justice. The 2015 Discussion Paper noted the potential benefits of an internal appeal mechanism:

An internal right of appeal affords parties to a dispute a cost effective option of review of a decision; it can enable the Tribunal to correct any defects in the original decision making without the expense and time of requiring Supreme Court review, and ensures consistency in its own decision making; and its provisions can be drafted to prevent unnecessary or unmeritorious litigation and ensuring appropriate finality in decision making.

12.4.13 The Discussion Paper proposed that the envisaged TASCAT single tribunal structure should provide for an internal right of appeal, with leave to appeal needing to be obtained from the President. Under this mooted approach, the President would also retain a broad discretion as to the manner in which an appeal is heard and determined. The Institute understands that, at the time of writing, final recommendations of this review are not publicly available.

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774 See for example Civil and Administrative Tribunal Act 2013 (NSW) s 32; Guardianship and Administration Act 1993 (SA) s 64. The Care and Consent to Medical Treatment Bill 2016 (Tas) incorporates an equivalent provision: see cl 25.

775 Guardianship and Administration Act 1993 (SA) s 64(b). A decision of the Board not to authorise publication of a report of proceedings before the Board may not be the subject of an application for internal review: s 64(a).

776 Ibid s 64(c).

777 Ibid ss 64(g), 64(h).

778 Department of Justice, Government of Tasmania, A Single Tribunal for Tasmania, Discussion Paper (September 2015). The Discussion Paper recommends that the jurisdiction of the Guardianship and Administration Board be included as part of any new single Civil and Administrative Appeals Tribunal.

779 Ibid 118.

780 The article that the Discussion Paper refers to suggests that legislation could include a non-exhaustive list of matters that could be considered relevant to determining whether to exercise the discretion including whether an arguable and material error of law is raised, whether a materially different order would result if they were successful, the availability of fresh evidence, findings of fact based on no probative evidence, whether an appeal is justified given the value of the claim, the likelihood of success, and the interests of justice: K P O’Connor, ‘Appeal Panels in Super Tribunals’ [2013] 32(1) University of Queensland Law Journal 31, 41.

781 Department of Justice, above n 778, Recommendation 4.7.

782 It is noted that the 2017–2018 State Budget included provision of $100,000.00 to investigate accommodation options for the establishment of a Tasmania Civil and Administrative Tribunal (TASCAT): Parliament of Tasmania, Government of Tasmania, Government Services: Budget Paper No. 2 Vol 1 (2017–18) 111.
12.4.14 The Institute’s Issues Paper asked whether it would be beneficial to enable an aggrieved person to seek an internal review of the Board’s decision, prior to, or as an alternative to, appealing to the Supreme Court.

**Should the Act enable internal reviews of the Board’s decisions?**

12.4.15 There were 12 responses to this question. All respondents except for COTA indicated some level of support for providing an internal review process. COTA commented that it ‘believes it should be possible to devise a workable and efficient mechanism for external review, such as an ombudsman.’

12.4.16 In response to this question, the Board submitted:

The Board acknowledges that an internal review of a Board’s decision would be less expensive, complex and formal than appeal proceedings in the Supreme Court.

If the Act enabled internal reviews, it is considered that internal reviews should be allowed only on a question of law or only about the merits of a decision if the Appeal Panel grants leave.

From a practical perspective, the formation of an internal review panel would currently have implications for the sizing of the membership of the Board, its workload and on resources. The Board’s current composition of membership does not delineate between senior members and members and all members except the President are casual appointments. The formation of an Internal Appeal Panel would be best facilitated if and when the Board is part of a single tribunal and can utilise part time or permanent senior members and heads of divisions from the guardianship division and other divisions within a civil and administrative tribunal.

12.4.17 PCT commented that resourcing considerations should not impact upon the provision of accountability mechanisms including appeals processes:

Increased workload is not an appropriate excuse for not providing accountability mechanisms … In terms of accountability, there should be allowances for internal reviews and audits. Benchmarking should also occur.

12.4.18 Similar to the Board’s submission above, two responses suggested that there needs to be discretion to disallow an appeal in certain circumstances. Members of the Elder Law Committee commented, for example, that ‘the tribunal must always have discretion not to re-list in circumstances e.g. vexatious litigant.’ The Registrar currently has the ability, under s 69A of the Act, to apply to the Supreme Court for a vexatious proceedings order under the *Vexatious Proceedings Act 2011* (Tas).

12.4.19 The Institute considers that the existing appeal provisions are a key area in which reform is required. The right of appeal is a fundamental safeguard to protect the rights and interests of people who are the subject of orders of the Board. It is therefore important that appeal mechanisms are appropriate, effective and accessible. Accountability also assists to instil public confidence in the...
jurisdiction. It is unsatisfactory for legislation which impacts the rights of individuals to contain appeal provisions that are perceived as inaccessible. This is particularly when, pursuant to ss 11(4)–(5) of the Act, the Board is not bound by the rules of evidence. Parties are often unrepresented and may not appreciate the implications of Board decisions until after those decisions are made or implemented. Based upon respondents’ support for this reform, the Institute proposes revision to the Act to provide for internal reviews of Board determinations. The Institute agrees with respondents who commented that it is important to minimise the potential abuse of internal appeal mechanisms by vexatious litigants. It is therefore appropriate that there be some discretion to disallow an application for an internal review in exceptional and limited circumstances.

12.4.20 The Board’s comments about the practical impacts of reform upon its resourcing and structure are noted. The Institute considers this reform of critical importance to progressing obligations under the Convention and that the Board must be adequately resourced to implement the change. If it were considered not feasible to implement this reform in the absence of amalgamation to a single tribunal structure, then this reform ought to be prioritised if or when that project advances.

External review of decisions

12.4.21 The following two matters lead the Institute to conclude that the right of an internal appeal is insufficient, of itself, to resolve present concerns about the appeal provisions of the Act:

- the need to ensure that the Board is properly equipped to facilitate internal reviews of decisions; and
- the importance of providing an independent mechanism to appeal decisions to instil public trust and confidence in the jurisdiction. One advantage of the existing approach is that the Supreme Court is independent of the Board, providing accountability and reducing perception of bias.

12.4.22 The Board commented that an effective internal review procedure could be achieved through the establishment of the proposed TASCAT, with this structure enabling the tribunal to draw upon senior members from other divisions to provide independence. The Institute agrees that this would appear to provide an accessible but independent appeal mechanism. Noting that the Board’s submission does not clarify if or when it may be part of a newly proposed TASCAT, and that at the time of writing, this matter remains unclear, the Institute has framed its recommendation to propose that the Act provide a simple, free and independent appeal process irrespective of if and when the proposed TASCAT is established.

12.4.23 The perceived limitations of the Supreme Court, as discussed earlier in this Part, relate to the associated formalities and cost. Enabling internal appeals of decisions alleviates these issues but does not provide the degree of independence that the Supreme Court provides. The Institute therefore recommends that:

- the existing legislative framework, along with the Court’s practices and procedure be reviewed to provide accessible appeal pathways to appeal Board decisions to the Supreme Court;
- there be publicly available, accessible information produced and disseminated to explain to members of the community the appeal process; and
• consistent with the approach in South Australia, that the Act provide that no order for costs may be made against an applicant in an appeal if he or she is the person to whom the decision appealed against relates.\textsuperscript{784}

12.4.24 The effect of these proposals would be to provide dual appeal pathways, enabling both internal and external reviews of decisions. The recommendations respond both to any actual difficulties with the Supreme Court rules and procedures, as well as reducing any issues relating to community perception.

Recommendation 12.1

(1) That the Act provide the ability to apply to the Board for an internal review of its original decisions by a division of the Board not comprising members who were involved in the original decision.

(2) That the Supreme Court of Tasmania rules, practices and procedures be reviewed to facilitate accessible pathways to appeal Board decisions to the Supreme Court.

(3) That there be publicly available, accessible information produced explaining the appeal process and which is provided to parties following a determination of the Board.

(4) That legislation provide that no order for costs may be made against an applicant in an appeal if he or she is the person in respect of whom the decision appealed against relates.

Statements of reasons

12.4.25 A statement setting out reasons for the Board’s decision is not prepared or distributed to parties as a matter of course. A person who is aggrieved by a decision may request a written statement setting out the Board’s reasons for its determination.\textsuperscript{785} A request must be made within 21 days after a determination.\textsuperscript{786} The statement of reasons must be provided within 21 days of the Board receiving the request.\textsuperscript{787} It is the Board’s practice to publish de-identified statements of reasons online.\textsuperscript{788} Its practice direction states its rationale for doing so being that:

\begin{quote}
Publication of de-identified statement of reasons is generally in the public interest as it contributes to the community’s understanding of the relevant areas of law and the operations of the Board.\textsuperscript{789}
\end{quote}

12.4.26 The Issues Paper commented that to promote and preserve the privacy of people who are subject to applications before the Board, it may be appropriate to limit those who are entitled to receive a statement of reasons. It was noted that this could be limited to people who appeared before

\textsuperscript{784} See Guardianship and Administration Act 1993 (SA) s 64(j).
\textsuperscript{785} Guardianship and Administration Act 1995 (Tas) s 74(1).
\textsuperscript{786} Ibid.
\textsuperscript{787} Ibid s 74(2).
\textsuperscript{789} Practice Direction – De-identification of statements of reasons for publication, above n 788, 1.
the Board or who were entitled to appear before the Board. The Institute asked for comment about who ought to be able to request and obtain a statement of reasons.

Who should be eligible to obtain a statement of reasons from the Board?

12.4.27 There were a range of responses to this question. The Board agreed that, in the interests of privacy, those classes of individuals entitled to request and obtain a statement of reasons should be limited. It commented:

Whatever terminology is used the Board is supportive of the Act clearly defining a limited class of individuals who is entitled to request a statement of reasons.

One option for reform flagged in the Issues Paper is to limit the class of individuals to people who ‘appeared before the Board or who were entitled to appear before the Board.’ The dictionary meaning of appear is ‘come into sight; become visible or noticeable, especially without apparent cause; present oneself formally in a court or tribunal.’ All people present at a Board hearing therefore appear ‘before the Board’. As the Board’s hearings are open to the public, concerns arise as to whether this is opening up eligibility of persons requesting a statement of reasons too widely. If only the term ‘entitled to appear before the Board’ is adopted this could be construed in a number of different ways including parties only, or those individuals who receive notice of hearing, and so further clarity would be required. Eligibility could be limited to parties and their legal representatives, depending on whether ‘parties’ is defined in the Act and if so, how it is defined.

12.4.28 Two other submissions suggested that statements of reasons should be available to limited groups, including the Board, the person in respect of whom a hearing relates, their ‘next of kin’, and representatives. The OPG considered the current arrangements to be fair and reasonable but stated that it would not object if the class was narrowed to those who attended or were entitled to attend the hearing. Members of the Elder Law Committee submitted that the present requirement of needing to be a ‘person aggrieved’ is appropriate and that there is no need for further limitation. The Public Trustee submitted that administrators ought to be entitled to a statement of reasons.

12.4.29 Three submissions supported statements of reasons being made publicly available. Reasons provided included the need for transparency, accountability and for educational and jurisprudential purposes. Speak Out submitted that represented people ‘want to know why a guardian or administrator was appointed.’ They also endorsed advocates and support people being given reasons, if the represented person wants them to have that information.

12.4.30 It is agreed that it is important that there is both accountability and transparency in Board proceedings. It is also important that members of the public have trust in the Board’s accountability as part of building public confidence. These considerations must be balanced with the need to preserve individuals’ right to privacy, particularly those in respect of whom a hearing relates, noting that guardianship matters often involve personal and at times sensitive matters. It is recommended, to preserve individuals’ right to privacy, that the class of eligible individuals able to request a statement of reasons be limited to those with a proper interest in the matter.

790 Including with leave.
791 TLRI, above n 69, Question 7.1(ii).
12.4.31 Presently, statements of reasons are not produced for all matters. Two responses submitted that statements of reasons should be produced and provided to all parties in all cases, rather than only provided upon request. Some members who attended Carers Tasmania meetings explained the rationale being that written reasons ensure that people affected by a decision know the reasons why the Board decided as it did, so that they know what they are appealing.

12.4.32 The Institute acknowledges that it may be difficult for individuals to understand the reasons for Board decisions without those reasons being provided in writing. This is particularly so as hearings may be brief and potentially stressful or emotional for those involved. In the absence of advisors, advocates or other supports, it might be difficult for some individuals to understand the reasons for a decision. The Institute considers that these issues may be addressed as part of a broader strategy of making available supports for those involved in Board hearings. This could incorporate information being provided verbally, which has the advantage of assisting individuals with low literacy levels. Further, providing information in this way would be more informal, enabling people to ask questions. Information could be provided faster, rather than needing to await a written statement. These options are considered further in Part 15.\textsuperscript{792}

12.4.33 The Board’s workload and resourcing implications is a further reason that reform requiring statements of reasons for all matters has not been recommended. It is likely to be unworkable for the Board to provide written statements of reasons for every decision, noting that there are multiple hearings scheduled in each session. One of the Board’s performance indicators measured by the State Government is the number of hearings per sitting, with a target of five hearings per sitting in the 2018–2019 State Budget.\textsuperscript{793} It recorded an average of 4.4 hearings per sitting in the 2016–2017 financial year.\textsuperscript{794} Reform requiring statements of reasons to be supplied for all matters would have the effect of either:

- reducing the number of matters that could be heard each day, impacting the productivity of the jurisdiction;\textsuperscript{795}
- requiring the Board to reduce the length of hearings, which may impact the quality of decision-making; or
- necessitating an increased need for additional resources and funding or reallocation of existing resources.

12.4.34 It is suggested that the classes of individuals entitled to request a statement of reasons be consistent with the list of those eligible to appeal a determination,\textsuperscript{796} or others considered appropriate

\textsuperscript{792} See [15.4.28]–[15.4.34].

\textsuperscript{793} Parliament of Tasmania, Government of Tasmania (2018–19), above n 782, 159.

\textsuperscript{794} Ibid.

\textsuperscript{795} Guardianship and Administration Act 1995 (Tas) s 72 provides a statutory timeframe in which hearings must be listed following receipt of an application. In 2016–2017, 97.6% of matters were listed within the statutory timeframe, whilst in 2015–2016, only 75% of matters were: Parliament of Tasmania, Government of Tasmania, above n 782, 159.

\textsuperscript{796} See Guardianship and Administration Act 1995 (Tas) s 76. Classes of individuals eligible to appeal a determination are: the person in respect of whom the hearing was held; the applicant; the Public Guardian; any guardian or administrator of the person in respect of whom the hearing was held; if the matter relates to the provision of health care and treatment, then the registered health practitioner proposing to carry out the health care or treatment; and any other person who appeared before the Board.
as assessed by the Board. This proposal is not intended to alter the Board’s ability to publish de-
identified decisions at its discretion.\textsuperscript{797}

\begin{center}
\textbf{Recommendation 12.2}
\end{center}

That the Act limit those who are eligible to request a statement of reasons of the Board’s
determination to:
\begin{itemize}
\item[(a)] those classes of individuals who are entitled to appeal a determination of the Board; and
\item[(b)] any other person that the Board considers has a proper interest in the matter.
\end{itemize}

\textbf{Appeals against representatives’ decisions}

12.4.35 There are no specific provisions in the Act that enable a person to appeal or object to the
decision of a representative. In practice, if a person is aggrieved by a representative’s decision, or lack
of decision, then they could apply to have the representative removed. This may not, however,
resolve the situation where a decision has already been implemented.

12.4.36 The Issues Paper noted that a potential advantage of providing a specific means or process
for individuals to object to a representative’s decision (or lack of decision) may be to achieve greater
accountability. Potential problems with this approach were also identified, including delay, and that it
removes decision-making from individuals deemed suitable to act in the role. It could reduce public
confidence if all decisions of representatives could be disputed. Further issues could include the risk
of vexatious or unmeritorious objections. One alternative identified was inclusion of provisions
within the Act dealing with the use of alternative dispute resolution to better facilitate the informal
resolution of disputes about representative’s decisions.

\textbf{Mediation}

12.4.37 Alternative dispute resolution (ADR) describes situations where an independent person
(for example, a mediator) helps parties in dispute to try to resolve issues between them.\textsuperscript{798} The\textit{Alternative Dispute Resolution Act 2001} (Tas) (‘ADR Act’) describes mediation as ‘a structured
negotiation process in which the mediator, as a neutral and independent party, assists the parties to a
dispute to achieve their own resolution of the dispute.’\textsuperscript{799}

12.4.38 The Act does not provide for the use of mediation to resolve disputes. In practice, the
Board may give informal advice and recommendations to parties to consider ADR, or could direct
representatives to do so. The Board also has flexibility to conduct its hearings in an informal style to
attempt to resolve conflict amongst parties in a style more akin to a mediation than a court
environment. The Board’s submission commented that: ‘A number of Board members have
qualifications, training and experience in mediation and use these skills within the hearing process to
assist the person, parties and the decision making process.’

\textsuperscript{797} \textit{Guardianship and Administration Act 1995} (Tas) s 13(2).
\textsuperscript{798} National Alternative Dispute Resolution Council, Attorney-General’s Department, Government of Australia,
\textit{Your Guide to Dispute Resolution} (2012) 5
\hspace{1cm}<https://www.ag.gov.au/LegalSystem/AlternateDisputeResolution/Documents/Your%20Guide%20to%20Dispute%20Resolution.pdf>.
\textsuperscript{799} \textit{Alternative Dispute Resolution Act 2001} (Tas) s 3(2).
12.4.39 Some jurisdictions have enacted legislative provisions providing for the use of ADR as a method to seek to resolve disputes within the guardianship jurisdiction. As commented in the Issues Paper, it is common for statute to incorporate ADR processes prior to a formal court hearing.\(^{800}\) ADR has been broadly supported in other reviews as a method to resolve conflict in less formal ways than a tribunal.\(^{801}\)

12.4.40 The Issues Paper asked whether the Act should provide for the use of ADR.

<table>
<thead>
<tr>
<th>Should the Act provide for alternative dispute resolution, for example mediation, before a hearing?(^{802})</th>
</tr>
</thead>
</table>

12.4.41 There was unanimous support for incorporation of ADR processes within the Act.\(^{803}\) The Board noted that it is not a prescribed tribunal under the \(\text{ADR Act}\). It commented that: ‘While amending the Alternative Dispute Resolution Regulations appears appropriate, the Board believes it would also be appropriate to have clear powers for ADR in the Act.’

12.4.42 EOT commented:

EOT has considerable expertise in alternative dispute resolution processes and at an operational level would welcome further discussion regarding the capacity of EOT to provide services to assist either the Board or the Public Guardian in fulfilling this function.

12.4.43 PCT submitted that:

For issues relating to ‘bad death’ experiences it should be mandatory for treating professionals to explain issues to family members prior to any formal conflict resolution process.

12.4.44 Two submissions commented that ADR may not always be appropriate or feasible. Members of the Elder Law Committee commented ‘this should always be considered. The problem is that if a person lacks capacity, how can they negotiate?’ Several respondents also commented that ADR should be available, but that it should not be mandatory.

12.4.45 The Issues Paper included a separate question about whether use of ADR should be mandatory before a matter is listed for hearing.

<table>
<thead>
<tr>
<th>Should the Act require compulsory alternative dispute resolution prior to a hearing?(^{804})</th>
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\(^{800}\) See for example, \(\text{Supreme Court Rules 2000 (Tas)}\) Pt 20; \(\text{Magistrates Court (Civil Division) Rules 1998 (Tas)}\) Pt 4.

\(^{801}\) The use of alternative dispute resolution was strongly supported in the Department of Justice’s Discussion Paper, ‘ADR (Alternative/Appropriate Dispute Resolution) must form part of the legislative foundation. The application and use of ADR within a Single Tribunal is critical to achieving multiple outcomes related to speed, efficiency, usability and accessibility’: Department of Justice, above n 778, 77. See also House of Representatives Standing Committee on Legal and Constitutional Affairs, above n 264, [3.221]; Independent Advisory Council of the National Disability Insurance Scheme, \(\text{How can the NDIS help participants enhance their personal safeguards in order to experience greater independence, economic participation and community inclusion? (Briefing Paper, November 2015)}\) 21.

\(^{802}\) TLRI, above n 69, Question 7.2(i).

\(^{803}\) Fifteen responses (including two from consultation sessions convened by Carers Tasmania).

\(^{804}\) TLRI, above n 69, Question 7.2(iii).
12.4.46 There were nine responses to this question, with seven stating that ADR should not be compulsory. Consistent with some of the earlier responses, it was commented that there may at times be reasons why mediation would be inappropriate. COTA also commented that ‘alternative forms of dispute resolution are unlikely to be effective if they are not entered into voluntarily.’

12.4.47 The Institute considers that enshrining the use of ADR is a critical reform to improve operation of the Act. ADR serves several functions, including ‘outcomes related to speed, efficiency, usability and accessibility.’ It may lead to more flexible and tailored solutions, greater satisfaction for the parties, a reduction in the number of Board hearings, and may ultimately eliminate the need for a representative appointment. It may also limit or reduce conflicts within families which may arise due to a perceived lack of communication or trust amongst members. A specific provision within the Act providing for the use of ADR signals the importance of trying to resolve matters informally and without the Board’s involvement. Use of ADR is therefore consistent with the principle of adopting the least restrictive alternative to meet a person’s needs.

12.4.48 It is important that the Board retain discretion to decide when referral to ADR processes may be appropriate. There may be occasions when the use of ADR is inappropriate. This might occur where there is power imbalance, allegations of abuse or neglect, history of family violence, or issues requiring the Board’s involvement.

**Recommendation 12.3**

1. That the Act give the Board power to refer a matter for mediation.
2. That the Board have mediation services available.
3. That the use of mediation not be compulsory.
4. That the Board be added as a prescribed tribunal under the *Alternative Dispute Resolution Act 2001 (Tas)*.

**An increased role for the Public Guardian?**

12.4.49 One of the Public Guardian’s functions is to give advice on the powers that may be exercised under the Act. This includes advice about the Act’s operation and appropriate alternatives to taking action under the Act. The Issues Paper commented that one option for reform could be an increased role for the Public Guardian to mediate to attempt to resolve disputes. One potential benefit suggested was reduction in the number of applications to the Board. However, the Institute is also cognisant that any reforms providing for an additional role for the Public Guardian would require adequate resourcing noting the already stretched resources of the OPG.

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805 Department of Justice, above n 778, 77. See also House of Representatives Standing Committee on Legal and Constitutional Affairs, above n 264, [3.221]; Independent Advisory Council of the National Disability Insurance Scheme, above n 801, 21.

806 For further discussion about the relevance of considering a party to mediation’s equal ability to participate in negotiations and arguments against compulsory mediation in the guardianship jurisdiction, see Robyn Carrol and Anita Smith, ‘Mediation in Guardianship Proceedings for the Elderly: An Australian Perspective’ (2010) 28 *Windsor Yearbook of Access to Justice* 53; Smith and Rigby, above n 433, 176–177.

807 *Guardianship and Administration Act 1995 (Tas)* s 15(1)(j).
12.4.50 Powers to this effect are conferred upon the Public Advocates in South Australia and Queensland. In South Australia, eligible persons may apply to the Public Advocate to provide preliminary assistance to resolve a range of matters relating to advance care directives. This includes:

- ensuring that the parties to the matter are fully aware of their rights and obligations;
- identifying the issues (if any) that are in dispute between the parties;
- canvassing options that may obviate the need for further proceedings; and
- where appropriate, facilitating full and open communication between the parties.

It also has power to mediate a matter, to make declarations in relation to matters falling within the scope of its authority as outlined in the Act and to give advice. The Public Advocate may refuse to determine an application if in their opinion it is more appropriate that the matter be dealt with by the Tribunal.

12.4.51 The Institute requested submissions about whether the Public Guardian should have any direct or increased role to try to resolve disputes.

### Should the Public Guardian have increased powers in relation to resolving disputes?

12.4.52 There were eight submissions addressing this question, five of which supported an increased role for the Public Guardian to mediate disputes. In supporting this reform, MIGA stated that it had observed performance of this mediation role by the South Australian Public Advocate as playing ‘an important and valuable role around resolving and mediating disputes, including amongst persons responsible.’

12.4.53 The OPG submitted:

Improved investigation and education powers for the OPG, in addition to our current function of providing information on the operation of the Act, would certainly place the OPG in a better position to provide informal dispute resolution assistance.

The OPG is not opposed to taking on a more formal conciliation role where there is a dispute or grievance about the decision of a formally appointed representative. Such a role fits well with the Public Guardian’s other functions and is conferred on Public Guardians and Public Advocates in other jurisdictions.

12.4.54 Members of the Elder Law Committee expressed the view that this reform was ‘probably not necessary except perhaps to take on an advocacy role and assist with ADR.’ It went on to

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808 Advance Care Directives Act 2013 (SA) ss 45(1), (2). An equivalent provision is included in the Care and Consent to Medical Treatment Bill 2016 (Tas): see cl 19; Guardianship and Administration Act 2000 (Qld) s 41. See also NSWLRC’s recent recommendations, above n 24, Recommendation 13.1(3).
809 As defined in Advance Care Directives Act 2013 (SA) s 43.
810 Ibid s 44.
811 Ibid s 45(1).
812 Ibid ss 45(2), 45(5)(a), 45(5)(b).
813 Ibid s 45(7).
814 TLRI, above n 69, Question 7.2(ii).
comment that ‘[t]his could save a lot of time and cost.’ The Board did not lodge a submission to this question, and the Public Trustee stated that it held no view.

12.4.55 As noted, one of the existing functions of the Public Guardian is to give advice about appropriate alternatives to taking action under the Act. Implicitly, this includes advising disputing parties to consider ADR. It is suggested that the Public Guardian have a more direct power to herself conduct mediations and make certain declarations, with the South Australian Act providing a useful guide for any legislative reform. This broader reform is consistent with earlier recommendations made in Part 5 proposing a role for the Public Guardian to attempt to resolve disputes in relation to advance care directives. This proposal is recommended for the following reasons:

- it provides another means to utilise ADR to attempt to resolve disputes. The benefits of ADR were discussed in the previous paragraph;
- it provides a free and accessible means of utilising ADR rather than commercial ADR providers which might involve a fee;
- attempts could be made to resolve disputes quickly and informally;
- it provides representatives access to information and guidance, functioning as support for supporters, and aiding good decision-making; and
- it complements the Public Guardian’s educative function and aligns with the Public Guardian’s expertise given existing roles under the Act.

12.4.56 It is noted that the OPG states that its present caseload acting as guardian for individuals precludes it from performing its systemic advocacy function assigned under the Act. It will be important to ensure that the OPG is adequately resourced to undertake this proposed new function. The reform may, however, have a positive effect upon resourcing of the jurisdiction as a whole with the aim that it will reduce Board applications and hearings.

**Recommendation 12.4**

That the Public Guardian have power to attempt to resolve disputes involving representatives, consistent with Recommendation 5.7.

**Disputes between representatives**

12.4.57 The Issues Paper raised the importance of avoiding and limiting disputes between representatives. Disputes may arise where decisions about a person’s life have both personal and financial components. For example, a decision about a represented person’s potential move to alternative accommodation involves a personal matter (i.e., where they live) and financial matter (i.e., the funding of that accommodation). Conflict between representatives could impede or delay decision-making and potentially compromise the interests of a represented person.

12.4.58 There are no specific provisions in the Act that address how conflicts between representatives are resolved. The Board has the power to give representatives advice and directions

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815 Guardianship and Administration Act 1995 (Tas) s 15(1)(j).
816 See Recommendation 5.7.
and has power to remove representatives if the test for their removal is satisfied.\textsuperscript{817} The Victorian \textit{Powers of Attorney Act 2014} enables attorneys to apply to VCAT for orders in relation to disagreements between representatives. That legislation provides a default position that it is an enduring guardian’s decision that prevails over that of an attorney.\textsuperscript{818} The Victorian Act requires an attorney to implement a decision of an enduring guardian unless the result would be a serious depletion of the donor’s financial resources.\textsuperscript{819} The Institute sought comment about whether a provision of this type would be of any benefit in reforming legislation.

\begin{itemize}
\item[Should there be a default priority given to the decisions of a guardian, or administrator/attorney?\textsuperscript{820}]
\end{itemize}

12.4.59 There was little support for legislative reform to provide a default priority to the decision of any particular representative. Only the OPG endorsed this reform, commenting:

The OPG believes a guardian’s decision should prevail over that of a financial administrator/attorney, presuming it is within the means of the represented person and would not result in a serious or detrimental depletion of their finances.

12.4.60 The Public Trustee submitted:

The Public Trustee takes the view that the issue of priority should not be a factor in decision-making but rather restricted to the powers and duties of the representative. If there is a conflict or discrepancy as to the application these powers and duties it is appropriate that tribunal of fact (the board) settle.

12.4.61 The Board did not endorse a default priority for representatives but raised another alternative that has been adopted and recommended in other jurisdictions:

The Board notes the Northern Territory guardianship legislation provides that where there is a dispute that multiple decision makers cannot resolve by themselves, the tribunal can make orders to facilitate the resolution of their differences. NSWLRC in its ‘Draft Proposals’ in its review of the NSW \textit{Guardianship Act 1987} has recommended that ‘The new Act should provide that, if there are 2 or more representatives and the representatives cannot agree on one or more decisions that need to be made, after attempting to resolve the disagreement (whether informally or through mediation) the representatives may apply to the Tribunal for direction to resolve any such disagreement.

This type of approach appears to be more flexible and adaptable to individual circumstances, than the legislation directing which decision maker’s decision will take priority.

12.4.62 Members of the Elder Law Committee observed that disputes between representatives are uncommon and that many individuals have only an administrator or guardian acting for them.

12.4.63 Reflecting the submissions received, reform providing a default priority to one representative is not proposed. Existing provisions address the potential for disputes, including via the Board’s ability to give representatives advice and directions, and the ability to remove

\begin{itemize}
\item[817] Refer to \{12.5\} below.
\item[818] \textit{Powers of Attorney Act 2014} (Vic) s 71.
\item[819] Ibid s 72.
\item[820] TLRI, above n 69, Question 7.2(iv).
\end{itemize}
representatives if appropriate.\textsuperscript{821} It is also envisaged that Recommendations 12.3 and 12.4 proposing an increased role of ADR to resolve disputes will also have a positive impact upon disputes that may arise.

\textbf{Disputes in relation to decisions of the Public Guardian or Public Trustee}

12.4.64 There are no special provisions in the Act in relation to appealing a decision of the Public Trustee or Public Guardian. Both have internal review procedures, and more formal complaints may be made to the Ombudsman. The Board also has power to supervise their actions as representatives in the same way that it does private representatives. The Issues Paper did not ask whether there should be any special provisions dealing with a person’s ability to object to a decision of the Public Guardian or Public Trustee. Nevertheless, the OPG submitted that:

\begin{quote}
The OPG believes consideration should be given to the Act providing some limited mechanism for the Board to review a decision made by the Public Guardian or The Public Trustee after internal review mechanisms have been pursued. However this requires very careful consideration. Such a mechanism should not simply provide an alternative forum for someone to seek a different decision — the transfer of authority for decision-making from the Public Guardian or The Public Trustee back to the Board should be avoided. The President of the Board should probably have the discretion to accept or reject an application for review of a decision; if accepted, a panel of the Board could have the power to affirm the decision or send it back to the Public Guardian or The Public Trustee for reconsideration. This would put the focus on the process of decision-making and avoid the pursuit of a different decision on the ground that a represented person or interested party simply disagrees with the decision made.
\end{quote}

12.4.65 As this was the only submission raising this issue, the Institute has not considered the matter further.

\textbf{Other options?}

12.4.66 The Institute asked more broadly whether there were other ways that the Act might better facilitate the resolution of disputes or disagreements amongst representatives.

\begin{quote}
\textbf{How else could the Act better resolve disputes or disagreements between representatives?}\textsuperscript{822}
\end{quote}

12.4.67 Responses to this question primarily raised ADR or informal approaches to resolve disputes. One respondent raised the benefits of ensuring that representatives are educated about their role and responsibilities. These strategies are considered elsewhere in this Report.

\textbf{12.5 Revoking or altering the appointment of a representative}

12.5.1 This next section reviews when and how representatives may be removed if they are acting improperly or become inappropriate for the role. The following parts of this Part review when Board orders appointing representatives ought to be terminated due to lack of need.

\\textsuperscript{821} \textit{Guardianship and Administration Act 1995 (Tas)} ss 31, 61 (in relation to offering advice and directions), ss 67, 68 (in relation to removing representatives).

\textsuperscript{822} TLRI, above n 69, Question 7.2(v).
12.5.2 Removing an inappropriate representative is one way to protect the interests of a represented person and thus serves as a safeguard. It touches upon two of the ALRC’s Safeguards Guidelines:

- Safeguards should ensure that interventions for persons who require decision-making support are … (c) subject to regular, independent and impartial monitoring and review; and
- Support in decision–making must be free of conflict of interests and undue influence.823

12.5.3 It is appropriate and desirable that the Act provide broadly consistent tests to remove both enduring guardians and Board-appointed representatives where it is inappropriate for them to continue in the role. The following paragraphs explain the current tests to remove enduring guardians and Board-appointed representatives. Options for reform are then evaluated and proposed.

Revoking or altering an instrument

12.5.4 The Board has power to revoke or amend an instrument.824 The Public Guardian, the enduring guardian, the donor, their administrator or any person the Board considers has ‘a proper interest in the matter’ may apply to the Board for the review of an instrument.825 The drafting of the section does not enable the Board to review an instrument ‘of its own motion’, meaning that it cannot instigate its own review.826 The Board may instigate the review of an enduring power of attorney under the *Powers of Attorney Act*,827 and can also review orders appointing administrators and guardians of its own motion.828 This can, and has, created issues where the Board has considered it appropriate to instigate a review of an instrument, but has not had the power to do so under the Act. The Board’s submission expressed its concern in this regard. The OPG also proposed this as a matter requiring legislative reform. The Institute agrees that it is appropriate to provide consistency with other provisions and enable the Board to conduct a review of an instrument of its own motion.

Recommendation 12.5
That the Board have power to review an instrument of its own motion.

Issues with the document itself

12.5.5 The Board has power to declare an instrument invalid if satisfied that the donor did not have the capacity to make the instrument, it is contrary to the Act, or the donor was induced to make it by reason of dishonesty or undue influence.829

12.5.6 The Act only deals with revocation of instruments. It does not deal with the revocation of revocations of instruments, unlike the *Powers of Attorney Act*.830 It is appropriate for the Board to have

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823 ALRC, above n 3, Recommendation 3-4.
824 *Guardianship and Administration Act 1995* (Tas) s 34.
825 Ibid s 34(3).
826 Ibid s 34.
828 Ibid s 67.
829 Ibid s 34(1A).
830 Ibid s 33(2).
The equivalent powers to review Revocations as it does for instruments. The OPG’s submission supported this reform.

**Recommendation 12.6**

That the Act confirm that the Board’s powers to revoke instruments extend equally to revocations of instruments.

**Issues with the enduring guardian**

12.5.7 To revoke the appointment of an enduring guardian, the Board must be satisfied that the enduring guardian:

- is not willing or able to act in that capacity; or
- has not, in that capacity, acted in the best interests of the donor; or
- has acted in an incompetent or negligent manner or contrary to the Act.\(^{831}\)

12.5.8 It is not explicit that the Board can only revoke an instrument where the donor does not have the ability to do so themselves. It is appropriate that this is confirmed as it would be inappropriate to revoke the appointment of an enduring guardian where the donor retains the ability to do so themselves. This is consistent with the test to revoke the appointment of an enduring guardian in Victoria.\(^{832}\)

12.5.9 There are differences between the Act and the equivalent powers to revoke an enduring power of attorney under the *Powers of Attorney Act*. These include:

- after revoking an enduring power of an attorney, the Board may appoint a substitute attorney.\(^{833}\) There is no express power under the Act to appoint a substitute enduring guardian;\(^{834}\) and
- the Board can suspend an enduring power of attorney.\(^{835}\) There is no equivalent power to suspend an instrument within the Act. The Board’s submission raised this as a matter for reform.

The Institute recommends consistency with the *Powers of Attorney Act*.

**Recommendation 12.7**

(1) That the wording of s 34(1)(b) of the Act be revised to confirm that the Board may only revoke or amend an instrument where the donor does not have decision-making ability to revoke or amend the instrument.

(2) That the Board have power to appoint a substitute enduring guardian after revoking an enduring guardian’s appointment where the instrument does not already provide a substitute.

(3) That the Board have power to suspend an instrument.

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\(^{831}\) *Guardianship and Administration Act 1995 (Tas)* s 34(1)(b).

\(^{832}\) *Powers of Attorney Act 2014 (Vic)* s 120(2).

\(^{833}\) *Powers of Attorney Act 2000 (Tas)* s 33(2)(b).

\(^{834}\) The Board’s submission commented, however, that it may use its powers to amend an instrument to appoint a substitute enduring guardian.

\(^{835}\) Ibid s 33(4A)(a).
Revocation or alteration of appointment as guardian and administrator

12.5.10 The Board can review an order appointing an administrator or guardian.\(^{836}\) It may do so of its own motion or after receiving an application by, or on behalf of, a represented person or any other person.\(^{837}\) After conducting a review, the Board may vary or continue a guardianship or administration order, subject to any conditions or requirements it considers necessary, or it can revoke the order.\(^{838}\)

12.5.11 The Act does not set out any test that the Board must apply when deciding whether to revoke, vary or continue an order. The Issues Paper listed examples of tests that apply to revoke the appointment of a representative elsewhere, including where:

- they are no longer competent;\(^{839}\)
- they are no longer suitable;\(^{840}\)
- someone else is more appropriate to be the representative;\(^{841}\)
- they request to be removed;\(^{842}\)
- it would be in the represented person’s best interests;\(^{843}\)
- they have failed to exercise their functions or powers;\(^{844}\) or
- they have contravened the Act.\(^{845}\)

The Issues Paper asked for views about what test(s) should apply to remove a representative.

What test should apply to revoke the appointment of a representative?\(^{846}\)

12.5.12 There were 11 responses to this question. Many referred to removal of a representative where there is evidence of abuse, maltreatment or maladministration of a person’s financial affairs. More broadly, it was submitted that a representative ought to be removed where they are not performing the role adequately or breaching the Act. On the other hand, it was commented that

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\(^{836}\) Guardianship and Administration Act 1995 (Tas) s 67.

\(^{837}\) The section does not require the applicant to have ‘a proper interest in the matter’ as is required for other applications under the Act.

\(^{838}\) Guardianship and Administration Act 1995 (Tas) s 68(1). The section does not refer to the Board being able to make ‘any orders or directions that it could make in relation to hearing an application for administration or guardianship’, as is included elsewhere.

\(^{839}\) Guardianship and Management of Property Act 1991 (ACT) s 31. This includes where the interests of the adult have not been adequately protected, they have neglected their duties, or abused their powers, or contravened the Act: Guardianship and Administration Act 2000 (Qld) s 51(5).

\(^{840}\) Guardianship and Management of Property Act 1991 (ACT) s 31.

\(^{841}\) Guardianship and Administration Act 2000 (Qld) s 31(4).

\(^{842}\) Guardianship Act 1987 (NSW) s 25U.

\(^{843}\) Ibid.

\(^{844}\) Guardianship and Management of Property Act 1991 (ACT) s 31.

\(^{845}\) Ibid.

\(^{846}\) TLRI, above n 69, Question 7.3(i).
there should be a substantive reason to remove a representative rather than conduct perceived as minor.\footnote{An attendee at a Carers Tasmania facilitated meeting commented that doing something contrary to the represented person’s interests shouldn’t be as minor as something like failing to put sugar in their tea.}

12.5.13 The Public Trustee submitted:

The PT takes the view that if the person has regained capacity then the representative’s appointment will be revoked. Further, if a representative is in substantial breach or a conflict arises in respect of their capacity to undertake their duties and exercise their powers under the Act, then the Board should have the power to revoke the appointment.

12.5.14 It is proposed that the Act outline a test for the Board to apply to remove a representative from the role (as distinct from terminating its order appointing a representative). As noted above, there is presently no test that the Board must apply. There is, however, a test to apply to remove an enduring guardian. It provides appropriate guidance and equality of treatment for the tests to be consistent where possible.

12.5.15 It is suggested that the following tests that currently apply to the removal of enduring guardians remain and that they be extended to also apply to Board-appointed representatives:

- where the representative is not willing or able to act in that capacity; or
- where the representative has acted in an incompetent or negligent manner or contrary to the Act.

Both of these remain appropriate grounds to remove a representative, and no submissions proposed reform to these elements of the test.

12.5.16 The Issues Paper noted that the Act does not currently contemplate the Board revoking or altering the appointment of a representative because of a change in circumstances, for example, if the relationship between a donor and representative ends and it becomes inappropriate for them to continue in the role. Currently, to remove an enduring guardian in these circumstances, the Board would need to consider that, because of the breakdown in a relationship, the enduring guardian is not ‘able’ to act as enduring guardian. The OPG submitted:

the OPG believes consideration should be given to empowering the Board to consider the appropriateness of the representative continuing in the role subsequent to a significant change in the relationship between the donor and the representative such as separation or divorce. This could potentially be by way of a test about the suitability of the representative or changes in circumstances such that someone else is more appropriate.

The Board also endorsed this reform as did PCT.

12.5.17 The Issues Paper noted that in Queensland and the Northern Territory, the tribunal may revoke an instrument where it is satisfied that, because of a change in the donor’s circumstances, or other circumstances, the document is inappropriate.\footnote{Powers of Attorney Act 2000 (Qld) s 117; Advance Personal Planning Act 2016 (NT) s 61(2)(h).} The Northern Territory Act provides:
61 Tribunal may amend or revoke advance personal plan

(2) There are grounds for amending the advance personal plan if one or more of the following applies:

(h) there has been a major change in circumstances since the plan was made;

Example for subsection (2)(h)

Major changes in circumstances might include the following:

(a) a person appointed as decision maker losing decision-making capacity;
(b) the adult getting divorced or becoming estranged from other family members;
(c) a decision maker being convicted of an offence that makes it unsuitable for him or her to continue to be a decision maker.

(3) The Tribunal may amend the advance personal plan if satisfied that:

(a) there are grounds for amending the plan; and
(b) the amendment is reasonably necessary to address those grounds; and
(c) if the adult had planning capacity, he or she would agree to the amendment.

(4) However, the Tribunal may amend the advance personal plan so as to terminate the appointment of a person as a decision maker only if satisfied that doing so is the only practicable way to address the grounds for amendment.\(^{849}\)

12.5.18 The Institute endorses the Northern Territory approach and proposes that this form the basis for reform in Tasmania. This approach is reflective of the importance of ensuring that the Act gives priority to an individual’s will and preference by providing that the tribunal may only alter the appointment of a representative where it considers that the person would agree to the amendment. The appointment of an enduring guardian is one expression of a person’s will and preference. Their choice of enduring guardian might not necessarily reflect what is considered by others to be in their ‘best interests’. Consistent with the overriding principle of the Convention, and as reinforced and interpreted by the ALRC’s recommendations, a person’s will and preference should only be overridden to prevent harm and to preserve and promote the individual’s rights.

12.5.19 In relation to Board-appointed representatives, it is proposed that the test require the Board to evaluate the suitability of the representative against the eligibility requirements to be appointed to the role.\(^{850}\) This is consistent with submissions received, and the equivalent section in the Northern Territory.\(^{851}\)

Recommendation 12.8

That, to revoke the appointment of a representative, the Board need to be satisfied that:

(a) in relation to all representatives (enduring guardians and Board-appointed representatives):

- the representative is not willing or able to act in that capacity; or

\(^{849}\) Advance Personal Planning Act 2016 (NT) s 61.

\(^{850}\) Currently in Guardianship and Administration Act 1995 (Tas) ss 21, 54. These provisions are discussed below at [12.8.32]–[12.3.34].

\(^{851}\) Guardianship of Adults Act 2016 (NT) ss 37(1)(b), s 37(2).
• the representative has acted in an incompetent or negligent manner or contrary to the Act; or

(b) in relation to enduring guardians only, that there has been a major change in circumstances since the appointment was made and:

• the amendment is the only practicable way to address this circumstance; and

• if the donor had decision-making ability, he or she would agree to the amendment; and

(c) in relation to Board-appointed representatives only, that the representative no longer meets the eligibility requirements that apply to be appointed as a representative.

**Automatic revocation**

12.5.20 The appointment of a representative is not automatically revoked in any circumstances, for example, upon the ending of a relationship. The Issues Paper noted that in Queensland, the appointment of a representative is automatically revoked upon the ending of the relationship between the represented person and the representative. It was asked whether members of the public considered it appropriate to provide for the automatic revocation of representatives upon the happening of certain events. This issue was also addressed separately in relation to the appointments of enduring guardians, discussed in Part 4.

**Should the appointment of a representative be automatically revoked in certain circumstances? If so, when?**

12.5.21 There were eight responses to this question with mixed responses received. Half of respondents endorsed automatic revocation of the appointment of a representative in certain circumstances. These included:

• upon the death of the donor or representative;

• incapacity of the representative;

• where the representative no longer wishes to continue in the role;

• where the representative cannot be contacted and therefore cannot fulfil the role;

• where there is significant concern about or harm to the represented person, or they have acted unlawfully;

• there is a conflict of interest; and

• in circumstances similar to those contained in the ACT legislation, including revocation upon marriage or divorce (unless the enduring document states a contrary intention).

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852 The Powers of Attorney Act 2000 (Tas) provides that an enduring power of attorney is automatically revoked if the donor dies, the donor and the attorney cease to be married, or parties to a registered personal relationship under the Relationships Act 2003 (Tas), or upon an attorney being subject to a mental incapacity: Powers of Attorney Act 2000 (Tas) s 32AE(3). The NSWLRRC has recently endorsed this approach: NSWLRRC, above n 24, Recommendation 8.18.

853 Guardianship and Administration Act 2000 (Qld) s 26.

854 See [4.6.8]–[4.6.15].

855 TLRI, above n 69, Question 7.3(ii).

856 The Public Trustee’s submission stated on the other hand that the ‘Public Trustee takes the view that death does not constitute revocation but rather expiration of the order.’
12.5.22 Other responses indicated a preference for the revocation of an appointment to be a matter for the Board’s discretion.

12.5.23 This matter was also considered in Part 4 in relation to any automatic revocation of the appointment of an enduring guardian. Recommendation 4.13 proposes that the Act confirm that the appointment of an enduring guardian is revoked upon the death of the donor, and that it provide that an enduring guardian’s appointment be suspended if the enduring guardian does not have decision-making ability to act in that capacity. The Act already confirms that an order appointing an administrator ceases to have effect (except in relation to payment of funeral expenses) upon the death of the represented person. Recommendation 12.8 proposes that the Board be able to remove a representative if the representative is not willing or able to act in that capacity.

12.5.24 With this context, and reflecting the submissions received, the Institute concludes that the further matters to be resolved are the suspension of the appointment of an order appointing a representative where the represented person does not have decision-making ability to act in that capacity, and, in relation to administrators, upon an administrator becoming bankrupt or insolvent. This later recommendation is consistent with the approach in Queensland, and the approach that applies under the Tasmanian Powers of Attorney Act in relation to attorneys. In circumstances where an order is suspended due to an administrator becoming bankrupt or insolvent, then it is appropriate to require that administrator to advise the Board so that it can review its order and make any subsequent orders as required. This is required in Queensland.

12.5.25 The Board would retain discretion to remove a representative in other circumstances, including where there was a major change in circumstances including the nature of the relationship between the representative and the represented person, as outlined in Recommendation 12.8.

**Recommendation 12.9**

(1) That the Act provide that an order of the Board appointing a representative is suspended if the representative does not have decision-making ability to act in that capacity.

(2) That an order appointing an administrator be suspended upon the administrator becoming bankrupt or insolvent.

(3) That if the appointment of an administrator is suspended because of bankruptcy or insolvency, that administrator be required to advise the Board of that circumstance.

**Steps after an appointment is revoked**

12.5.26 The Act does not impose any requirements upon former representatives to do anything to conclude their role, including the handover of documents and assets to a newly appointed representative or the person themselves. Members of the Elder Law Committee commented upon this issue, stating ‘[o]nce a representative is no longer acting the Tribunal has no power.’

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858 See [4.6.8]–[4.6.15].
859 Guardianship and Administration Act 1995 (Tas) s 56(6).
860 Guardianship and Administration Act 2000 (Qld) s 26(2).
861 Powers of Attorney Act 2000 (Tas) s 32AE(5).
862 Guardianship and Administration Act 2000 (Qld) s 26(3).
12.5.27 In New South Wales and the Northern Territory, legislation provides that former administrators are required to take all reasonable steps to provide for the transfer of control of the estate of a represented person to either the person if they have gained capacity, to their administrator, or the executor or administrator of their estate (as relevant). It is an offence to intentionally engage in conduct that contravenes these provisions and the person is reckless in relation to the result.

12.5.28 The Institute asked whether individuals considered that the Act should contain provisions requiring former representatives to do anything upon their appointment being revoked.

Should the Act impose requirements upon former representatives to facilitate the transfer of their role and assets upon their powers ending?

12.5.29 There were five responses to this question with four supporting reform to confirm the duty of a former representative to facilitate the handover of control and assets upon ceasing in the role. The fifth submission suggested that instead, the Act could confirm that the former representative ‘not unreasonably obstruct’ this process.

12.5.30 Based on support for this approach, and to support the represented or former represented person’s interests being promoted, it is proposed that the Act confirm that former representatives must facilitate the transfer of their role upon their appointment ending.

**Recommendation 12.10**

That the Act require former representatives to facilitate the handover of authority upon termination of their appointment. Handover should occur as follows:

(a) if a new representative is appointed, then to the new representative;
(b) if an order appointing a representative is terminated, then to the person who was formerly a represented person; and
(c) if terminated because of the death of the represented person, then to their legal personal representative.

12.6 Monitoring of representatives

12.6.1 The ALRC’s Safeguards Guidelines provide that interventions for people who require decision-making support must be subject to regular monitoring. This section considers how the Act deals with monitoring of representatives. Different provisions apply to Board-appointed representatives and enduring guardians. These are discussed in turn below.

**Monitoring of Board-appointed representatives**

12.6.2 The Board oversees the activities of representatives. The Public Guardian has power to investigate complaints and allegations against representatives or any other matter that the Board

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863 Guardianship Act 1987 (NSW) s 25Q; Guardianship of Adults 2016 (NT) s 92(1).
864 Guardianship of Adults Act 2016 (NT) s 92(2).
865 TLRI, above n 69, Question 7.3(iii).
866 Guardianship and Administration Act 1995 (Tas) ss 63, 66.
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refers. The Board also has discretion to delegate its powers and functions in relation to receiving reports from administrators. The Issues Paper noted that in most jurisdictions, representatives report to the respective state Public Trustees rather than to the tribunal. It was observed that the Public Trustee has appropriate expertise to conduct this function and that it would reduce the Board’s workload (but increase the Public Trustee’s workload).

12.6.3 The Issues Paper asked who ought to be responsible for receiving and interrogating representative’s reports.

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12.6.4 There were eight responses addressing this question, with six supporting retention of existing arrangements of representatives reporting to the Board. The Board submitted:

The Board sees benefit in following the lead of other guardianship jurisdictions and having administrators report to the Public Trustee, who have their own financial and legal department and personnel with appropriate skill and expertise.

12.6.5 The OPG commented that ‘the Board should be able to outsource the monitoring and audit of complex financial matters/estates’, commenting that the Public Trustee could perform this function. The Public Trustee submitted that there be no change to the existing arrangements.

12.6.6 The Institute considers that there is merit in this potential reform being the subject of further investigation and reflection, for the reasons articulated in the Board’s submission. Recommendations have not been made as part of this review given the desirability of further consultation with key stakeholders impacted by the potential reform, notably the Public Trustee. Relevant considerations include resourcing implications and how to address conflicting interests where the Public Trustee is acting as administrator. It is also noted that the Public Trustee is a Government Business Enterprise (GBE) and any transfer of the auditing function should not result in any increase in cost to the represented person. If this reform were to proceed, it would also need to be decided whether accounts would also need to be provided to the Board or only the Public Trustee.

12.6.7 Members of the Elder Law Committee submitted that there may be merit to reform making provision for reports to be provided to family members or others close to a represented person:

Whilst it is important not to make representative’s job too burdensome, could there be some provision for reporting to other family with a legitimate interest (e.g. spouse or

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867 Ibid s 17. The Public Guardian reports that she receives few requests from the Board to investigate matters, with the Board undertaking that function. The Public Guardian has expressed a view that this function should be one for the Public Guardian to perform, rather than the Board as practice has developed: OPG, above n 578, 22–23.

868 Guardianship and Administration Act 1995 (Tas) s 64.

869 Trustee and Guardian Act 2009 (NSW) pt 4.5 div 2; Guardianship and Administration Act 1990 (WA) s 80(1); Guardianship and Management of Property Act 1991 (ACT) s 26(1); Guardianship and Administration Act 1986 (Vic) s 58(1); Guardianship and Administration Act 1993 (SA) s 44.

870 TLRI, above n 69, Question 7.4(i).

871 Related to this point, Speak Out submitted that ‘[s]ome of us think people who get paid shouldn’t be administrators. you shouldn’t pay money for this service when you don’t have much money.’
child) upon that family member’s request? It is one reason people will apply to the GAB to be appointed as the new guardian - only because they are being shut out.

There could be a list as to basic reporting requirements (e.g. location of person). This requirement could be imposed on an ‘unless directed by the Board’ basis. There would need to be an ability for the guardian to apply for an exception to reporting requirements where there is a good reason (e.g. there might be reasons where it would not be safe for a spouse or child to know of the represented person’s whereabouts, such as where there is a history of domestic violence).

12.6.8 Recommendation 3.3 proposes that one of the revised guiding principles of the Act be that ‘the role of families, carers and other significant persons in an adult’s life to support the adult to make decisions must be acknowledged and respected.’ Given the need to balance the desirability of carers and other informal supporters being kept informed of relevant information, with the right of a represented person to privacy, the Institute has not proposed mandatory (or opt out) reporting requirements to families and other carers. It is considered that this is a matter for the Board to consider in its discretion in each individual case. This would include reflection upon the guiding principles of the Act, including the fundamental requirement of promoting an individual’s views, wishes and preferences.

Frequency of reports

12.6.9 There are different reporting requirements for guardians and administrators within the Act. Administrators must provide the Board with a statement of the estate accounts at times that the Board determines. The Act does not state how frequently accounts must be supplied and it is a matter for the Board, although the Institute understands it is the Board’s usual procedure to require annual accounting. Failure to provide a statement of accounts without reasonable excuse is an offence with a penalty able to be imposed.

12.6.10 At least once every 12 months, the Board must obtain and consider a written report from a representative on the circumstances of a represented person. There is otherwise no prescribed reporting requirement for guardians, although the Board can make orders requiring guardians to provide reports or records.

12.6.11 If the Board requests a representative to provide a written report, this must be provided within 14 days of that request (or the Board may allow a further period). Failure to provide the report as requested is an offence and a fine may be imposed.

12.6.12 The Issues Paper asked about the regularity of reporting requirements placed upon representatives.

How frequently should reports be required?

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872 In a form approved by the board and verified by statutory declaration signed by the administrator with such other evidence as the board may require: Guardianship and Administration Act 1995 (Tas) ss 63(1), 63(2).
873 Guardianship and Administration Act 1995 (Tas) s 63(7).
874 Ibid s 66(1). The Board advises that failure to submit receipts and statements within three months of the first request will trigger an automatic review hearing: Guardianship and Administration Board, above n 235, 9.
875 Ibid s 66(3).
876 Ibid s 66(2).
877 TLRI, above n 69, Question 7.4(ii).
12.6.13 Nine responses addressed the matter of representative’s reporting requirements. Four responses\(^{878}\) submitted that there is no need to change the existing reporting requirements. The Public Trustee submitted that this should be a matter that the Board determines in its discretion on a case-by-case basis. In addressing a later question in the Issues Paper, the Public Trustee also submitted that:

Safeguards of representative persons could be improved with increased reporting and accounting responsibilities for representatives. However, this would come at a cost that should be pragmatically balanced.

12.6.14 The Institute has concluded that the existing provisions governing the frequency in which Board-appointed representatives must report to the Board\(^{879}\) are appropriate.

12.6.15 Speak Out advocates commented upon the content of representative’s reports. They suggested that representatives should be required to set out within their report what they consider to be desirable future steps to enable the represented person to make their own decisions, including articulating opportunities to progress and develop their decision-making skills. They also submitted that the Board should be required to speak with the represented person themselves and not rely solely upon a written report from a representative.

12.6.16 The Institute endorses these suggestions, and notes that they align with or complement other recommendations made in this Report including:

- Recommendation 7.3, which proposes that the Board’s standard application forms require applicants to describe what supports have been provided to a person prior to making an application for the appointment of a representative. If applicants must describe informal supports provided prior to the making of an application, then it is appropriate for there to be an equivalent ongoing requirement to articulate what supports have been offered or are available to build a represented person’s decision-making skills; and

- Recommendation 8.3, which proposes that representatives have an express duty to offer decision-making support to a represented person and to develop their decision-making abilities. Requiring representatives to report against this duty assists to promote compliance.

12.6.17 For these reasons, the Institute proposes that the Board’s forms and procedures require representatives to report against their efforts to support a represented person to make their own decisions and to consider and articulate future opportunities to build their decision-making skills.

12.6.18 It is also proposed that, to the greatest extent possible, the Board be required to give a represented person the opportunity to speak directly with the Board to convey their views about the arrangements and their appointed representative. This serves the following functions:

- it promotes the importance of a represented person’s views, wishes, and preferences. To reflect this approach, it is proposed that a represented person be given the opportunity to speak with the Board, rather than this being a mandatory requirement — as a represented person should have the right to decline an invitation consistent with their wishes;

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\(^{878}\) Board, OPG, members of the Elder Law Committee, Keith Anderson. Four responses to this question did not directly answer the issue of the frequency of provision of accounts

\(^{879}\) See [12.6.9]–[12.6.10].
• it aligns with the importance of including a represented person in Board proceedings as much as possible, a matter discussed further in Part 15; and

• it acts as a safeguard by providing an opportunity for a represented person to raise any concerns that they hold, and for there to be an independent assessment of the person’s circumstances.

Recommendation 12.11

(1) That reports from representatives require representatives to:

(a) describe attempts to encourage and support the represented person to develop their decision-making skills; and

(b) articulate any future opportunities identified to build the represented person’s decision-making skills.

(2) That the Board’s processes when receiving reports from representatives provide opportunity for a represented person to speak directly with the Board’s registry staff as part of the reporting process wherever possible.

Oversight of enduring guardians

12.6.19 As noted above, there are different oversight and reporting requirements for enduring representatives (attorneys, under the Powers of Attorney Act, and enduring guardians under the Act). This review is limited to a review of the oversight provisions governing enduring guardians which are included within the Act.

Notification of commencing to act

12.6.20 Subject to the terms of an instrument, an enduring guardian is not required to notify the Board or any other person that their powers have been triggered or that they have commenced acting as a person’s enduring guardian. An enduring guardian does not necessarily need any particular evidence to trigger their powers having effect.880 The same approach is taken in relation to attorneys under the Powers of Attorney Act.

12.6.21 The Issues Paper commented that, without the need to give notice, it can be difficult to ascertain who has an enduring guardian acting on their behalf. This information could assist to provide greater oversight over the activities of enduring guardians and provide a check to ensure that enduring guardians are only acting when the donor does not have decision-making ability. The Issues Paper also noted that requiring enduring guardians to give notice that they have commenced acting might create issues, including:

• the likely cost and complexity of resourcing this;881

• that a person’s loss of decision-making ability is typically not an ‘event’, but a process that occurs over time. A person’s ability might also fluctuate. This can make it difficult to determine the point at which an enduring guardian’s powers are activated; and

880 Although this may be prudent.

881 QLRC, above n 25, [104].
an enduring guardian might start assuming roles over only certain, limited aspects of a donor’s life, given the relative nature of decision-making ability and that it depends on the nature of each decision to be made. Notification that an enduring guardian has commenced acting might create an inaccurate perception that the scope of an enduring guardian’s authority extends beyond those matters for which the donor does not have decision-making ability. This may have unintended, adverse consequences for the donor exercising their legal capacity.

12.6.22 The Institute notes the following options:

- to make no reform to the Act;
- to mandate reporting to the Board or another individual or body upon an enduring guardian commencing to act in the role.

An example of this approach was recommended by the ACTLRAC. It recommended that, for an enduring guardian to commence acting, an application to the tribunal should be required. Its rationale is that the tribunal can then confirm that attempts to provide the person with support have been exhausted. The ACTLRAC recommended that an enduring guardian be permitted to act in an emergency where a donor has lost decision-making capacity, but if the donor did not recover within the short term, then an application be made to the tribunal. The NSWRLC’s recent final report on its review of guardianship legislation in New South Wales, on the other hand, did not advocate this approach; or

- to provide an option for donors of instruments to nominate that their enduring guardian must notify the Board or another individual or body upon them commencing in the role.

An example of this approach is the Victorian Act which provides that a donor can nominate a person who the enduring guardian must take reasonable steps to notify when they commence acting. The QLRC also recommended that the standard form instrument make it clear that a donor can nominate a person who must be notified when the enduring guardian’s powers are activated.

12.6.23 The Institute sought to understand whether there was support for reform to the Act to require that an enduring guardian give notice upon them considering that their powers have been invoked.

Should an enduring guardian have to notify the Board or the Public Guardian that their appointment has become operative, or to have their powers confirmed?

12.6.24 There were eight responses to this question. Four supported reform requiring an enduring guardian to notify the Board upon them commencing to act in the role. In supporting this reform, the Board commented:

882 ACTLRAC, above n 24, Recommendation 8.2. See also VLRC, above n 24, [16.123]–[16.125].
883 ACTLRAC, above n 24, Recommendation 8.3.
884 NSWRLC, above n 24, [14.64].
885 Powers of Attorney Act 2014 (Vic) s 40.
886 QLRC, above n 25, Recommendation 16-16.
887 TLRI, above n 69, Question 7.5.
There is merit in an enduring guardian being required to notify the Board that their appointment has become operative. In practice, this question is not infrequently contentious on applications to review an instrument that seeks the removal of a particular guardian. It is also an opportunity to put guardians on notice of their obligations to the appointor. It would also be helpful if such notification were accompanied by a medical certificate verifying incapacity to make relevant decisions, thereby ensuring that the instrument is not abrogating a person’s rights.

12.6.25 The OPMHS also commented:

Yes – it would be very helpful to have a record of whether someone is actually acting as an enduring guardian and it might be worthwhile to ask for an independent capacity assessment to ensure that people do not just take over when in fact they shouldn’t.

12.6.26 The OPG reserved its position, stating:

The OPG believes there is some merit in this proposal however there are also some difficulties, as outlined in the Issues Paper. Aside from the costs and practicalities from an administrative point of view, we are concerned that formal notification that the appointee has commenced acting might lead to a presumption or perception that the represented person has a global loss of capacity, rather than a domain or decision-specific or a temporary loss of capacity. The OPG is very much in favour of nationally consistent legislation for enduring guardianship; as policy work is underway at a national level in this area, we reserve our view.

12.6.27 The Public Trustee stated that it held no view.

12.6.28 Members of the Elder Law Committee did not support reform to the existing arrangements. It commented that ‘[t]he operative point is often a gradual process. Family representatives may not know an exact date.’

12.6.29 The Institute considers that oversight over the activities of enduring guardians is desirable. Rationales include:

- as discussed in Part 6, the assessment of a person’s ability to make decisions is fundamental to the operation of the Act. It is therefore critical that this assessment is conducted accurately. A representative may not be properly trained to conduct that assessment and may also have conflicting interests. Requiring the enduring guardian to have to notify a person or body that it is their view that their powers have been triggered enables that conclusion to be challenged;

- it provides greater transparency and accountability. The ability to better supervise enduring guardians might be particularly helpful where the donor is socially isolated and does not have others within their existing social networks to observe their enduring guardian’s conduct;

- periodic oversight is a safeguard that already exists for those with a Board-appointed representative;

- the ALRC’s Safeguards Guidelines advocate the need for regular monitoring; and

- a number of respondents expressed a view that there should be reform to the Act dealing with the reporting requirements of enduring guardians.
12.6.30 Whilst it is agreed that there is merit to providing an independent and specialist assessment of the need for a representative decision, the Institute has not made an equivalent recommendation to that proposed by the ACTLRAC. This is due to the issues outlined above, including:

- that a person’s loss of ability is typically not an ‘event,’ but a process that occurs over time. Alternatively, a person’s decision-making ability might fluctuate;

- a person’s ability to make decisions is domain-specific. It is foreseeable that a provision to this effect would necessitate an application to the Board on each occasion a decision needed to be made, so that an assessment could be made of the individual’s ability to make decisions at that time, and in relation to that matter specifically. This would jeopardise the functioning of the jurisdiction by substantially increasing its workload; and

- an order or declaration confirming whether the powers of an enduring guardian have been activated might create misunderstanding about the enduring guardian’s actual authority. It might be incorrectly understood that the enduring guardian has power to act over multiple areas of a person’s life, rather than their power being limited to perhaps a small number of areas of a person’s life.

12.6.31 A further rationale for not proposing reform at this time is the appropriateness of consistent approaches applying to enduring guardians and attorneys under the Powers of Attorney Act. If reform were made to the Act to require enduring guardians to seek an order of the Board to trigger commencement of their powers, then it would be appropriate for an equivalent position to apply in relation to attorneys. The Institute’s Terms of Reference for this project did not extend to review or consideration of the need for reform to the Powers of Attorney Act and broader consultation is appropriate in order to determine the desirability of reform to the legislative framework governing enduring appointments collectively. It is noted that Recommendation 17.4 proposes that there be a separate review of the Powers of Attorney Act in light of the matters raised in this Report, including the discussion in this Part.

12.6.32 It is noted that, not uncommonly, third parties are involved when enduring guardians make decisions on behalf of a donor. This could include, for example, the staff of a residential care facility, or a health professional. Those third parties are already able to apply to the Board where they hold concerns about the enduring guardian’s exercise of powers. An effective use of resources would be to ensure that professionals commonly dealing with representatives are educated about the principles of the Act, including the need to ensure that representatives are only acting whilst a person does not have decision-making ability, and that support is first provided to a person to ensure that there is maximum opportunity for a person to make a decision themselves. Similarly, there needs to be understanding of the role of the Public Guardian and Board in receiving complaints or concerns from the community where individuals or organisations are concerned about the purported exercise of a representative’s authority. Education should also reinforce that representatives have the ability to apply to the Board for advice and directions, including in relation to the limits of their role or extent of their powers. Recommendations in relation to education are addressed in Part 18.888

12.6.33 The Institute endorses the Victorian approach where legislation confirms a donor’s ability to direct their enduring guardian to notify a person or organisation that they have commenced acting

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888 Recommendation 18.1.
The Act already implicitly enables a donor to include as a direction to their enduring guardian a requirement to notify a person or organisation upon them commencing to act in the role.\footnote{\textit{Guardianship and Administration Act 1995} (Tas) s 32(6).} The standard form instrument\footnote{Ibid sch 3.} and template available via the Board, however, do not specifically reference the ability to nominate a person who must be informed upon the enduring guardian commencing their role.\footnote{It is noted that the Board’s factsheet about enduring guardianship gives an example of a donor providing a condition that ‘[w]hen my guardian assumes his or her role, I direct my guardian to advise my attorney [name] of my condition so that they may arrange for my Enduring Power of Attorney to take effect.’: Guardianship and Administration Board, \textit{Enduring Guardianship Infosheet} <www.guardianship.tas.gov.au/__data/assets/pdf_file/0007/207619/Enduring_Guardian_infosheet_Oct_2014.pdf>.} It is recommended that these be revised to draw a donor’s attention to this option.

**Recommendation 12.12**

1. That the Act confirm a donor’s ability to nominate in their instrument a person or body that their enduring guardian must take reasonable steps to notify upon them commencing to act in the role for the first time.

2. That the standard form instrument provide a space for a donor to nominate a person or body that their enduring guardian must take reasonable steps to notify upon them commencing to act in the role for the first time.

**Reporting requirements**

Subject to the terms of an instrument, there is no periodic review of an enduring guardian’s activities. The Board and the Public Guardian oversee the activities of enduring guardians if and when matters are brought to their attention. The same approach applies to attorneys under the \textit{Powers of Attorney Act}. This is a significant difference in approach between the monitoring of Board-appointed guardians and administrators. It is noted though, that suitability criteria must be satisfied to be appointed as a representative by the Board, whilst an enduring guardian’s suitability is a subjective matter that the donor determines.

Given these issues, the Institute sought to understand whether the community expects that enduring guardians should need to periodically report to the Board once their powers have been invoked.

**Should enduring guardians need to periodically report to the Board?**

There were eight responses to this question with most responses either explicitly or implicitly endorsing this reform. The OPG submitted:

\footnote{TLRI, above n 69, Question 7.6.}
the OPG believes careful consideration needs to be given to the establishment of effective but not overly burdensome safeguarding measures. Our tentative view is that a regime of periodic reporting is not currently feasible (even if desirable), and that strengthened investigation powers for the Public Guardian in addition to the Board’s ability to review enduring instruments would go some way to providing effective oversight and monitoring.

12.6.38 The Institute observes that instituting the need for enduring guardians to periodically report to the Board involves similar considerations to the matters discussed above in relation to the question of enduring guardians giving notice upon them commencing to act. As discussed above, one of the concerns of having to give notice, or seek a Board declaration that an enduring guardian’s powers have commenced, is that it might give an incorrect perception of an enduring guardian’s ability to make decisions — given that a person’s ability to make decisions is time dependent and domain specific. Board-appointed representatives are, however, required to provide reports irrespective of whether they have in fact made decisions. One complexity is determining the point at which an enduring guardian should need to commence furnishing reports, given that the term of their appointment is not as clearly defined as is the case for Board-appointed representatives.

12.6.39 There is merit to further investigating this alternative. Recommendation 3.1 endorses the ALRC’s Decision-Making Principles guiding the review of the Act. Principle 4 of the Decision-Making Principles provides for the need for legal frameworks to have appropriate and effective safeguards. The need for regular monitoring is one of the ALRC’s Safeguards Guidelines. These Principles and supporting Guidelines are intended to support the overarching requirements of the Convention of ensuring that interventions for those requiring decision-making support are subject to appropriate and effective safeguards to protect abuse and are subject to regular review. It is accepted that periodic reporting by Board-appointed representatives serves as a safeguard to protect represented people. It would seem appropriate for similar safeguarding mechanisms to apply to enduring guardians. Further consideration of this complex question should include consultation with stakeholders impacted by the Powers of Attorney Act, noting the desirability of consistency between reporting requirements for both enduring guardians and attorneys.

12.6.40 As highlighted above, donors can already give direction to their enduring guardians that require them to report to someone when they are acting. The Board’s factsheet about making an instrument advises donors that they are able to direct their enduring guardian to report to someone when acting. Its standard form does not refer specifically to this option, although it refers more broadly to the ability to make an enduring guardian’s appointment subject to conditions. It is suggested that the standard form instrument provide a separate section for donors to elect a person to whom their enduring guardian is to report. This makes this option explicit and allows donors to reflect on their wishes in relation to reporting requirements when making an instrument.

Recommendation 12.13

That the standard form instrument provide a space for a donor to nominate a person or body who their enduring guardian must report to whilst acting in the role.

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895 Guardianship and Administration Act 1995 (Tas) s 32(6).
896 Guardianship and Administration Board, above n 892.
12.6.41 The Issues Paper noted that one alternative instead of mandatory reporting requirements could be to provide for the random auditing of enduring appointments. The House of Representatives Standing Committee on Legal and Constitutional Affairs suggested that random auditing of enduring appointments might be beneficial to prevent abuse, but noted that funding would need to be considered, along with who and how it would be implemented and on what scale.\textsuperscript{897} The committee also noted the need to ensure that a program did not deter people from acting or be too onerous on representatives.\textsuperscript{898} The ALRC did not, however, make recommendations about the random auditing of enduring appointments in relation to financial matters in its recent \textit{Report on Elder Abuse}, although this was raised in its Discussion Paper.\textsuperscript{899} It suggested that a scheme would have merit, but considered that this should be reviewed once there was a national registration scheme for enduring documents.\textsuperscript{900} The Institute notes that the desirability of a registration scheme to carry out the random auditing of instruments is not a barrier in Tasmania, given that the Act already provides for the compulsory registration of instruments.\textsuperscript{901} The OPG submission stated that ‘[o]ur tentative view is that the idea of random auditing of enduring powers of attorney has some merit.’

12.6.42 The Institute understands that further work is advancing nationally in relation to investigating the merits of this reform. The Institute endorses this being the subject of further analysis and consideration.

\textit{Record keeping}

12.6.43 Requiring representatives to maintain records assists to monitor their activities and is aimed at preventing abuse or a misuse of powers. The ALRC supports obligations requiring representatives to maintain records.\textsuperscript{902}

12.6.44 Enduring guardians must keep accurate records of all dealings and transactions that they make as an enduring guardian. Records must be retained for at least seven years after they cease to act, or, alternatively, they may deposit their records with the Board. Failure to do so may result in a fine.\textsuperscript{903} An equivalent provision is not included in relation to Board-appointed representatives. This may merely be due to oversight given that this reform was enacted to mirror equivalent amendments made to the \textit{Powers of Attorney Act} in relation to attorneys. It is appropriate that consistent requirements apply to both.

\textbf{Recommendation 12.14}

That an equivalent provision to \textit{s 32D(1)} of the Act be included in relation to Board-appointed administrators and guardians, confirming that administrators and guardians must keep accurate records of all dealings and transactions that they make as representatives.

\textsuperscript{897} House of Representatives Standing Committee on Legal and Constitutional Affairs, above n 264, [3.105].
\textsuperscript{898} Ibid [3.106].
\textsuperscript{900} ALRC, above n 66, 198, [5.177].
\textsuperscript{901} \textit{Guardianship and Administration Act 1995} (Tas) s 32(2)(d).
\textsuperscript{902} ALRC, above n 66, Recommendation 5-1(g).
\textsuperscript{903} \textit{Guardianship and Administration Act 1995} (Tas) ss 32D(1), (2).
Steps after the death of a represented person

12.6.45 An administrator must advise the Board of a represented person’s death within seven days after being notified of the represented person’s death. An equivalent provision applies to attorneys to notify the Recorder of Titles, although there is no time period within which to do so. Within 28 days of notifying the Board, administrators must provide the Board with a statement of estate accounts. Failure to comply with these requirements, without reasonable excuse, amounts to an offence. A fine may be imposed.

12.6.46 The Issues Paper queried whether these timeframes were overly burdensome and asked for public comment about whether these timeframes require revision.

Does there need to be any change to the time periods in which administrators must report to the Board after the death of a represented person?

12.6.47 There were five responses to this question, with none indicating a need for any revision to the current provisions. Reform is therefore not proposed.

12.7 Regular review

12.7.1 The Convention requires safeguards for decision-making to apply for the shortest time possible. This section considers how the Act provides for the review of the appointment of representatives.

Reviews of appointments of enduring guardians

12.7.2 The review of appointments of enduring guardians is considered at [12.6.19]–[12.6.42] above.

Reviews of Board orders appointing administrators and guardians

Length of orders

12.7.3 The Board has discretion to nominate the period in which an order appointing an administrator or guardian operates. Section 24 provides that ‘a guardianship order lapses on the expiration of 3 years after the date on which it is made unless continued under section 68.’ Section 52 is equivalent for administrators. The Board’s submission clarified that the current wording of s 68 enables the Board to vary or continue an order following a review and does not limit the period in which an order can be continued. It commented that ‘[i]n practice, the Board has made orders up to 5 years in length in some limited circumstances where a person’s disability and incapacity are highly unlikely to change and where need is also unlikely to change.’

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904 Ibid s 63(3).
905 Powers of Attorney Act 2000 (Tas) s 17.
906 Guardianship and Administration Act 1995 (Tas) s 63(3)(b). In a form approved by the Board, verified by statutory declaration with any required supporting evidence: s 63(3).
907 Ibid s 63(7).
908 TLRI, above n 69, Question 7.7.
12.7.4 Other jurisdictions have a range of periods in which orders appointing representatives may last. Some provide a shorter period (for example, one year) in which an initial order may last, with longer periods permitted (for example, five years) if extended upon review. The Issues Paper commented that providing a shorter time period in which an order can last results in more regular review of the activities of representatives, enabling the Board to more quickly respond where a representative is acting contrary to the Act. On the other hand, mandating a more regular review would increase the workload of both the Board and representatives. The Issues Paper asked what duration was considered appropriate for orders appointing representatives.

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12.7.5 There were 12 responses to this question. The Board submitted that:

   it is appropriate to have clear time limits for Orders that are not too long. When setting
   the length of order, consideration should be given to the UN Convention to ensure that:
   ‘Safeguards shall ensure that measures relating to the exercise of legal capacity are
   proportional and tailored to the person’s circumstances, apply for the shortest time
   possible and are subject to regular review by a competent, independent and impartial
   authority or judicial body.’

12.7.6 The OPG made similar comments:

   The Act does not currently specify a maximum period of appointment for an order
   continued upon review — the OPG believes that the Act should specify this period to be
   three years in most circumstances.

   However, there is a very small cohort of persons with profound disabilities for whom
   there is no prospect of any improvement in capacity, and for whom there are clear
   ongoing need/s for an administrator or (less frequently) a guardian. The OPG believes
   consideration should be given to longer orders in these cases where The Public Trustee or
   the Public Guardian has been appointed. The OPG is less certain about more lengthy
   orders for people with a private guardian administrator and would not recommend more
   than three years for a private administrator.

   It also commented that:

   The OPG believes the current maximum period of three years for an initial appointment
   is appropriate, with a specific requirement that the Board considers the least restrictive
   option in the circumstances. In the context of the duration of an order, consideration of
   the least restrictive option should include the likelihood of improvements to the
   represented person’s capacity with supports; the prospect that likely changes to
   circumstances (such as stable accommodation) will result in the alleviation of a need for
   substitute decision-making; and the possibility that short term intervention to establish
   supported arrangements (such as direct debits for bill payment and negotiation of debt
   repayments) will mitigate the need for administration.

12.7.7 Four submissions suggested that there is no need to change existing provisions. Two
   supported the Board having discretion to determine the appropriate length of an order on a case-by-
   case basis. Three submissions commented that three years is a long time, or too long a time for
   orders appointing representatives.

910 TLRI, above n 69, Question 7.8.
12.7.8 On balance, the Institute does not propose any change to the existing arrangements, except for two matters:

- to outline factors that the Board must consider when deciding the length of orders, consistent with the OPG’s recommendations. This is proposed on the basis that it promotes orders being of as short a duration as possible; and
- to limit the length of orders that may be made upon review of an initial order. As the Board noted, limiting the length of orders is consistent with the Convention which requires interventions to apply for the shortest time possible.

Recommendation 12.15

(1) That the Board be required to consider the following matters when determining the duration of an order appointing a representative:

- the likelihood of improvements to the represented person’s decision-making ability;
- the prospect that likely changes to circumstances including short term interventions to establish supported arrangements will mitigate the need for a representative; and
- that the order is the least restrictive of the person’s freedom of decision and action as is possible in the circumstances.

(2) That any continuation of an order appointing a representative be permitted to last for a maximum of three years, after which time the order lapses unless it is continued in accordance with the Act.

Test to review orders appointing a representative

12.7.9 Reviews of orders appointing representatives can be conducted at other times. On review, the Board may vary or continue an order, make the order subject to conditions or requirements that it considers necessary, or it can revoke an order. A hearing must be held for the Board to renew an order. In the 2016–2017 financial year, the Board conducted 989 reviews of orders, representing 56 per cent of the total applications received.

12.7.10 The Act does not set out a test that the Board must apply when reviewing an order appointing a representative. The Issues Paper commented that it may be appropriate for the Act to require the same test to be applied when reviewing an order as the Board applies when making an order appointing a representative. This test was discussed in Part 8.

12.7.11 The Issues Paper asked whether the Act should provide a test that the Board must apply when reviewing orders appointing representatives.

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911 Guardianship and Administration Act 1995 (Tas) s 67.
912 Ibid s 68(1).
913 Ibid s 67.
914 Guardianship and Administration Board, above n 235, 18.
915 Guardianship and Administration Act 1995 (Tas) ss 20, 51. The NSWLRC recommended that the tribunal need to consider whether there is still a need for the order, whether the representative is still eligible and suitable, and whether the representative is meeting their responsibilities and carrying out their required functions: NSWLRC, above n 24, Recommendation 9.17.
Should the Act provide a test to apply when reviewing an order appointing a representative? If so, what test should apply?\footnote{TLRI, above n 69, Question 7.9.}

12.7.12 The Board submitted that ‘[i]t appears appropriate that the same test used to make the initial order be used when reviewing an order’, noting that this is the approach it presently takes.\footnote{Referring to the decisions of B (Administration) (Guardianship) [2009] TASGAB 19 and HFO (Review of Administration) [2012] TASGAB 6.} Members of the Elder Law Committee also proposed that the test to review an order appointing a representative be consistent with the test to appoint a representative. The OPG expressed a similar view, commenting that it also provides an opportunity to reflect upon the suitability of the appointed representative.

12.7.13 The Institute agrees with these responses. Whilst it may be implicit that the Board should apply the same test as it does to appoint a representative as it does when reviewing the appointment, it is an appropriate that this be explicit.

**Recommendation 12.16**

That, to continue an order appointing a representative, the Board need to be satisfied that the test for the appointment of a representative continues to be met.

### 12.8 Conflicts of interest

12.8.1 The Convention provides that safeguards for decision-making must be free of conflict of interest and undue influence.\footnote{Convention on the Rights of Persons with Disabilities art 12(4). See also ALRC, above n 3, Recommendation 3-4.} This section considers how the Act addresses conflicts of interest, or potential conflicts of interest and puts forward proposals for reform.

#### Enduring guardians

12.8.2 The Act sets out when an enduring guardian can enter into a conflict of interest transaction.\footnote{This is consistent with the ALRC’s, Elder Abuse Final Report, Recommendation 5-1(d): see, ALRC, above n 66.} ‘Conflict of interest’ is defined in relation to enduring guardians as meaning a conflict between the duties of the enduring guardian in relation to the donor and the interests of the enduring guardian or their relative, business associate or close friend.\footnote{Guardianship and Administration Act 1995 (Tas) s 32C(2).} An enduring guardian may enter into conflict transactions where the donor has specifically approved of the particular conflict transaction, or class of transactions, or all conflict transactions in the appointing instrument.\footnote{Ibid ss 32C(1)(a)–(c). This is equivalent to the Powers of Attorney Act 2000 (Tas) s 32AC.} Conflicts are not presently dealt with in the standard form instrument.\footnote{Guardianship and Administration Act 1995 (Tas) sch 3.} The ALRC has recommended that instruments include guidance on what conflicts are and how they can be managed.\footnote{ALRC, above n 66, [5.61].} The Institute endorses this proposal, and recommends this as a matter for reform. This serves an educative function, with the goal being to minimise enduring guardians either intentionally or inadvertently acting in a position of conflict. It would also provide opportunity for a donor to consider, when...
making an instrument, any particular conflict transaction or class of transactions of which they approve, consistent with their right to do so under the Act.\textsuperscript{924}

**Recommendation 12.17**

That the standard form instrument explain what conflicts of interest are and how they may be managed.

**Board-appointed representatives**

12.8.3 To be appointed, Board-appointed representatives must satisfy the Board that they are not in a position where their interests conflict, or may conflict, with the interests of the proposed represented person.\textsuperscript{925} The Issues Paper commented that this appears to be a broad test, and raised concern about the potential for a protectionist approach resulting in the appointment of the Public Trustee or Public Guardian in favour of private individuals with an existing relationship with the proposed represented person. In New South Wales, instead of assessing whether a proposed guardian has interests that conflict, or may conflict, with the proposed represented person’s interests, consideration is only given to ‘undue conflict.’\textsuperscript{926} Similarly, in the Northern Territory and Queensland, it is the ‘extent’ of a conflict of interest that is assessed, rather than the existence of a conflict itself.\textsuperscript{927} In Alberta, Canada, a conflict of interest will only prevent an applicant being appointed as a representative where the conflict of interest leads to a substantial risk that the proposed representative will not act in the represented person’s best interests.\textsuperscript{928} Alberta’s Act also confirms that being a relative or beneficiary of the person’s Will does not in itself amount to a conflict of interest.\textsuperscript{929} The QLRC recommended that legislation clarify that just because an applicant is in conflict with another family member does not, of itself, mean that the applicant is not appropriate to act as a representative.\textsuperscript{930} A provision to this effect is included in the South Australian Act.\textsuperscript{931}

12.8.4 The Act does not impose any continuing obligation upon representatives to monitor or report conflicts of interests, or potential conflicts of interests, that may arise following their appointment. A conflict may not be identified until the Board reviews its order, which might be some time after the conflict arose. The VLRC recommended that representatives be given a duty to monitor the potential for conflicts of interest and to seek advice if required.\textsuperscript{932} Representatives in Queensland have a continuing obligation to notify the tribunal about conflicts, or likely conflicts of interest. A fine may be imposed in cases of a breach.\textsuperscript{933}

\textsuperscript{924} Guardianship and Administration Act 1995 (Tas) ss 32C(1)(a)–(c). This is equivalent to the Powers of Attorney Act 2000 (Tas) s 32AC.

\textsuperscript{925} Guardianship and Administration Act 1995 (Tas) ss 21(1)(b), 34(1)(d)(ii).

\textsuperscript{926} Guardianship Act 1987 (NSW) s 17(1)(b). The NSWLRC has recently recommended that the assessment should be based upon whether the proposed representative has or may have a conflict of interest in relation to any of the decisions referred to in the order, and will be aware of and respond appropriately to any conflicts: NSWLRC, above n 24, Recommendation 9.6(e).

\textsuperscript{927} Guardianship of Adults Act 2016 (NT) s 15(2)(b); Guardianship and Administration Act 2000 (Qld)s 15(1)(c).

\textsuperscript{928} Adult Guardianship and Trusteeship Act 2008 (Alberta) ss 28(2), 49(2).

\textsuperscript{929} Ibid s 49(3).

\textsuperscript{930} QLRC, above n 25, Recommendation 14-9.

\textsuperscript{931} Guardianship and Administration Act 1993 (SA) s 50(2).

\textsuperscript{932} VLRC, above n 24, Recommendation 288.

\textsuperscript{933} Guardianship and Administration Act 2000 (Qld) s 17.
12.8.5 The Act does not define ‘conflict of interest’ for the purposes of ss 21 and 34 which deal with Board-appointed representatives. The term is defined only in relation to enduring guardians. The Issues Paper asked whether the term ‘conflict of interest’ should be defined or explained in relation to Board-appointed representatives.

(ii) Should the term ‘conflict of interest’ be defined or explained?

12.8.6 The Public Trustee submitted:

There should be education around this issue for non-professional representatives. … a statutory definition should be avoided to save potential legal argument with a preference for explanation in the form of education.

12.8.7 Another submission also noted difficulties with defining ‘conflicts of interest’ and the importance of instead educating representatives about conflicts. A further respondent endorsed the Act providing an explanation, rather than a definition, of what is meant by conflict of interest. Members of the Elder Law Committee supported a statutory definition, but also encouraged the use of guidebooks to provide further explanation and examples of conflicts of interest. Social Work Services RHH commented that the Handbook for Private Guardians provides a useful explanation of what conflicts of interest are, including providing examples. Another submission supported inclusion of a statutory definition of the term.

12.8.8 The Institute supports inclusion of a broad statutory definition explaining what is meant by ‘conflicts of interest’ in relation to Board-appointed representatives. It is suggested that the existing definition used to explain conflicts of interest in relation to enduring guardians be adopted. Submissions calling for education for representatives about what are conflicts of interest, including through the use of handbooks and other educational material, are also endorsed.

12.8.9 The Issues Paper also asked for feedback about whether there needs to be any reform to the provisions of the Act dealing with conflicts of interest.

(i) When should conflicts or potential conflicts of interest prevent a person from acting as a representative?

12.8.10 In response to this question, the Public Trustee commented that:

Conflict of interests should be avoided where they have a tangible impact on the representative acting in the ‘best interests’ of the represented person.

12.8.11 The OPG commented: ‘The OPG is of the view that the extent and effect of conflicts of interest is of relevance and the legislation should reflect this.’ The Board similarly submitted that:

In practice the Board has leaned towards interpreting this [existing provisions] in a practical way, given it is almost inevitable that certain representatives, for example spouses or parents, will have personal interests in an issue.

Amending the Act so that the Board can assess the extent of the conflict rather than the existence of a conflict itself, is appropriate.

934 TLRI, above n 69, Question 7.13(ii).
935 See Guardianship and Administration Board, above n 185, 45.
936 TLRI, above n 69, Question 7.13(i).
12.8.12 Members of the Elder Law Committee submitted:

Representatives should not be ruled out simply because they are a beneficiary. Relevant factors for consideration might however include, for example, where there is unequal distribution in an estate and the family is not in agreement and/or where there is a disabled child. There should be a duty to report conflicts of interest arising after the appointment is made.

12.8.13 Another submission also supported Board-appointed representatives reporting conflicts of interest arising after their appointment.

12.8.14 Attendees of consultation meetings facilitated by Carers Tasmania commented that they perceived that at times the requirement that there be no actual or potential conflicts of interest is interpreted too strictly. One example provided was a proposed representative being rejected on the basis that they were a beneficiary of the proposed represented person’s estate despite being a close family member and the proposed represented person’s carer for several years. These views are balanced with Social Work Services RHH’s observation that in some instances perpetrators of abuse against a represented person had been appointed as their representative. It commented that ‘[w]hile there should be consideration of preservation of existing relationships, consideration should also be given to those extreme cases where either party is either a perpetrator or victim of abuse.’

12.8.15 To address issues raised in this Part, and reflecting submissions received, the Institute proposes the following revisions to how the Act deals with conflicts of interest:

**Considering the extent and likelihood of conflict**

12.8.16 In response to submissions received, it is proposed that rather than the test requiring the Board to be satisfied that the proposed representative is not in a position where their interests conflict, or may conflict, with the interests of the proposed represented person, the Board be required to consider:

- the extent to which the represented person’s and the person’s interests are likely to conflict; and
- whether the person is likely to comply with the Act.

12.8.17 This is consistent with existing provisions in Queensland and the Northern Territory. It provides appropriate flexibility by requiring consideration not only of the existence of a conflict, but the extent of that conflict. The critical factor is whether the existence of a conflict is likely to affect the proposed representative’s ability to comply with their duties imposed by the Act.

**The relevance of being a beneficiary of the represented person’s estate**

12.8.18 It is proposed that the Act confirm that being a relative or beneficiary of a person’s Will does not, of itself, mean that the person is in a conflict of interest and is inappropriate to act as their representative. This is consistent with an equivalent provision in Alberta, Canada. The intention is to ensure that a person who might be best placed to fulfil the role of representative is not eliminated.

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938 *Guardianship of Adults Act 2016* (NT) s 15(2)(h); *Guardianship and Administration Act 2000* (Qld) s 15(1)(c).
939 *Adult Guardianship and Trusteeship Act 2008* (Alberta) s 49(3).
only because they may benefit from the represented person’s estate upon their death. There are likely many situations where this may arise, where a person closest to the proposed represented person nominates to be their representative but may also be a beneficiary under their Will. As noted above, the focus should instead be upon whether that circumstance impacts the proposed representative’s ability to perform the role and uphold their duties.

Conflict amongst family members

12.8.19 It is also recommended that the Act confirm that, just because an applicant is in conflict with another family member does not, in itself, mean that they are inappropriate to act as a representative. This is consistent with recommendations of the QLRC and the Act in South Australia. New legislation proposed in Victoria also provides that the tribunal must not assume without any evidence that a proposed represented person’s relative who is proposed as the guardian or administrator is not suitable to be appointed as the guardian or administrator merely because that relative disagrees with another relative of the proposed represented person about a matter pertaining to the proposed represented person.

12.8.20 In addressing a later question in the Issues Paper, the OPG submitted:

it should be open to the Board to appoint the Public Guardian or The Public Trustee in situations of high family conflict, even where there might be one or more family members who would otherwise be suitable for appointment, absent the family conflict.

12.8.21 This proposed reform would not preclude the Board from determining that an applicant is unsuitable to act in the role because of conflict within family. Instead, as noted above, assessment should be based upon whether the individual is suitable and likely to comply with the Act.

Ongoing duty to report conflicts

12.8.22 It is proposed that representatives have an ongoing duty to report conflicts, or potential conflicts of interest. This enables the Board to independently assess the situation and determine whether this change in circumstance impacts the representative’s suitability. This is consistent with the VLRC’s recommendations, and legislation in Queensland.

Recommendation 12.18

That the Act deal with conflicts of interests involving guardians and administrators as follows:

(a) that the existing definition of ‘conflict of interest’ in s 32C(2) of the Act be moved to the definition section (s 3) so that it applies to all uses of that term throughout the Act;

(b) that the test for appointment as a representative require the Board to consider:

(i) the extent to which the interests of the proposed represented person and proposed representative are likely to conflict; and

(ii) whether the proposed representative is likely to comply with the Act;

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940 QLRC, above n 25, Recommendation 14-9; Guardianship and Administration Act 1993 (SA) s 50(2).
941 Guardianship and Administration Bill 2018 (Vic) cl 32(5)(b).
942 VLRC, above n 24, Recommendation 288.
943 Guardianship and Administration Act 2000 (Qld) s 17.
(e) that the Act state that being a relative or beneficiary of a represented person’s Will does not of itself amount to a conflict of interest;

(d) that the Act state that, just because the proposed representative is in conflict with a close relative of the proposed represented person, does not, of itself, mean that they are not suitable to act as a representative; and

(e) that representatives have a duty to report conflicts of interest, or potential conflicts of interest, that arise during the course of their appointment to the Board.

Gifts

12.8.23 The Board has power to authorise an administrator to make gifts from a represented person’s property. Gifts may be to family or other people for whom the represented person might be expected to provide.944 Under the Powers of Attorney Act, there are some gifts that an attorney can make without Board approval. These include gifts to relations or close friends of a seasonal nature (for example, Christmas presents), or for a special event (for example, a birthday).945 Similar provisions apply in the Northern Territory and Queensland, enabling administrators to make some gifts.946 Reforms proposed in Victoria provide for an administrator being able to make certain gifts and donations,947 but with administrators having to include within their annual accounts details of any gifts over $100 that were made to the administrator, their relative or close friend, or connected organisation.948

12.8.24 In Tasmania, attorneys can make reasonable charitable donations of the nature that the donor made when they had capacity, or donations that the donor might be reasonably expected to make, without Board approval.949 This includes reasonable gifts to the attorney themselves or an associated charity.950

12.8.25 The Issues Paper asked whether administrators ought to be permitted to make certain gifts in the absence of the prior approval of the Board.

(i) Should administrators be able to make gifts without the Board’s prior approval?

(ii) If so, what gifts ought to be authorised?951

12.8.26 Seven submissions addressed this matter, five of which either supported, or did not oppose, providing consistency with equivalent powers granted to attorneys under the Powers of Attorney Act. Those who did not support amendment either commented that existing arrangements are not problematic, or that the ability to make gifts risks the potential for abuse or exploitation. The Board noted that:

944 Guardianship and Administration Act 1995 (Tas) s 58.
945 Powers of Attorney Act 2000 (Tas) ss 31(3)(a)–(b).
946 Guardianship of Adults Act 2016 (NT) s 30; Guardianship and Administration Act 2000 (Qld) s 54.
947 Guardianship and Administration Bill 2018 (Vic) cl 47.
948 Ibid cl 61(4)(b).
949 Powers of Attorney Act 2000 (Tas) s 31(1).
950 Ibid ss 31(1), (4).
951 TLRI, above n 69, Question 7.14.
There are many individual considerations to gifting, including the person’s wishes if ascertainable regarding gifting, whether it is the person’s usual practice to gift and if so in what circumstances; whether the person can afford to gift and if so how much should be gifted.

12.8.27 In endorsing consistency with the Powers of Attorney Act, the Public Trustee commented that ‘[i]t is not unreasonable for an administrator to keep an account of gifts paid’ and that ‘[a]nnual submission of accounts should be made to the Guardianship and Administration Board.’

12.8.28 Presumably one of the reasons that the Powers of Attorney Act authorises attorneys to make certain gifts without Board approval is because performance of their role does not require them to routinely report to the Board. An administrator’s appointment, on the other hand, only becomes effective because of Board orders which are made following a hearing. As the OPG observed, ‘[t]he Board is able to approve token seasonal gifts on the initial appointment or reappointment of an administrator.’ The Board’s hearing thus provides it with the opportunity to consider the circumstances and make orders approving certain gifts where it deems appropriate. These different contexts raise the question of whether there is any utility to reform to the existing position for administrators.

12.8.29 The potential for the misuse of these powers is also noted. It is observed, however, that the Victorian approach proposes to mitigate the risk of abuse by requiring administrators to detail in their annual accounts gifts over $100 made to them or an associated individual or organisation. The Victorian Bill also provides that the gifting powers do not apply if VCAT orders otherwise. This enables the tribunal to disallow an administrator to make some or all gifts that would otherwise be permissible, thereby enabling it to reverse the default position.

12.8.30 A further consideration is that enabling administrators to make certain gifts that reflect a represented person’s wishes (or likely wishes) promotes their will and preference. It also provides a less restrictive alternative. These considerations have been endorsed as principles which should govern reform to the Act.

12.8.31 If government were not persuaded to enact provisions enabling administrators to make certain gifts consistent to the powers granted to attorneys, then it is the Institute’s view that consideration be given to revising the existing section in the Powers of Attorney Act. As already commented, if concerns relate to the potential for administrators to abuse their power, then this risk is greater for attorneys due to the lack of reporting requirements and Board oversight.

**Recommendation 12.19**

(1) That administrators be authorised to make certain gifts and donations without Board approval equivalent to s 31 of the Powers of Attorney Act 2000 (Tas), subject to any contrary orders of the Board.

(2) That administrators be required to include an account of any gifts made when submitting accounts to the Board, subject to any contrary orders of the Board.

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952 Guardianship and Administration Bill 2018 (Vic) cl 47.

953 See Recommendation 3.3.
Eligibility to act as a representative

12.8.32 The Act provides tests that the Board must apply when deciding who to appoint as a representative. To be appointed as a guardian, an adult must satisfy the Board that:

- they will act in the best interests of the proposed represented person;
- they are not in a position where their interests conflict, or may conflict, with the interests of the proposed represented person. This test was considered above;\(^\text{954}\) and
- they are suitable to act as the guardian.\(^\text{955}\)

Whether a proposed guardian is suitable is assessed taking into account:

- the wishes of the proposed represented person so far as they can be ascertained;
- the desirability of preserving existing family relationships;
- the compatibility of the person with the proposed represented person and any administrator of their estate; and
- whether the person will be available and accessible to fulfil the requirements of the role.\(^\text{956}\)

12.8.33 To be appointed as an administrator, an adult must satisfy the Board that they:

- will act in the best interests of the proposed represented person;
- are not in a position where their interests conflict, or may conflict, with the interests of the proposed represented person;
- are suitable to act as administrator; and
- have sufficient expertise to administer the estate.\(^\text{957}\)

Suitability is assessed taking into account:

- the wishes of the proposed represented person so far as they can be ascertained; and
- the compatibility of the person with the proposed represented person and their guardian (if any).\(^\text{958}\)

12.8.34 ‘Sufficient expertise’ is not part of the test that applies to guardians. The desirability of preserving family relationships and being available and accessible are factors that must be taken into account when appointing guardians but are not part of the test to assess whether an administrator is suitable.\(^\text{959}\)

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\(^\text{954}\) See [12.8.3].

\(^\text{955}\) Guardianship and Administration Act 1995 (Tas) s 21(1). Note that the NSWLRC has recently recommended that a person at or above the age of 16 could be appointed as a representative where they are the person’s primary carer, are already supporting the person or making decisions, and that the proposed functions are consistent with their decision-making abilities: NSWLRC, above n 24, Recommendation 9.5(2)(b).

\(^\text{956}\) Guardianship and Administration Act 1995 (Tas) s 21(2).

\(^\text{957}\) Ibid s 54(d).

\(^\text{958}\) Ibid s 21(2).

\(^\text{959}\) Ibid s 54(1)(d).
12.8.35 The Issues Paper asked for feedback about the tests that a proposed representative should need to satisfy to be appointed as a representative.

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<td>What test should a person need to meet to be appointed as an administrator?</td>
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12.8.36 There were 12 submissions addressing the first question, and 10 addressing the second. Members of the Elder Law Committee submitted that they did not consider any change was needed. Other responses stated that the proposed representative should need to satisfy the Board that:

- they have common sense;
- they are responsible;
- they are competent. In addressing this consideration, the Public Trustee commented that the proposed represented person should need to have the requisite skills, or have access to appropriate support to competently perform the role;
- they are not in a position of conflict;
- they genuinely understand the views, values and wishes of the proposed represented person; and
- they are able to act in the proposed represented person’s best interests (including demonstrating this by working through hypothetical scenarios).

12.8.37 Speak Out advocates noted the need to have as a primary consideration the wishes of the proposed represented person. Another response commented on the importance of consulting with carers to ascertain their views.

12.8.38 Two submissions commented that, instead of providing the Board with a National Police Records Check, a Working with Vulnerable People check should be submitted. Presently the Registration to Work with Vulnerable People Act 2013 (Tas) applies only to children, although will ultimately have extended application to certain regulated activities involving adults.  

12.8.39 Suggestions were also made in relation to the Board’s processes when hearing applications for the appointment of representatives. Social Work Services RHH commented that it would be beneficial for proposed representatives to be provided with a copy of the Handbook for Guardians/Handbook for Administrators upon lodging their application, prior to the Board’s hearing. It stated this would provide a proposed representative the opportunity to gain further information about the role and duties of a representative, so that they can consider their suitability and understand more fully what it entails. It would also better enable an applicant to speak to their

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960 TLRI, above n 69, Question 7.10.
961 Ibid Question 7.11.
suitability and that, if appointed, they would act in accordance with the Act. Whilst the Institute’s Terms of Reference asked only about legislative reform, the Institute acknowledges this is a useful suggestion.

12.8.40 Based on submissions received, and recommendations made elsewhere in this Report, the Institute recommends the following revisions to the existing tests:

A single test to assess the eligibility and suitability of all Board-appointed representatives

12.8.41 The first recommendation is that, for simplicity, the Act provide a single test to assess the suitability of a proposed representative. Having the test within one section rather than two would eliminate unnecessary duplication and reduce the size of the Act. It also has the benefit of ensuring that the tests that assess suitability are consistent. As noted above, the tests currently differ, requiring the Board to consider the desirability of preserving family relationships and whether a proposed guardian is available and accessible, but not a proposed administrator. It is considered that these factors should be equally relevant for proposed administrators as they are for guardians.

That the proposed representative will comply with the Act

12.8.42 Currently, proposed representatives must satisfy the Board that they will act in the represented person’s best interests. It is observed that acting in accordance with a represented person’s best interests is only one of the existing duties of representatives. Requiring assessment of whether the proposed representative would likely comply ‘with the Act’ instead is broad enough to ensure that all relevant matters are assessed — including their likely compliance with the Act’s guiding principles, and duties of representatives.

Taking into account ‘the views, wishes and preferences’ of the proposed represented person

12.8.43 The third recommendation is that the language used reflect the shift in focus to promote a person’s ‘views, wishes and preferences’, consistent with recommendations made elsewhere in this Report.

Assessment of existing relationships that are important to the person

12.8.44 The fourth recommendation is that the focus be upon considering relationships that are important to the proposed represented person, irrespective of whether those groups or individuals are connected through family. It might, for example, be their neighbour or carer that has the closest, ongoing relationship with the person. It is these key relationships that should be preserved and promoted. This approach reflects comments made during consultation meetings and is also the approach taken under the recently debated revisions to the Victorian legislation.

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963 Guardianship and Administration Act 1995 (Tas) s 21(1). The NSWLRC has recently made recommendations that a person at or above the age of 16 could be appointed as a representative where they are the person’s primary carer, are already supporting the person or making decisions, and that the proposed functions are consistent with their decision-making abilities: NSWLRC, above n 24, Recommendation 9.5(2)(b); Guardianship and Administration Act 1995 (Tas) s 21(2).

964 Guardianship and Administration Bill 2018 (Vic) cl 32(3)(b).
That the proposed representative has the requisite skills or access to appropriate support to competently perform the role

12.8.45 This recommendation is based on the Public Trustee’s submission. It suggested that the test assess whether a proposed representative has the requisite skills, or access to appropriate support, to competently perform the role. Currently the ‘expertise’ of a proponent is only assessed in relation to administrators. The Institute agrees that assessment of an applicant’s skills to perform the role is a relevant consideration for both guardians and administrators.

12.8.46 The Institute is further persuaded by this suggestion because of its focus upon the proposed representative’s skills and expertise to perform the role with support. Representatives can and should (where appropriate) seek out, consider and rely upon quality advice. There are many occasions where individuals retain advisors to assist them, including accountants, financial advisors, lawyers or other professional advisors. It should not be necessary for representatives to themselves possess skills in each of these areas to perform the role. The focus should instead be upon whether, firstly, the proposed representative has access to advice or support to perform the role, and secondly, whether they are likely to identify circumstances in which external support or advice may be beneficial, and then seek out that advice.

Working with Vulnerable Adults Check

12.8.47 The final recommendation is based on two submissions received where it was observed that a Working with Vulnerable Adults check may be a more appropriate and relevant search to confirm the suitability of an individual to act as representative than the existing National Police Records Check. The Institute proposes that this matter be reviewed separately as part of the expansion of the jurisdiction of the Registration to Work with Vulnerable People Act 2013 (Tas) to regulated activities involving adults.

Other suggestions

12.8.48 Other suggestions that were made in submissions included:

- that proposed representatives undergo psychological testing.

Whilst the Institute notes that this might be beneficial in detecting any particular mental health conditions that might be relevant to performance of the role, the Institute does not accept this suggestion. It would create a practical barrier to individuals wishing to apply to be someone’s representative. The associated cost and delay would likely jeopardise the efficiency of the jurisdiction. Further, the Board is able to request evidence that it considers appropriate; and

- that the views of carers be considered.

The proposed test would take into account the importance of preserving existing close relationships of a proposed represented person. This, along with reform to the guiding principles of the Act to acknowledge the important role of carers and others close to a represented person, would promote the views of carers being considered as part of deciding upon the suitability of a representative.

The age of representatives

12.8.49 Carers Tasmania submitted that a person under the age of 18 years should be able to be appointed as a guardian in exceptional circumstances. In proposing this reform, Carers Tasmania
commented that there are occasions where a child performs the role of primary carer, for example, for their parent, grandparent, or sibling. It was observed that they play a critical function in supporting and caring for the person, but experience situations where they feel excluded from important decisions, and which naturally impact the child as their carer.

12.8.50 This issue was also raised in Part 4 dealing with the appointment of enduring guardians. PCT’s submission to a question in that part supported a child being eligible to be appointed as an enduring guardian in exceptional circumstances. Members of the Elder Law Committee also commented that it is not unreasonable for a person under the age of 18 years to be an enduring guardian. The Institute’s conclusion in responding to this issue in Part 3 was that a person under the age of 18 years be eligible for appointment as an enduring guardian, but that their appointment not be effective (in other words, that they not be able to act) until they have attained the age of 18 years. The rationale for this reform was to address circumstances where a donor might have declining abilities and may not have the ability to appoint an enduring guardian if they were to await their preferred nominee reaching adulthood. This rationale does not apply to the present discussion where it is the Board that is appointing the representative in circumstances where a represented person is unable to do so themselves. The Institute has not, on this basis, made recommendations for reform in this area.

Recommendation 12.20

That the assessment of the eligibility of administrators and guardians under the Act be revised as follows:

(a) to provide a single section in the Act setting out what factors the Board must consider when assessing the suitability of proposed representatives (both administrators and guardians);
(b) to require the Board to be satisfied that the proposed representative understands their obligations and duties and will act in accordance with those obligations and duties;
(c) to take into account ‘the views, wishes and preferences’ of the proposed represented person, instead of ‘wishes’;
(d) instead of considering the importance of preserving ‘existing family relationships’, the assessment be of ‘existing relationships that are important to the person’;
(e) instead of there being an assessment of the ‘sufficient expertise’ of a proposed representative, the Board evaluate whether the proposed representative has the requisite skills or access to appropriate support to competently perform the role; and
(f) that whether a representative be required obtain a Registration to Work with Vulnerable Adults Check be considered as part of future reform to the Registration to Work with Vulnerable People Act 2013 (Tas).

965 See [4.3.10]–[4.3.16].
966 See Recommendation 4.3.
**Priority given to professional or private administrators?**

12.8.51 The Public Trustee has statutory advantage over private individuals wishing to be an administrator as it does not need to satisfy any test of suitability or eligibility. In 2016–2017, the Board appointed private administrators in 30 per cent of administration orders made. It appointed private guardians in 39 per cent of guardianship orders made.

12.8.52 The VLRC recommended that legislation state that a tribunal must consider the desirability of appointing a representative who has an existing personal relationship with the proposed represented person, rather than a professional representative. Recent reforms proposed in Victoria have adopted this recommendation. They provide that, in assessing a person’s suitability to be appointed as a representative, the tribunal must consider ‘the desirability of appointing a person who is a relative of the proposed represented person, or who has a personal relationship with the proposed represented person, rather than appointing a person with no such relationship.’

12.8.53 In New South Wales, the tribunal cannot appoint the Public Guardian as guardian if some other person can be appointed. A similar provision exists in the Northern Territory. In the ACT, where the Public Trustee and Guardian is appointed as representative of last resort, they must make endeavours to find a suitable person to act as the representative and if they do so, they must apply to the tribunal. The Issues Paper commented that this approach may be beneficial in relation to the choice of guardian due to the personal nature of the role. On the other hand, there may be reasons why in an individual case it might be inappropriate to appoint family or friends, and the Board should not be unduly constrained. It was asked whether private representatives ought to be given any statutory priority to professional representatives.

**Should the Act require the Board to give priority to family or close friends acting as representatives?**

12.8.54 There were 14 responses to this question, with seven supporting the Act stating that private representatives be given priority over professional representatives. The Public Trustee submitted:

> All things being equal priority should be given to family. However, there are, in Public Trustee’s view, a multitude of factors bearing on an appropriate determination to the appointment of a representative including but not limited to the nature of the estate, family dynamics, financial circumstances et cetera.

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968 Ibid 21.

969 Guardianship and Administration Board, above n 235, 19.

970 VLRC, above n 24, Recommendation 179.

971 Guardianship and Administration Bill 2018 (Vic) cl 32(3)(c).

972 Guardianship Act 1987 (NSW) s 15(3). The NSWLRC have recently endorsed this approach: NSWLRC, above n 24, Recommendation 9.3(3).

973 Guardianship of Adults Act 2016 (NT) s 13(2).

974 Public Trustee and Guardian Act 1985 (ACT) s 19C.

975 TLRI, above n 69, Question 7.12.
Part 12: Safeguards for Representative Decision-Making

12.8.55 The OPG made similar observations, stating that the Act should state a priority for family members but that the Board should not be overly constrained particularly in situations of family conflict. Members of the Elder Law Committee expressed a similar view,\(^{976}\) as did other respondents.

12.8.56 The Board submitted:

Discretion as who to appoint, when considering the criteria in the Act is useful. For example, in applications involving complex family dynamics, it is sometime appropriate and indeed needed on the evidence to appoint an independent administrator/guardian while on other occasions, despite the family dynamics it is appropriate on the evidence, to appoint a family member. The Board does not see any need to change the Act in this respect.

12.8.57 Other responses also noted that there are some circumstances where private representatives may be inappropriate. Speak Out submitted that each situation is different and that some people it consulted with thought it was better to have someone who knows the represented person. Others commented that they would prefer to have people other than families appointed as their representative. They submitted that there should be a choice.

12.8.58 The Institute considers that the draft Victorian approach provides an appropriate balance between the need to promote private representatives acting as a representative where suitable, and the need for the Board to retain a level of discretion. For the same reasons as articulated earlier in this Part, a minor revision is proposed, to remove reference to the desirability of a person having a family relationship with the proposed represented person. Instead, it is considered that the focus be upon personal relationships that the proposed represented person has, irrespective of whether those relationships are through family.

**Recommendation 12.21**

That when deciding upon who to appoint as a representative, the Board be required to consider the desirability of appointing a person who has a personal relationship with the proposed represented person, rather than a person without a personal relationship.

**Ineligibility to be a representative**

12.8.59 There are no classes of individuals who are automatically prohibited from acting as a representative. A person declared bankrupt, or who has been convicted of an offence of dishonesty or fraud may be appointed as an administrator if they satisfy the Board that they are ‘suitable.’ The ALRC supports there being no blanket prohibition on who can act as a representative.\(^{977}\) They recommend that an applicant’s suitability is a matter for the relevant tribunal in its discretion.\(^{978}\)

12.8.60 Two submissions commented that a proposed represented person should not have any relevant prior criminal convictions, for example for fraud, theft or violent crimes. Similar comments were made that the proposed represented person not be bankrupt or a discharged bankrupt.

12.8.61 The Institute agrees that these factors may be relevant to the suitability of a proposed representative. Nevertheless, the Institute agrees with the ALRC’s recommendation that there not be

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\(^{976}\) Referring to the decision *Holt v Protective Commissioner* (1993) 31 NSWLR 227, 242 (Kirby P).

\(^{977}\) ALRC, above n 66, [5.69].

\(^{978}\) Ibid.
a blanket prohibition and instead, that this be a factor that the Board considers and assesses at its discretion on a case-by-case basis.

12.9 Privacy considerations

12.9.1 Respect for a person’s right to privacy is a critical part of the Convention. Article 22 provides:

1. No person with disabilities, regardless of place of residence or living arrangements, shall be subjected to arbitrary or unlawful interference with his or her privacy … Persons with disabilities have the right to the protection of the law against such interference or attacks.

2. States Parties shall protect the privacy of personal, health and rehabilitation information of persons with disabilities on an equal basis with others.

12.9.2 Recommendation 8.3(2) proposes that one of the revised duties of representatives be to respect a represented person’s right to privacy. Other aspects of preserving a person’s right to privacy are considered in the following paragraphs.

Disclosing information to the Board

12.9.3 People who make a report or provide information to the Board or the Public Guardian are not liable for doing so if they acted in good faith and had reasonable and probable grounds for believing the report or information to be true. Medical practitioners may divulge information about a person without their consent. A person who makes a malicious or false report or information is guilty of an offence. A fine may be imposed.

12.9.4 There is no positive obligation imposed to report potential breaches of the Act, or abuse or neglect by representatives. This can be contrasted with the approach taken under the Children, Young Persons and their Families Act 1997 (Tas) in relation to children where that Act creates a positive duty for people to take steps to prevent abuse and neglect. This includes requiring mandatory reporting for certain professionals. The Issues Paper commented that imposing mandatory reporting requirements could assist to prevent, better detect and respond to abuse of represented people. On the other hand, the reporting of abuse may be contrary to the wishes of a represented person and infringes their autonomy and freedom of choice. It was noted that the Queensland Act includes whistle-blower protections that protect a person from civil and criminal liability if they disclose information about a person’s conduct that breaches the Act.

12.9.5 The Issues Paper asked whether there needs to be any changes to the way in which information is provided to the Board.

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979 Convention Committee, above n 21, [47].
980 Guardianship and Administration Act 1995 (Tas) s 85(1).
981 Ibid s 11(12).
982 Ibid s 85(2).
983 Ibid s 13.
984 Children Young Persons and their Families Act 1997 (Tas) s 14.
985 Guardianship and Administration Act 2000 (Qld) s 247.
Does there need to be any changes to:

- when and how information can be provided to the Board?  

12.9.6 There were eight submissions addressing this matter. Three submitted that the existing provisions are appropriate. Both the Board and Social Work Services RHH proposed reforms to the relevant sections of the Act. The Board submitted:

[Section 11(11)] is an important provision of the Act regularly used by the Board to obtain information it needs for hearing. In practice it is the Board’s Registrar who requests information or documentation prior to hearing, and accordingly it would be appropriate for this section to be amended to read that. Section 11(11) of the Act could also be clarified to include report, document or information. It would also be useful for the group or entity it relates to, to be widened to include financial institutions, and private medical practitioners and for the term ‘service provider’ to be defined perhaps by way of a non-exhaustive list. This section could also be clarified to indicate that information can be obtained by the Board at no cost to it.

The Institute accepts these suggestions, proposing that, for the avoidance of doubt, the term ‘document’ be defined in accordance with the Supreme Court Rules 2000 (Tas), which provides that:

- **document** includes the following:
  
  (a) any book, map, plan, graph or drawing;
  
  (b) any photograph;
  
  (c) any label, marking or writing which identifies or describes anything of which it forms a part or to which it is attached;
  
  (d) any disk, tape, soundtrack, film, negative or other device in which sounds, data or visual images are embodied so as to be capable of being reproduced, with or without the aid of equipment;
  
  (e) anything on which is marked a word, figure, letter or symbol which is capable of carrying a definite meaning to a person conversant with it.

12.9.7 In response to the Institute’s question, Social Work Services RHH commented:

The collection, use and disclosure of information needs clear guidance in the Act.

Any party collecting, using or disclosing information should consider the privacy of the proposed represented person.

This should also extend to any person asked to provide information for the purposes of a Guardianship or Administration matter — for example families, interested parties and health professionals needs to be advised why information is being collected, how it will be used and why/when it would be disclosed and to whom.

The Institute considers these matters as requiring education rather than legislative reform.

12.9.8 Some attendees of a Carers Tasmania facilitated consultation session expressed support for mandatory reporting of conduct amounting to abuse or maltreatment. This matter is considered later in this Part as part of a broader strategy to respond to issues of abuse.

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986 TLRI, above n 69, Question 7.15.

987 Supreme Court Rules 2000 (Tas) r 381.
12.9.9 In responding to a separate question in the Issues Paper, dealing with reform to the Public Guardian’s investigative powers, MIGA submitted that, if powers of investigation were extended to compel health practitioners to provide information, then there ought to be scope for non-compliance with a request based on a reasonable excuse, including where provision of the information or document might tend to incriminate the person. This exception applies in Queensland with the exception of witnesses answering questions. The Health Practitioner Regulation National Law adopts an equivalent approach. It is appropriate that the same approach apply under the Act.

**Recommendation 12.22**

That s 11(11) of the Act be revised as follows:

(a) to confirm that the powers in this section extend to the Registrar;

(b) to require provision of a document in addition to a report or information, with ‘document’ being defined in accordance with r 381 of the *Supreme Court Rules 2000 (Tas)*;

(c) to extend the group or entity this section relates to, to include health practitioners and for the term ‘service provider’ to be better articulated including providing examples;

(d) to provide that the cost of providing a document, report or information is to be borne by the person, group or entity providing the document, report or information; and

(e) to require individuals to comply with a request for a document, report or information unless the person has a reasonable excuse, with a reasonable excuse including that compliance with the request may tend to incriminate the person.

**Disclosure of information that the Board obtains**

12.9.10 The Act provides that a person’s personal history or records that the Board or Public Guardian obtain must not be disclosed apart from at a hearing or where it is the Board or Public Guardian’s opinion that disclosure is in a represented person’s best interests or disclosure has been authorised. Contravention is an offence with a fine or imprisonment, or both, able to be imposed. Section 11(7) provides that: ‘Evidence given before the Board is not to be used in any civil or criminal proceedings other than proceedings for an offence against this Act or an offence committed at, or arising out of, a hearing before the Board.’

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988 *Guardianship and Administration Act 2000 (Qld)* ss 130(4)–(5), 210A(4)–(5), 44(4)–(5), 76(6)–(7), and ss 137(2)–(3) in relation to witnesses.

989 Health Practitioner Regulation National Law sch 5, cl 2(3).

990 *Guardianship and Administration Act 1995 (Tas)* s 86(1).

991 Ibid s 86(4).

992 *Mental Health Act 2013 (Tas)* s 6(4) provides that:

‘Evidence given before the Tribunal is not admissible in any civil or criminal proceedings other than –

(a) proceedings for an offence against this Act; or

(b) proceedings for an offence committed at, or arising out of, a hearing before the Tribunal; or

(c) any other proceedings under this Act; or

(d) proceedings under the *Criminal Justice (Mental Impairment) Act 1999 or Guardianship and Administration Act 1995*; or

(e) proceedings where another Act specifically allows or requires the admission of that evidence.’
12.9.11 The Issues Paper asked whether there should be any changes in relation to when and how information obtained about a person can be disclosed.

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12.9.12 There were six written submissions addressing this question. Three indicated that there was no need for reform. A fourth respondent asserted that there should be the ability to subpoena evidence held by the Board for the purpose of other proceedings on the basis that ‘[p]arties need to get all the evidence and there shouldn’t be secret evidence.’ In addressing this matter, the Board commented that:

the flexibility and discretion afforded to the Board and President in section 86 of the Act is appropriate. It is the practice of the Board and President of the Board to exercise the discretion provided in section 86 in a manner that promotes the purposes and proper functioning of the Act. The Board gives weight to the fact that people freely disclose relevant information to the Board, which may be generally promoted by people feeling confident that the information they give to the Board will be held confidentially. The Board is also cautious of being used as an alternative forum for obtaining discovery of documents for what is effectively estate litigation. In practice, the Board receives requests for the release of financial, medical or other information in the nature of ‘discovery’ which is intended to be used in other court proceedings and which is clearly not in the best interests of the proposed represented person or represented person to be released.

12.9.13 One submission endorsed revision to the wording of s 86(2) to confirm that it is permissible to disclose information where required or permitted under another law.

12.9.14 Social Work Services RHH submitted that there should be amendment to when and how information obtained by the Board may be disclosed. It submitted:

A lot of sensitive information is given to the board which is then disseminated to parties who may not require that level of information. For example social workers may be given extensive information on financial matters prior to a hearing or some interested parties may receive reports including information from other parties.

The proposed represented person has a right to privacy and all information should not be routinely disclosed. There should also be scrutiny of dissemination of information provided by someone (eg a close family member or friend) to the board, where that information could result in harm (eg where the proposed represented person has been a perpetrator of abuse to the family member giving supporting information to the board, especially where there is a risk of ongoing or increased abuse to that family member as a consequence of providing information).

12.9.15 The relevant section provides the Board with discretion to release information in circumstances other than the hearing setting but does not limit the circumstances in which the Board may release information during a hearing. It is proposed that the Act enable a person providing information to the Board to apply for an order providing that the information not be disclosed to other parties. The relevant Victorian legislation, for example, provides that:

993 TLRI, above n 69, Question 7.15.
994 The Board, the Public Trustee, members of the Elder Law and Succession Committee of the Law Society.
(1) A person may make an application to the principal registrar that any documents lodged in relation to a proceeding under the Guardianship and Administration Act 2018 not be disclosed to a specified person or class of persons.

(2) The principal registrar must determine an application under subclause (1) fairly and according to the merits of the application.\(^{995}\)

**Recommendation 12.23**

(a) That the Act enable a person to apply to the Board for an order that any document, information or report lodged with the Board not be disclosed to specified person or class of persons.

(b) That s 86(2) of the Act be revised to provide that sub-s (1) ‘does not prevent the disclosure of information as required or permitted by any law [or] if, in the case of information relating to the personal affairs of another person, that other person has given consent in writing.’

**Conduct of hearings**

12.9.16 Hearings are open to the public.\(^{996}\) A person with a direct interest may request that the Board hold part or all of a hearing closed to the public.\(^{997}\) Enabling the public to attend Board hearings provides transparency. On the other hand, matters raised are often private and sensitive in nature. The Issues Paper queried whether, to maintain a person’s privacy, it may be appropriate to hold hearings in private, noting that proceedings are held in private in the Northern Territory.\(^{998}\)

**Does there need to be any changes to:**

- whether hearings are conducted in public or in private?\(^{999}\)

12.9.17 Four submissions addressed this question. Three considered the current provisions adequate. The Public Trustee considered that hearings should be held in private ‘to preserve confidentiality and give respect to the represented person and family.’ The Board’s submission did not address this question.

12.9.18 The Institute notes that a number of verbal submissions received raised the importance of the Board’s conduct and proceedings being transparent in order to provide accountability. As the Act already provides the Board with discretion to hold some or all of a hearing closed to the public, and that most submissions considered this approach adequate, the Institute has not proposed reform to this section.

**Searches of the register of instruments**

12.9.19 The register of instruments is available for public search. The VLRC recommended that only those people with a legitimate interest be able to search the register and that it be an offence to

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\(^{995}\) *Victorian Civil and Administrative Tribunal Act 1998* (Vic) pt 9 of sch 1 cl 37A.

\(^{996}\) *Guardianship and Administration Act 1995* (Tas) s 12(1).

\(^{997}\) Ibid s 12(2).

\(^{998}\) *Advance Personal Planning Act 2016* (NT) s 69; *Guardianship of Adults Act 2016* (NT) s 80.

\(^{999}\) TLRI, above n 69, Question 7.15.
search the register without legitimate interest.\textsuperscript{1000} The Institute asked whether stakeholders considered there ought to be any changes to the existing approach in Tasmania.

### Does there need to be any changes to:

- who is able to search the register of instruments\textsuperscript{2001}

12.9.20 There were six written submissions lodged in response to this question. The Board and one other respondent supported the VLRC’s approach of limiting those who can search the register of instruments to those with a legitimate interest. Whilst the OPG did not hold a strong view, it was inclined to support limiting access to the register in this way. Another verbal submission suggested that access to the register should probably be limited. Members of the Elder Law Committee, however, submitted that there is good reason for public access but did not elaborate further.

12.9.21 Instruments often contain private and sensitive information. It is important that donor’s privacy is respected and maintained. Donors should not be reluctant to make and register an instrument or fully convey their views, wishes and preferences worried that the information contained in their instrument may be publicly accessible. Two matters must be appropriately balanced: 1) the need to protect individuals’ privacy; and 2) the need to ensure that those that need to obtain a copy of an instrument are able to do so easily and quickly. This latter can be achieved without necessitating public access. The former, however, cannot. It is therefore proposed that the Act be revised to provide that only those with a legitimate interest are entitled to search the register.

#### Recommendation 12.24

That only those with a legitimate interest be able to search the register(s) of instruments and advance care directives and that it be an offence to search the register(s) without a legitimate interest.

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**Disclosure of a represented person’s Will**

12.9.22 The Act gives certain entitlements to some representatives and the Board to obtain copies of a represented person’s Will.\textsuperscript{1002} There is presently no consistency between these provisions.

12.9.23 Some submissions raised these parts of the Act as requiring reform. In relation to the Board’s powers, the Board submitted:

Section 88 of the Act gives the Board the power to require the production of a person’s Will but does not give the Board the power to require a copy be provided to it. To facilitate exercising the power in section 88(3) of the Act, which applies where the Board will open and read the Will for the purposes of a hearing, the Board may exercise its general power under section 11(8) of the Act to direct the registrar to serve on any person a summons to appear before the Board to produce a document (the Will) specified in the summons.

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\textsuperscript{1000} VLRC, above n 24, Recommendation 275.
\textsuperscript{1001} TLRI, above n 69, Question 7.15.
\textsuperscript{1002} Guardianship and Administration Act 1995 (Tas) ss 32B(2)–(3) in relation to enduring guardians, ibid s 88 in relation to the Board, Public Trustee and private administrators. There are no provisions in relation to Board-appointed Guardians. For relevant provisions, see Appendix 9 of the Issues Paper (TLRI, above n 69).
In practice, the Board’s Registrar requests a copy of the person’s Will, for the purpose of hearing. A copy of a Will if received is only disclosed to the Board for the purposes of the hearing. In some matters, the Will is relevant evidence of a person’s wishes. The Board notes it has no power of delegation and so it would be beneficial for this section to be amended to include the Registrar of the Board and to require a copy of the person’s Will to be produced and provided to the Board, when requested.

12.9.24 The Elder Law Committee advised that its members held mixed views about whether, and if so when and how representatives ought to be entitled to see a copy of a represented person’s Will. In addressing a question in Part 15, it also proposed reform in relation to the Board’s power to request and view a copy of a person’s Will:

The Committee considers that it is appropriate for the Board to have the power to make orders to deliver up testamentary documents to the Board upon notice to interested parties and after a hearing*. Access to testamentary documents obtained by the Board should only be granted to third parties by order of the Board noting the potential for abuse and pressure to be placed on a person around testamentary intentions.

The Committee was undecided on the question whether administrators and guardians should have the power to access wills without an order of the Board.

There is also concern about investigator’s powers to require production of testamentary wills without an order of the Board. This is a serious intrusion on the private intents and wishes of a person. Requirements to produce should not be a part of the initial investigatory process.

*There is also concern about investigator’s powers to require production of testamentary wills without an order of the Board. This is a serious intrusion on the private intents and wishes of a person. Requirements to produce should not be a part of the initial investigatory process.

12.9.25 Wills can contain information of a sensitive nature, including who is named (or excluded) as a beneficiary. Typically, a person’s Will is not required to be disclosed to anyone prior to their death. An individual’s right to privacy is a fundamental right reinforced in the Convention specifically in relation to people with disability. It is important that the Act reflects and supports this right, including in relation to access to a represented person’s Will. It might not be consistent with a represented person’s wishes for the contents of their Will to be disclosed prior to their death.

12.9.26 There might be occasions where a representative requires a copy of a represented person’s Will as part of carrying out their role. It might be useful to reveal a represented person’s wishes, or those close to the person who should be consulted and who might have information relevant to a represented person’s likely will and preferences. In the case of administrators, reading the Will might be important to understand the potential implications of altering investments or selling assets. Whilst the Act provides ‘anti-ademption’ provisions to deal with situations where the actions of an administrator would otherwise cause a specific gift in a Will to adeem,\(^\text{1003}\) it may be appropriate that the preferred course of action be to ensure that administrators have this information available if proposing to change the nature of a person’s assets. The terms of a person’s Will could also be useful to identify a represented person’s assets where unclear. It might also be appropriate for a representative to see the contents of a represented person’s Will where they consider that there could

\(^{1003}\) Guardianship and Administration Act 1995 (Tas) s 60.
be a need for a statutory Will. On the other hand, there are likely to be many situations where a represented person’s Will is not required when considering the exercise of a representative’s powers.

12.9.27 It is the Institute’s view that the relevance of a represented person’s Will to performance of a representative’s role is an assessment appropriate for the Board to make on a case-by-case basis. The Institute therefore recommends that representatives be able to apply to the Board for approval to obtain a copy of a represented person’s Will. This is already the position for administrators but it is proposed that it be extended to Board-appointed guardians, and for the same approach to apply to enduring guardians. This approach appropriately balances the need to preserve an individuals’ right to privacy whilst ensuring that a representative has the information that they require to best discharge their role and duties.

**Recommendation 12.25**

1. That s 88 of the Act be revised to confirm that the powers granted to the Board may be exercised by the Registrar.

2. That representatives only have a power to obtain, read and copy a represented person’s Will with an order from the Board.

3. That the Act define ‘Will’ to include a Will, alleged Will, part of a Will, or a revoked Will or other testamentary document, including Codicil.

**12.10 Other safeguarding options**

12.10.1 Some jurisdictions have other legislative safeguards aimed at advancing the interests of people subject to guardianship laws. These include:

**Criminal or civil penalties for representatives**

12.10.2 The Act does not create any specific penalties or offences for representative who breach their duties, or who abuse, exploit or neglects a represented person. Ultimately, their actions may amount to a criminal offence under other legislation.

12.10.3 In the Northern Territory, decision-makers who intentionally engage in conduct that fails to comply with the duties of decision-makers, or is not in accordance with the guiding principles of their Act, and who are reckless in relation to the adult, are guilty of an offence. A higher penalty is imposed where the decision-maker does so with the intention of obtaining a benefit for themselves or another person. Offences are also created for people who induce a decision-maker to

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1004 Refer to the Will Act 2008 (Tas) pt 3.
1005 Guardianship and Administration Act 1995 (Tas) s 88(2).
1006 Sec, for example, Criminal Code 1924 (Tas) ch XVI.
1007 Advance Personal Planning Act 2016 (NT) s 78(1); Guardianship of Adults Act 2016 (NT) s 87(1).
1008 Advance Personal Planning Act 2016 (NT) s 78(3); Guardianship of Adults Act 2016 (NT) s 87(2).
contravene their duties or other provisions of the Act.\footnote{Advance Personal Planning Act 2016 (NT) s 79; Guardianship of Adults Act 2016 (NT) s 88(1). Higher penalties apply if the person does so with the intention of obtaining a benefit for themselves or others: Advance Personal Planning Act 2016 (NT) s 79(2); Guardianship of Adults Act 2016 (NT) s 88(2).} It is also an offence in Victoria and the Northern Territory to purport to be a representative.\footnote{Medical Treatment Planning and Decisions Act 2016 (Vic) s 41; Guardianship of Adults Act 2016 (NT) s 86(1).}

12.10.4 The ALRC has stated that it does not support guardianship laws duplicating offences that are set out in other legislation.\footnote{ALRC, above n 899, [4.20], [4.35]–[4.40].} The VLRC, however, supported guardianship legislation including civil penalties for representatives who abuse, exploit or neglect a represented person.\footnote{VLRC, above n 24, Recommendations 305–314.} This may be beneficial where a person is reluctant to pursue a matter more formally, for example involving the police and the courts.

12.10.5 Currently, the Act only imposes penalties against individuals. In Victoria, offences are created for bodies corporate and officers of a body corporate who breach the Act or fail to avoid an employee breaching the Act in certain circumstances.\footnote{Medical Treatment Planning and Decisions Act 2016 (Vic) s 93; Powers of Attorney Act 2014 (Vic) s 137.}

12.10.6 The Issues Paper asked whether there is utility in the Act containing specific offences and penalties where representatives breach the Act.

(i) Should the Act provide offences for representatives who breach the Act?  
(ii) If so, what consequences should be imposed?\footnote{TLRI, above n 69, Question 7.16.}

12.10.7 Four submissions addressed this question, with two supporting the creation of offences and two expressing concerns about this alternative. The OPG submitted:

The OPG would certainly not like to see penalties applied to representatives (enduring or Board-appointed) acting in good faith, and is loath to implement disincentives for people to undertake important roles in supporting and acting for their close family members and friends, often in very complex and difficult circumstances.

Our view is that support, guidance and education should be the focus … The OPG would like the legislation to strengthen our role in supporting, guiding and educating private representatives. Together with stronger and broader powers for investigation, this would provide better safeguarding mechanisms.

There is work afoot, nationally, by the Working Group on Protecting the Rights of Older Australians for the Council of Attorneys-General with projects being undertaken by AGAC. This work is looking at the development of a model law for enduring appointments, as well as approaches to education and support for newly appointed private guardians and administrations, and approaches to penalties for failing to meet their obligations. The OPG would like to see the results of this work before forming any firm view.

12.10.8 Members of the Elder Law Committee commented that the Criminal Code appears to adequately deal with representatives who breach the Act. The Public Trustee on the other hand submitted that:
Yes there should be offences.

It goes without saying that the consequences need to be proportional to the offence. For example, in cases of misappropriation there should be an offence under the Act that would facilitate institution of criminal charges. Offences should also ground statutory remedies, for example, breach of statutory duty.

12.10.9 The Institute acknowledges the OPG’s submission and agrees that this option be further considered following separate reviews being coordinated and conducted nationally following the ALRC’s recommendations in its *Elder Abuse* final report.1015

### Compensation

12.10.10 The ALRC proposed that Tribunals have the same powers as the Supreme Court to award remedies where a represented person suffers financial loss because of the actions of representatives.1016 It explained its rationale as follows:

In many instances of financial abuse (or abuse by a guardian which causes loss), there are limited options for an older person to seek redress, and few consequences for the representative who has misused their power. An abused person may want their money or assets returned, but may not want police involvement, preferring to retain relationships and not see the person prosecuted. They also may not be willing or able to afford to commence a civil action in the Supreme Court.1017

12.10.11 The ALRC suggested that enabling tribunals to deal with these matters would be a practical way to redress loss and enable a just, quick and economical resolution in a more flexible and informal environment.1018 Their recommendation was supported by a number of stakeholders.1019 In several jurisdictions, tribunals can award compensation.1020 Two submissions to this review endorsed this as a potential option for reform. EOT, for example, submitted:

We are also supportive of the introduction of appropriate mechanisms for providing redress in circumstances where substitute decision makers have misused or abused their powers, noting that this issue will need to be considered as part of the establishment of a single Civil and Administrative Tribunal.

12.10.12 The Institute endorses the ALRC’s reasoning and agrees with EOT that this option be further developed upon the creation of the Tasmanian Civil and Administrative Tribunal.

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1016 ALRC, above n 66, [5.82].
1017 Ibid [5.82]–[5.83].
1018 Ibid [5.89].
1019 Ibid [5.88].
1020 *Powers of Attorney Act 2014* (Vic) s 77; *Powers of Attorney and Agency Act 1984* (SA) s 7; *Guardianship and Administration Act 2000* (Qld) s 59; *Advance Personal Planning Act 2016* (NT) s 83; *Guardianship of Adults Act 2016* (NT) s 94. The ALRC noted that this may not be as easy to implement in Tasmania without a civil and administrative tribunal: ALRC, above n 66, [5.88]. Although, the move to a single Civil and Administrative Appeals Tribunal in Tasmania is the subject of a separate review. The TLRI understands that recommendations are being considered by Parliament.
**Recommendation 12.26**

That providing the Board with the ability to award remedies where a represented person suffers financial loss because of the actions of a representative be considered as part of instituting the Tasmanian Civil and Administrative Tribunal.

**Undertakings**

12.10.13 Representatives are not required to give any undertaking that they will uphold their duties and act within their powers. It is the practice of the Board to have administrators sign an acknowledgment to acknowledge their understanding and acceptance of key aspects of their role.  

12.10.14 To signify the seriousness of the role of a representative, it has been recommended that board-appointed representatives should need to give an undertaking that they will fulfil their obligations and responsibilities. This is required in the Irish Republic. The ALRC recommends, however, that sanctions not be imposed where a representative fails to comply with an undertaking.

12.10.15 In its submission, the OPG commented:

> Whilst the legislation does not require it, the Board’s processes when appointing a private guardian or administrator include providing the new appointee a copy of the relevant handbook (see 7.16) and asking that they sign an acknowledgement that their duties and obligations have been explained. We believe this is good practice and would not oppose the legislation requiring the representative to give such an undertaking.

12.10.16 Recommendation 4.10 of this Report proposes that enduring guardians be required to undertake that they will act in accordance with the Act and that they have read and understood any advance care directive of the donor. Consistent with this recommendation, it is proposed that the current practice of the Board be enshrined within the legislation, requiring representatives to acknowledge certain matters and undertake to do certain things upon their appointment.

**Recommendation 12.27**

That upon appointment, Board-appointed representatives be required to declare that they:

- understand their obligations;
- understand the consequences of failing to comply with their obligations; and
- undertake to act in accordance with the Act.

**12.11 Other suggestions**

12.11.1 As a concluding question for this Part, the Issues Paper asked for any other suggestions to improve the safeguarding provisions of the Act.

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1021 Guardianship and Administration Board, above n 235, 9. At the time of writing, an equivalent acknowledgment is being developed for guardians.

1022 ALRC, above n 66, [10.16], Recommendation 10-1; VLRC, above n 24, Recommendations 295, 296.


1024 ALRC, above n 3, [10.16].
Part 12: Safeguards for Representative Decision-Making

How else could the Act be improved in relation to safeguards for representative decision-making?1025

12.11.2 Most suggestions have been captured elsewhere in this Report. The following four suggestions are not addressed elsewhere and are thus considered in the following paragraphs.

**Capacity assessments to register instruments**

12.11.3 COTA submitted that ‘there should be independent professional evaluation of an individual’s capacity to enact/activate an enduring guardianship before it is registered.’ The Institute understands this suggestion to relate to the need to be satisfied that a donor had the necessary decision-making ability to make the instrument, to safeguard against the risk of abuse or undue influence. This matter is similar to discussion in Part 4 in relation to whether a professional witness should be required to witness a donor execute an instrument.

12.11.4 Recommendation 12.5 proposes that the Board be given power to review an instrument of its own motion. The Board’s submission commented that this would address circumstances where it has some evidence that a donor may not have had the decision-making ability to make an instrument. As discussed in Part 4, the Institute has not made recommendations proposing that there be a mandated requirement that one of the witnesses to an instrument be a professional, for example, a medical practitioner or lawyer. This was explained for several reasons, including that it would impose a barrier to a person expressing their views, wishes and preference, and that involvement of a professional witness may not reduce circumstances where donors create instruments without the necessary decision-making ability to do so. For the same reasons, the Institute has not made recommendations proposing that there be an independent professional assessment of a donor’s capacity to make an instrument before it can be registered.

**Clarifying the Board’s powers to give advice**

12.11.5 Members of the Elder Law Committee submitted in response to this question that ‘there should be greater clarification around the role of the Board in providing advice.’ It is considered that this issue may be best addressed through education rather than legislative reform. Part 18 of this Report makes recommendations about the need for education about the Act and Recommendation 18.1 proposes roll-out of an education campaign, including for representatives, about the operation of the Act.

**Monitoring of administrators**

12.11.6 The OPG commented that:

Consideration should be given to the Board requiring an administrator (and potentially an attorney operating under an enduring power) to be supervised or monitored by either The Public Trustee or another professional trustee should it be considered necessary. In such consideration, the Board should take into account such matters as: the size and complexity of the represented person’s property; whether there are other measures to protect the represented person; and potential conflict between represented person and representative.

1025 TLRI, above n 69, Question 7.17.
In some instances where supervision is deemed necessary, it may be appropriate for the representative to seek authorisation with respect to specified financial decisions.

12.11.7 As this was the only submission raising this alternative, the Institute has not made recommendations for reform but would not object to a reform to this effect.

**Responding to elder abuse**

12.11.8 The Board made a number of observations about the existence of elder abuse in the community and the need for legislation to effectively respond to this emerging issue:

Elder abuse has become an issue of increasing concern across the nation. Legislation has generally not kept pace in dealing adequately with what often constitutes criminal behaviour in relation to the vulnerable aged. The Board has experienced an increase in applications for review of both enduring guardians, but particularly enduring power of attorneys because of concern about questionable or potentially criminal behaviour by attorneys against the donor, often an elderly relative. The following is a recent example of an application to review an enduring power of attorney before the Board:

An attorney, who was the daughter of the donor, acting under an operative enduring power of attorney, took a sum of money from her mother’s bank account and divided it between herself and her sibling. Whilst the donor confirmed that this was in accordance with her wishes, at the time of the withdrawal she did not have capacity to make this decision. The attorney failed to understand that this was unlawful — because her mother agreed to it and the siblings would ultimately inherit the estate — and neither the donor nor the attorney considered the Centrelink implications of the transaction which were significant and contrary to the donor’s best interests. It left the donor without any savings.

Attorneys commonly do not appreciate that their behaviour may amount to a crime. The fact that there have been very few prosecutions in Australia for elder abuse points to the difficulty of applying the criminal law to this pattern of behaviour. Legislation governing the scope of authority of decision makers under such instruments might better safeguard the interests of the vulnerable by clearly naming and defining elder abuse, stipulating types of proscribed behaviour by appointees and imposing adequate penalties for breach.

12.11.9 The issue of elder abuse was considered at a recent Symposium on Elder Abuse and Neglect convened by a partnership of COTA, EOT, the University of Tasmania and the Institute. Recommendations made by over 60 stakeholders who attended the symposium included the following legislative options to tackle the issue of elder abuse:

- introduction of a Tasmanian Charter of Human Rights, to embed a human rights culture within the community.  
  The Institute has previously also made recommendations proposing introduction of a Tasmanian Charter of Human Rights; and

- adoption of adult safeguarding legislation, providing adult safeguarding agencies power to safeguard and support at risk adults. This is consistent with the recommendations of the ALRC.

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1027 Ibid Recommendation 4.
12.11.10 The issue of elder abuse has recently been the subject of enquiry by Coroner McTaggart where she commented that:

Elder abuse is recognised worldwide as a serious human rights violation requiring urgent action. It is also a major public health problem that results in serious health consequences for the victims, including increased risk of morbidity, mortality, institutionalisation and hospital admission. It has a negative effect on families and society at large.\textsuperscript{1031}

Coroner McTaggart went on to state that:

It would appear that there may well be a lack of monitoring of older persons being cared for in the community. Whilst there are considerations of autonomy and freedom of choice, effective measures for the protection of older persons from abuse are desirable.\textsuperscript{1032}

Coroner McTaggart recommended that the State Government review legislation to determine whether current components of legislation effectively and efficiently prevent or respond to abuse, neglect or exploitation of older persons and implement legislative reform where necessary.\textsuperscript{1033}

12.11.11 The recent report into the review of the \textit{Disability Services Act} also raised the issue of mandatory reporting of abuse against adults with disability.\textsuperscript{1034} The report summarises the issue raised by stakeholders as:

- Reporting of abuse is not mandated for people with disability
- Current national developments that support the reporting of abuse include national worker screening, a national complaints process and the National Abuse and Neglect Hotline.\textsuperscript{1035}

The report concludes that:

- This will largely be addressed by national worker screening that is currently being implemented\textsuperscript{1036}

12.11.12 These, and other approaches may form part of a comprehensive strategy to respond to elder abuse in Tasmania and the Institute endorses these, and other alternatives,\textsuperscript{1037} being further and separately investigated. The Institute recommends that the merits of introducing adult safeguarding legislation for ‘at risk’ adults\textsuperscript{1038} be the subject of separate review.

\textbf{Recommendation 12.28}

That the merits of introducing adult safeguarding legislation in Tasmania be reviewed.

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\textsuperscript{1029} Equal Opportunity Tasmania, Council on the Ageing Tasmania, University of Tasmania and Tasmania Law Reform Institute, above n 4, Recommendation 5.
\textsuperscript{1030} ALRC, above n 66, Recommendation 14.1.
\textsuperscript{1031} Janet Lois Mackozdi 2018 TASCD 274, [177].
\textsuperscript{1032} Ibid [186].
\textsuperscript{1033} Ibid [197].
\textsuperscript{1034} Review of the \textit{Disability Services Act 2011}, above n 106.
\textsuperscript{1035} Ibid 40.
\textsuperscript{1036} Ibid.
\textsuperscript{1037} See also discussion at [16.2.2]; Wendy Lacey, ‘Neglectful to the Point of cruelty? Elder abuse and the rights of older persons in Australia’ (2014) 34 \textit{Sydney Law Review} 99.
\textsuperscript{1038} Further discussion is contained in the ALRC’s Elder Abuse Final Report, Chapter 14.
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Part 13

Consent to Health Care and Treatment

13.1 Introduction

13.1.1 The Terms of Reference asked the Institute to review the provisions of the Act dealing with consent to medical and dental treatment, and specifically, how to address long term or indefinite medical treatment in institutional and non-institutional settings.

13.1.2 Article 25 of the Convention confirms the rights of people with disability to have access to health services on an equal basis with others. This Part explains the current provisions of the Act dealing with consent to treatment and recommends reform to ensure that the Act is appropriate in light of developments in policy, law and practice, and that the provisions are sustainable and responsive to the needs of Tasmanians.

13.2 Preliminary Matters

Where should these laws be located?

13.2.1 The Act sets out how substitute consent to medical treatment is provided. In some jurisdictions, consent to medical treatment is dealt with in separate Acts to guardianship laws. The Issues Paper commented that separate legislation may assist to provide a single, accessible method to locate statutory provisions dealing with consent to treatment. On the other hand, there may be overlap between a person’s need for decision-making support in relation to medical treatment, personal matters and financial matters, and this may support retention of these provisions within a single Act.

13.2.2 The Institute asked for views about whether there is any utility to separating those parts of the Act dealing with consent to medical and dental treatment into stand-alone legislation.

Should provisions relating to consent to medical and dental treatment be included in the Act, or separate legislation?

13.2.3 There were seven responses to this question with five supporting these provisions remaining in the Act and two expressing that they held no view. Reasons given for retaining these provisions within the Act included:

1039 Article 10 also records the right to life: Convention on the Rights of Persons with Disabilities art 10.
1040 For example, Medical Treatment Planning and Decision Act 2016 (Vic); Medical Treatment (Health Directions) Act 2006 (ACT); Consent to Medical Treatment and Palliative Care Act 1995 (SA).
1041 In 2016, Madeline Ogilvie introduced the Care and Consent to Medical Treatment Bill 2016 before Parliament. The Bill separates the provisions that are currently in the Act in relation to consent to treatment into separate legislation. The Bill was read for the first time by the House of Assembly in April 2016: see <http://www.parliament.tas.gov.au/bills/Bills2016/19_of_2016.htm>.
1042 TLRI, above n 69, Question 10.1.
that the needs of people without decision-making ability requiring medical treatment may also require decisions about personal and financial matters;\textsuperscript{1043} 

- that separate legislation would likely make the law more ‘unwieldy’ and confusing;\textsuperscript{1044} and 
- that there is no case for separate legislation.\textsuperscript{1045}

13.2.4 Consistent with submissions received, the Institute has not made recommendations proposing that Tasmania have separate legislation dealing with substitute consent to health care and treatment.

**Who should these provisions apply to?**

13.2.5 The Act deals with consent to medical and dental treatment for:

- children and adults; and 
- all people, regardless of whether they have a representative appointed.\textsuperscript{1046}

13.2.6 The result is a dual jurisdiction between the Family Court and the Board to deal with consent to treatment for children with disability unable to provide their own consent.\textsuperscript{1047} The Act does not, however, make this explicit. The *Mental Health Act*, on the other hand, confirms that the Act does not affect the jurisdiction of the Supreme Court and Family Court to give or refuse consent to treatment.\textsuperscript{1048}

13.2.7 The Board’s annual reports reveal the small number of applications made to the Board for consent to treatment more generally, with the number of applications in recent years being 11 (2011–2012), four (2012–2013), one (2013–2014), one (2014–2015), three (2015–2016), and three (2016–2017).\textsuperscript{1049} The Board commented that applications relating to consent to treatment for children are uncommon, stating that:

> While the Board has expertise in the disability sphere, applications regarding children are very uncommon. This may suggest that the Family Court is the forum that is being more regularly used for applications regarding medical treatment for children with decision making disability.

13.2.8 The Interim Children’s Commissioner also raised this matter in his submission, commenting:

> There are few reported decisions of the Guardianship and Administration Board (‘the Board’) concerning consent to medical treatment relating to children. In the most recent

\textsuperscript{1043} Guardianship Board. 
\textsuperscript{1044} OPMHS. 
\textsuperscript{1045} OPG. 
\textsuperscript{1046} Guardianship and Administration Act 1995 (Tas) s 36(1). 
\textsuperscript{1047} It is also part of the Supreme Court’s inherent *parens patriae* jurisdiction. 
\textsuperscript{1048} Mental Health Act 2013 (Tas) s 219. The NSWLRC has recommended that legislation confirm that it does not limit the Supreme Court’s inherent jurisdiction: NSWLRC, above n 24, Recommendation 15.1. 
of such reported cases, *NC (Medical Consent) [2014] TASGAB 15* (21 July 2014), the Board clearly contemplates dual jurisdiction to provide consent to ‘special treatment’ for children with that of the Family Court.\(^{1050}\) …

Section 38 of the Act provides that a person must not carry out medical or dental treatment on a person to whom Part 6 applies unless consent has been given in accordance with that Part, or is otherwise authorised by it. Significant penalties apply to persons who carry out treatment in contravention of Part 6.

The above prompts me to query whether treatment authorised by the Family Court for a child with a disability who lacks capacity would nevertheless be prohibited in Tasmania in the absence of authorisation under Part 6 of the Act. I note, for example, the *Mental Health Act 2013* (Tas) confirms its provisions do not limit the jurisdiction of the Family Court or the Supreme Court to give or refuse treatment.

I raise this as a potential issue, which may benefit from consideration, and potentially clarification, by the Solicitor General and/or others with relevant legal expertise …

The Interim Commissioner went on to comment that:

> it is not entirely clear to me whether a child with a disability is brought within the purview of Part 6 of the Act because they lack capacity solely due to their disability; or because of their immaturity by virtue of age and/or stage of development (ie they lack ‘Gillick competence’) or both. It would appear this would benefit from clarification.

If there are no changes to the G&A Act’s legislative framework governing medical treatment (including special treatment) for children with a disability who lack capacity to provide informed consent, there is, as indicated earlier in this submission, a need for expert legal consideration of the appropriateness of incorporating a section similar to section 219 of the *Mental Health Act 2013* noting section 38 of the G&A Act.

13.2.9 These submissions highlight that, if the Act continues to apply to children with disability, there is a need for legislative clarity around the respective roles of the Family Court, Supreme Court and the Board.

13.2.10 In some jurisdictions, guardianship laws dealing with substitute consent to medical treatment only cover adults, with the Family Court having jurisdiction over all children’s matters.\(^{1051}\) This aligns with the jurisdiction of the Family Court to make orders in relation to the welfare of children.\(^{1052}\) The Issues Paper asked whether the Act should continue to deal with consent to treatment of children.

### Should the Act deal with consent to medical treatment for children?\(^{1053}\)

13.2.11 There were six submissions addressing this question, with three supporting the Act continuing to apply to children with disability, two expressing no concluded position, and the Board suggesting that the Act should probably not deal with consent to treatment for children with disability.

\(^{1050}\) Referring to paragraphs 4, 5, and 6.

\(^{1051}\) In New South Wales, the provisions apply only to people at or over the age of 16 years: *Guardianship Act 1987* (NSW) s 34(1)(a).

\(^{1052}\) *Family Law Act 1975* (Cth) s 67ZC.

\(^{1053}\) TLRI, above n 69, Question 10.2(i).
13.2.12 The Board submitted:

Consistency and equity in the consent process for the treatment of children might be better achieved through the federal jurisdiction of the Family Court rather than under the various state legislative systems — especially as contradictory orders from different jurisdictions are capable of co-existing. The Family Court is experienced in dealing with children’s matters generally, and dealing with conflicting views of parties appearing before it. The Family Court also has the ability to appoint an independent children’s lawyer (ICL), who is a legal practitioner of 5 years post admission experience, successfully completed the ICL training course, has experience in conducting defended hearings in the family court or federal circuit court and can play an important role in providing independent evidence to the Court …

13.2.13 Whilst the Interim Children’s Commissioner did not express a concluded view, he made the following comments:

adoption of an ‘impaired decision-making capacity test’ would, in my opinion, raise clear questions around the need for and appropriateness of including in the G&A Act any provisions describing substitute decision-making for medical treatment for children. This is particularly so when one acknowledges that issues related to parental responsibility for children are defined and dealt with in the family law jurisdiction …

consideration of the G&A Act provisions around consent to medical treatment for children could more easily and appropriately occur in the context of debate around whether Tasmania should move to enacting separate legislation for consent to medical treatment generally. This would also provide an opportunity to consider consent to treatments beyond the normal authority of a parent or person with parental responsibility—such as sterilisation which is in a child’s best interests. In this respect, I note there exists within the family law jurisdiction well-established jurisprudence around treatment decisions considered to be outside of the usual bounds of parental authority including, but not limited to, sterilisation. I am not entirely sure that the G&A Act provides the appropriate context for consideration of issues such as this in relation to children …

Even if the G&A Act continues to be based on a substitute decision-making framework for which disability is a pre-condition, I have reservations around the appropriateness of continuing to include provisions describing parental responsibility regards medical treatment for children with a disability and who do not have capacity to consent. This is particularly so when one considers Article 7 of the CRPD and its focus on equality before the law.

13.2.14 Both the Board and the Interim Children’s Commissioner observed the differing outcomes that can result applying the Act and the jurisprudence of the Family Court in the context of

Note that the Interim Children’s Commissioner expressed reservations about forming a concluded view, and that there is a need to ensure that the outcome is not an inadvertent lessening of the rights of children, commenting ‘It is important to acknowledge that consideration of important policy issues relating to consent to medical treatment is complicated by the challenges involved in gaining a full picture of the complex legal situation as it relates specifically to children. It may, for example, be that proposals I put forward might inadvertently lead to a lessening of protections for children with disability. As the provision of legal advice is not within my functions, I leave it to those with relevant legal expertise to identify and resolve any potential unintended consequences…’ He also stated that: ‘In some respects it is difficult to comment on the current application of the G&A Act to children and young people, or on options for reform, without a clear understanding of the way in which its provisions regarding consent to medical and dental treatment interact with the jurisdiction of the Family Court.’
substitute consent to treatment for gender dysphoria. The Interim Children’s Commissioner, for example, explained:

It is useful to recall that anyone under the age of 18 years is regarded as a ‘child’ for the purposes of the Family Law Act 1975 (Cth). Section 61C of the Family Law Act provides that subject to any order of the Court, each of the parents of a child who has not turned 18 years of age has ‘parental responsibility’ for that child; an aspect of parental responsibility is the right and obligation to make decisions around medical and dental treatment for a child.

However, some decisions around medical treatment for children are considered to be beyond the normal authority of a parent or person with parental responsibility – and as such they require authorisation of the Family Court. For example, Court authorisation is required for surgery on a child which will result in sterilisation and which is not for the purpose of preserving life or treating and preventing grave physical illness.

I note the recent decision of the Full Court of the Family Court in Re Kelvin regarding potential sterilisation arising from Stage 2 treatment for gender dysphoria. The Full Court concluded that Stage 2 treatment for young people with gender dysphoria ‘can no longer be considered a medical procedure for which consent lies outside the bounds of parental authority and requires the imprimatur of the Court.’ The decision in Re: Kelvin is consistent with a recommendation of the UN Human Rights Committee that Australia:

‘[c]onsider ways to expedite access to stage two hormone treatment for gender dysphoria, including by removing the need for court authorisation in cases featuring uncontested agreement among parents or guardians, the child concerned and the medical team, provided that the treatment is provided in accordance with the relevant medical guidelines and standards of care.’

As is noted in the Paper at paragraph 10.8.26, Stage 2 treatment for gender dysphoria is likely to fall within the class of special treatment that currently requires consent from the Board. This is because it amounts to treatment that is reasonably likely to render a person permanently infertile. I raise this simply to demonstrate the potential for inconsistent overlap between the State and Federal jurisdictions.

13.2.15 The Interim Commissioner’s submission referred to the decision of the Board in NC.\textsuperscript{1055}

The Board in that decision stated:

4. The Guardianship and Administration Act 1995 was enacted after the High Court delivered its judgment in Secretary, Department of Health and Community Services v. J.W.B. and S.M.B. (Marion’s Case) [1992] HCA 15; (1992) 175 CLR 218. The Court was unanimous in that decision to the extent that:

‘the authority of parents does not, in the absence of special statutory provisions, extend to authorizing surgery involving the sterilization of a profoundly intellectually disabled child for other than the conventional medical purposes of preserving life and treating and preventing grave physical illness.’

5. The legislature, in enacting this Act, were clearly responding to the terms of the High Court’s decision and extended the authority to consent to a sterilisation procedure upon a child with a disability to the Guardianship and Administration Board, such that the Board holds dual jurisdiction to give such consent with the Family Court of Australia.

\textsuperscript{1055} NC (Medical Consent) [2014] TASGAB 15 (21 July 2014).
6. Whereas the High Court decision allowed parents the authority to consent to sterilisation for ‘conventional medical purposes of … treating and preventing grave physical illness,’ the legislature removed that authority in the enactment of Part 6 because the operation of that Part does not make an exception to section 38 or the definition in section 3 where the procedure is undertaken for the treatment of ‘grave physical illness.’ The High Court hesitated to use the terms ‘therapeutic’ and ‘non-therapeutic’ sterilisations because of the uncertainty and the lack of a clear ‘dividing line’ between those two concepts. It is possible that, for the same reasons, the legislature determined that application of a universal rule was preferable to attempting to delineate what was ‘therapeutic’ and ‘non-therapeutic’ in this respect.

13.2.16 The Institute also notes the decision of the High Court in P v P1056 where the High Court held that state guardianship legislation only applies to the extent that it is not inconsistent with the Family Law Act.

13.2.17 This Report has recommended that the Act no longer require the existence of a disability as a pre-condition to the operation of the Act, and that it instead apply to people who do not have the ‘decision-making ability’ to make a decision about a particular matter.1057 In the absence of legislative clarity, one implication of this approach could be to extend operation of the Act to a child without Gillick competence to consent to treatment.1058 Without anything further, this would have the potential to interfere with the jurisdiction of the Family Court. Options to resolve this situation could include:

- to maintain the status quo, with the Act continuing to apply only to children with disability without the decision-making ability to consent to treatment. The effect would be continuation of the dual jurisdiction between the Family Court and the Board in relation to children with disability; or
- to remove the Board’s jurisdiction in relation to consent to treatment for children with disability.

13.2.18 The first alternative results in children with disability being treated differently to children without disability. As discussed in Parts 2 and 6, the Convention requires non-discrimination on the basis of disability. For the same reasons as articulated in Part 6, the Institute considers that, to uphold the rights of children with disability, the Act should not contain laws applying only to children with disability. The focus should instead be upon an assessment of whether an individual child has the decision-making ability to give their own consent to treatment. If they do not, then it should be immaterial how that inability to consent arises — whether because of disability or because of age or maturity. To have the Act continue apply solely to children with disability would seem to be inconsistent with the reasoning supporting Recommendation 6.1.

13.2.19 As the Board and the Interim Children’s Commissioner’s submissions noted, the approach to substitute consent for treatment for gender dysphoria would now seem to differ between the Act and the jurisprudence of the Family Court following the recent decision of the Full Court of the

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1057 Recommendations 6.1, 6.3.
1058 ‘Gillick competence’ is where a ‘child achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed. It will be a question of fact whether a child seeking advice has sufficient understanding of what is involved to give a consent valid in law: Gillick v West Norfolk and Wisbech Area Health Authority [1986] AC 112.
Family Court in the case of Re Kelvin.\textsuperscript{1059} That case involved the giving of consent to Stage 2 treatment for gender dysphoria for a 17 year old child. ‘Stage 2’ treatment describes the administration of hormones to encourage the development of physical characteristics for individuals with a biological sex that does not align with their gender identity. Effects of this treatment can be irreversible and include the potential for long-term infertility. Under the Act, any treatment having the effect of rendering a person infertile is classified as ‘special treatment’, requiring the Board’s consent.

13.2.20 The Full Court of the Family Court decided in Re Kelvin that, unless there is controversy or disagreement amongst medical professionals or parents, substitute consent to Stage 2 treatment can be given by a parent. It concluded that ‘[t]he treatment can no longer be considered a medical procedure for which consent lies outside the bounds of parental authority and requires the imprimatur of the Court.’\textsuperscript{1060} Reasoning included the fact that gender dysphoria is a recognised mental disorder, and there are risks associated with not treating the medical condition.\textsuperscript{1061} The treatment was therefore considered to be therapeutic in nature.

13.2.21 The result would seem to be that a parent of a child\textsuperscript{1062} with gender dysphoria \textit{without a disability} can give substitute consent to Stage 2 treatment. Conversely, applying the Act, a parent of a child\textsuperscript{1063} \textit{with a disability} does not, as the Act provides that consent needs to be obtained in accordance with Part 6.\textsuperscript{1064} Under Part 6, only the Board could provide substitute consent to the treatment, as it falls within the definition of ‘special treatment’. The Institute notes the High Court decision of \textit{P v P} (referred to above) which confirms that, applying s 109 of the Constitution, state legislation only applies to the extent that it is not inconsistent with the \textit{Family Law Act}, being federal legislation. These are complex issues that require further detailed consideration and the Institute’s observations in this Report are preliminary only. The purpose of this discussion is to instead demonstrate the complexities that arise when assessing whether the Act should continue to retain provisions governing consent to treatment for children with disability.

13.2.22 One alternative to resolve the situation arising as a consequence of the decision in Re Kelvin could be to revise the definition of ‘special treatment’ so that Stage 2 treatment for gender dysphoria was excluded. The Act could either:

- provide that treatments rendering a person infertile are only ‘special treatments’ requiring the consent of the Board where they are non-therapeutic. A difficulty of this approach is that it might sometimes be difficult to distinguish between treatment that is therapeutic and that which is non-therapeutic;\textsuperscript{1065} or

\textsuperscript{1059} \textit{Re: Kelvin} [2017] FamCAFC 258 (30 November 2017).

\textsuperscript{1060} Ibid 164 (Thackray, Strickland, and Murphy JJ). This altered the prior decision of the Full Court of the Family Court in the case of Re Jamie [2013] FamCAFC 110 which provided that court authorisation was required where a child is not \textit{Gillick} competent to give informed consent.

\textsuperscript{1061} See discussion at ibid 152–163. Note that the \textit{Mental Health Act} excludes treatments intended to render a person permanently infertile from the definition of ‘treatment’ governed by the Act: see \textit{Mental Health Act 2013 (Tas)} s 4 for definition of mental illness, and s 6 definition of treatment. The \textit{Guardianship and Administration Act 1995 (Tas)} therefore applies, rather than the \textit{Mental Health Act}.

\textsuperscript{1062} Without \textit{Gillick} competence and therefore unable to provide one’s own consent to treatment

\textsuperscript{1063} Without the ability to understand the general nature and effect of the proposed treatment or indicate whether or not they consent: \textit{Guardianship and Administration Act 1995 (Tas)} s 36(2).

\textsuperscript{1064} See ibid s 38(1)(a).

\textsuperscript{1065} \textit{NC (Medical Consent)} [2014] TASGAB 15 (21 July 2014) 6.
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- specifically excluding treatment for gender dysphoria from the definition of ‘special treatments’.

13.2.23 An issue with either approach is that it does not provide a long-lasting solution. As demonstrated by the change of position between the Full Court of the Family Court in Re Jamie1066 in 2013, and its decision in Re Kelvin four years later, the view of the Family Court evolves in line with advancements in medical knowledge and treatments and reflecting community expectations. In explaining its approach, the Full Court commented in Re Kelvin that ‘judicial understanding of Gender Dysphoria and its treatment have fallen behind the advances in medical science.’1067 For the Act to reflect the Family Court’s approach in relation to consent to treatment for children, there would need to be a process to consider and, if appropriate, revise the Act to ensure consistency. A more reliable and effective approach would seem to be to provide the Family Court with exclusive jurisdiction in relation to substitute consent to treatment for all children.

13.2.24 A further alternative could be for the Act to confirm that it does not override the jurisdiction of the Family Court in relation to children. The question is whether there is then a need for provisions within the Act. As the Board also commented, the Family Court is a specialist jurisdiction in relation to matters involving children. It has the ability to appoint an independent children’s lawyer to represent the views and interests of a child. Having a single source of law to deal with the substitute consent to treatment for all children would seem to provide clarity.

13.2.25 The Institute is unable to reach a conclusion about these matters, noting that the preceding paragraphs demonstrate the range and complexity of issues to be resolved. The Institute’s Terms of Reference did not seek specific advice about this question, and thus the Institute has not made recommendations as part of this Report. It is recommended that this is a matter for separate review and consideration.

13.2.26 If the Act continues to apply to the giving of substitute consent to treatment for children with disability, then the Institute proposes reform to the wording of the Act to make clear the effect of valid consent having been obtained via the Family Court or Supreme Court. As observed previously, the current wording creates confusion about whether consent that is validly obtained under the Family Law Act adequately satisfies the test for consent under the Act.

### Recommendation 13.1

(1) That whether the Act should govern consent to health care and treatment for children be the subject of separate review.

(2) That, if the Act continues to apply to the giving of substitute consent to health care and treatment for children with disability:

(a) the Act contain a similar section to s 219 of the Mental Health Act 2013 (Tas), confirming that the Act does not affect the jurisdiction of the Supreme Court and Family Court to give or refuse consent to health care and treatment; and

(b) confirming the effect of valid consent or refusal to consent under the jurisdictions of either the Supreme Court and Family Court upon the operation of the Act.

1066 Re Jamie [2013] FamCAFC 110.

13.2.27 The Institute also asked whether stakeholders considered that the Act should have any different provisions or considerations for matters involving children, if it continued to apply to children.

**Should any different provisions apply to matters involving consent to treatment for children?**

13.2.28 One response stated that there probably should not be different provisions in relation to consent to treatment for children. Responses expressing a view that there should be special considerations commented:

- that the views and opinions of parents should be ‘given credence’; and
- that children ‘should be able to express their own wishes for themselves if they are of an age to understand all the circumstances around the decision-making — eg refusing to undergo further active treatment in terminal conditions.’ The Institute understands this submission to confirm the position at common law in relation to children with *Gillick* competence.

13.2.29 Other responses did not indicate any firm view, although the Interim Children’s Commissioner made the following observations:

> The *Convention on the Rights of Persons with Disabilities* (‘the CRPD’) recognises that children with disabilities should have full enjoyment of all human rights and fundamental freedoms on an equal basis with other children and recalls the obligations of state parties under the CRC.[3]

> While children with disabilities enjoy all of the rights set out in the CRPD, Article 7 is of specific relevance for children. It provides that:

1. States Parties shall take all necessary measures to ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children.
2. In all actions concerning children with disabilities, the best interests of the child shall be a primary consideration.
3. States Parties shall ensure that children with disabilities have the right to express their views freely on all matters affecting them, their views being given due weight in accordance with their age and maturity, on an equal basis with other children, and to be provided with disability and age-appropriate assistance to realize that right.

13.2.30 The Interim Children’s Commissioner also made submissions into the recent review of the *Disability Services Act*, commenting that the guiding principles of that legislation need to be revised in order to comply with the Convention. He submitted that this could be achieved through alignment with s 5 of the *NDIS Act* as it ‘imposes a duty on child representatives to ascertain the wishes of a child and recognises that their ability to undertake acts and make decisions increases as they develop.’ The report recommends that the *Disability Services Act* adopts the guiding principles of the *NDIS Act* to address this matter.1069

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1068 TLRI, above n 69, Question 10.2(ii).

13.2.31 The *Children Young Persons and Their Families Act 1997* (Tas) provides an overriding principle that it is the best interests of a child that must be the paramount consideration.\[1070\] The same principle applies under the *Family Law Act*.\[1071\]

13.2.32 This Report proposes reform to the guiding principles of the Act to focus upon a person’s will, preferences and rights.\[1072\] If the Act were to continue to apply to children insofar as consent to treatment is concerned, then the Act needs to provide separate guiding principles for decisions involving children, providing for the best interests of the child as being the paramount consideration.

**Recommendation 13.2**

That, if the Act continues to apply to children with disability, it provide that the best interests of the child must be the paramount consideration in relation to any exercise of function or power under the Act.

**When does Part 6 of the Act apply?**

13.2.33 Part 6 of the Act applies to a person with a disability who is incapable of giving consent to the carrying out of medical or dental treatment, whether or not the person is a represented person.\[1073\] It provides that a person is incapable of giving consent to the carrying out of treatment if the person:

- is incapable of understanding the general nature and effect of the proposed treatment; or
- is incapable of indicating whether or not he or she consents or does not consent to the carrying out of the treatment.\[1074\]

13.2.34 This Report proposes a revised definition of ‘decision-making ability’, consistent with the test of ‘decision-making capacity’ in the *Mental Health Act*.\[1075\] The test formulated would not require it to be established that a person has a disability. It is proposed that the Act provide a single test of decision-making ability applying to all decisions — including personal, financial and medical decisions.

13.2.35 Noting that the Act may continue to have application to children in relation to consent to health care and treatment, the Institute proposes that the definition of decision-making ability articulate what this means in the context of children. The *Mental Health Act* approach is endorsed, which provides as follows:

> (2) For the purposes of this Act, a child is taken to have the capacity to make a decision about his or her own assessment or treatment (decision-making capacity) only if a person or body considering that capacity under this Act is satisfied that –

(a) the child is sufficiently mature to make the decision; and

(b) notwithstanding any impairment of, or disturbance in, the functioning of the child’s mind or brain, the child is able to –

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1070 *Children Young Persons and Their Families Act 1997* (Tas) s 10E.
1071 See for example *Family Law Act 1975* (Cth) s 60B.
1072 See Recommendations 3.3 and 11.2.
1073 *Guardianship and Administration Act 1995* (Tas) s 36(1).
1074 Ibid s 36(2).
1075 Recommendation 6.3. This approach is endorsed in relation to assessing a person’s decision-making abilities in relation to consent to medical treatment in N Rendina et al, ‘Substitute consent for nursing home residents prescribed psychotic medication’ (2009) 24 *International Journal of Geriatric Psychiatry* 226.
This reverses the approach in relation to assessing an adult’s decision-making ability, where the construction creates a presumption that an adult has decision-making ability unless established otherwise.

**Recommendation 13.3**

1. That Part 6 of the Act apply to any person who does not have decision-making ability to give consent to the carrying out of health care and treatment, whether or not they are a represented person.

2. That, if the Act continues to apply to children with disability, the test of decision-making ability provide that a child is taken to have the ability to make a decision about his or her own health care and treatment (‘decision-making ability’) only if a person or body considering that ability under this Act is satisfied that:
   
   (a) the child is sufficiently mature to make the decision; and
   
   (b) the child is able to:
       
       (i) understand information relevant to the decision; and
       
       (ii) retain information relevant to the decision; and
       
       (iii) use or weigh information relevant to the decision; and
       
       (iv) communicate the decision (whether by speech, gesture or other means).

**What ‘medical treatment’ should Part 6 cover?**

13.2.36 The Act defines medical treatment to mean treatment including any medical or surgical procedure, operation or examination and any prophylactic, palliative or rehabilitative care that is normally carried out by, or under, the supervision of a medical practitioner.\(^{1077}\) The Issues Paper commented that this definition does not fit neatly with broader health care that other health professionals provide, for example, nurses, midwives, pharmacists, optometrists and chiropractors. It also does not align well with health care that is not strictly ‘treatment’ but may be recommended to treat a patient’s medical condition or health and wellbeing.

13.2.37 This restricted definition of ‘medical treatment’ impacts upon the application of Part 6 of the Act. ‘Treatment’ decisions are dealt with under Part 6 without necessarily requiring the formal appointment of a guardian. Broader ‘health care’ decisions may, however, require a guardian if they do not clearly fit within the existing definition of ‘treatment’. The result can be a more formal approach to substitute decision-making for ‘health care’ than ‘treatment’.

\(^{1076}\) Mental Health Act 2013 (Tas) s 7(2).

\(^{1077}\) Guardianship and Administration Act 1995 (Tas) s 3(1).
13.2.38 The Issues Paper asked whether and if so how the definition of ‘medical treatment’ should be revised.

13.2.39 Answers to this question were considered in Part 9. The conclusion reached in that part was that the current terms ‘medical treatment’ and ‘health care’ be replaced with the single term ‘health care and treatment’. It is proposed that this term be defined consistently with the Health Practitioner Regulation National Law. It also recommends that the Act confirm that the assessment and treatment of mental illness be excluded from the definition of ‘health care and treatment’ as this is dealt with under the Mental Health Act.

13.2.40 The effect of this approach is to have the same regime applying to decisions relating to treatment and health care. This gives persons responsible and guardians equivalent powers in relation to health care and treatment decisions and avoids unnecessary, inappropriate and unhelpful inconsistencies between approaches.

13.3 Treatment where consent is not needed

13.3.1 Under the Act, certain procedures can be performed without consent: where the treatment is minor, where the circumstances are urgent, and, in certain circumstances, where there is no person responsible able to consent.

13.3.2 The Issues Paper asked when consent to treatment should not be required.

13.3.3 Six submissions addressed this question. All referred to either or both the ability to provide treatment without consent in an emergency, or where the treatment is minor in nature, consistent with current permitted exceptions included in the Act. These existing provisions are considered below.

Urgent treatment

13.3.4 Consent to treatment is not required where it is considered necessary as a matter of urgency. The treatment must be:

- to save a person’s life;
- to prevent serious damage to the person’s health; or
- except in the case of special treatment, to prevent the person from suffering or continuing to suffer from significant pain or distress.

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1078 TLRI, above n 69, Question 10.3.
1079 Recommendation 9.4.
1080 TLRI, above n 69, Question 10.4(i).
1081 Guardianship and Administration Act 1995 (Tas) s 40.
1082 See [13.6].
13.3.5 The Issues Paper identified some variations between the provisions of the Act and other jurisdictions in relation to performing treatment without consent. These include:

- in Victoria, where urgent special treatment can be administered to prevent the person suffering pain and distress\(^{1083}\)
- in Queensland and Western Australia, where to perform urgent treatment in these circumstances, it must also not be reasonably practicable to obtain consent from the person responsible\(^{1084}\) and
- in South Australia, where treating medical practitioners must first make reasonable inquiries to ascertain whether the patient has an advance care directive.\(^{1085}\)

13.3.6 Four submissions referred to and endorsed treatment being able to be given without consent in cases of an emergency. The Issues Paper asked what treatments ought to be able to be performed in an emergency without consent.

**What treatment should be able to be given without consent in an urgent situation?**\(^{1086}\)

13.3.7 Both MIGA and the OPG endorsed the current sections of the Act governing urgent treatment. Both, however, supported legislative reform to clarify the effect of a valid ACD applying to the situation at hand. MIGA, for example, commented that ‘[i]t is important to clarify that treatment cannot be provided without consent if there is known to be a valid ACD in place which applies to the situation at hand.’

13.3.8 Legislative provisions confirming the effect of ACDs were discussed in Part 5. Recommendation 5.6 proposes that the Act confirm that a direction to refuse treatment in a valid ACD is binding and that it has the same effect as if the person made the decision with the decision-making ability to do so. The Institute endorses MIGA’s suggestion that the Act explicitly confirm the effect of an ACD in circumstances where the Act would otherwise permit urgent treatment to be performed without consent. This provides clarity, and promotes a patient’s views, wishes and preferences being upheld. In Victoria, for example, a health practitioner is not permitted to administer treatment if they are aware that the patient has refused that particular treatment or procedure, including in an ACD.\(^{1087}\)

13.3.9 MIGA submitted that provisions dealing with treatment in urgent circumstances should not be unduly proscriptive by specifying particular treatments, for example. Another respondent commented that the extent of treatment performed without consent should be limited to that required to eliminate the urgency.

13.3.10 The OPMHS made the following observation:

Consideration does need to be given to treatment being given over periods of days during which the GAB does not sit, e.g. detaining a person and treating them over a weekend in a hospital, against their will, is often necessary with no consent. For example a delirious

\(^{1083}\) *Medical Treatment Planning and Decision Act 2016 (Vic)* s 53(1)(c).

\(^{1084}\) *Guardianship and Administration Act 2000 (Qld)* s 63(1); *Guardianship and Administration Act 1990 (WA)* s 110ZI.

\(^{1085}\) *Consent to Medical Treatment and Palliative Care Act 1995 (SA)* s 13(1)(d).

\(^{1086}\) TLRI, above n 69, Question 10.5.

\(^{1087}\) *Medical Treatment Planning and Decision Act 2016 (Vic)* s 53(2).
elderly person with no person responsible, whose illness causing the delirium, or behaviour during the delirium, places them at significant risk of medical or other harm. This might not be considered an emergency by some.

13.3.11 This statement raises the following issues:

- the desirability of avoiding circumstances where a patient does not have a person responsible able to consent to health care and treatment. This issue is considered below;¹⁰⁸⁸
- the need for processes to be responsive. This matter is addressed throughout this Report, including Part 14; and
- specific considerations about detention of a patient. This matter is also considered in Part 14.¹⁰⁸⁹

The relevance of a patient’s objections is also considered separately below.¹⁰⁹⁰

13.3.12 Aside from confirming the effect of a valid ACD providing a refusal for health care or treatment, reflecting submissions received, it is not proposed that there be any revision to the current legislative provisions governing urgent health care and treatment.

**Recommendation 13.4**

That the Act confirm that health care and treatment is not be able to be performed without consent where the health practitioner is aware that the patient has refused that health care and treatment in a valid advance care directive.

**Minor treatment**

13.3.13 Consent is not required for:

- non-intrusive examinations made for diagnostic purposes (such as visual examination of the mouth, nasal cavity, eyes or ears);
- first-aid; and
- administration of pharmaceutical drug for which a prescription is not required and which is normally self-administered, if it is being used for its recommended purpose and dosage level.¹⁰⁹¹

Whilst not described as ‘minor treatments’, these treatments typically fall within that category.

13.3.14 Three submissions endorsed the ability to give ‘minor’ treatment without consent. The OPG and OPMHS made the following comments about existing provisions:

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¹⁰⁸⁸ See [13.4.11]–[13.4.22].
¹⁰⁸⁹ See [14.6].
¹⁰⁹⁰ See [13.3.29]–[13.3.44].
¹⁰⁹¹ *Guardianship and Administration Act 1995 (Tas)* s 3, definition of ‘medical treatment’.
13.3.15 The OPG stated:

We believe ‘minor treatment’ should be described or defined, and the Act should clarify that no consent is required for such care/treatment. The current formulation – where such interventions are excluded from the definition of medical treatment – is confusing (even to some medical practitioners) as it is not immediately apparent that it follows consent is not, therefore, required.

13.3.16 The OPMHS submitted that these minor treatments ought to be permitted without consent in the following circumstances:

where there is little risk, it promotes the health and wellbeing of the person, to which the person does not object. In such cases no harm is being done (including no distress of objection).

13.3.17 The Institute agrees with the OPG’s statement that the current formulation is confusing and does not clearly articulate how minor treatment can be performed in the absence of consent. To improve clarity, it is suggested that the Act define these treatments as ‘minor treatment’, and confirm that substitute consent is not required for minor treatment where the patient is unable to provide their own consent. This would not have any substantive impact upon the law applying to substitute consent to minor treatment, only the way that this is expressed in the Act.

13.3.18 The Institute also endorses comments of the OPMHS which imply that the Act should articulate circumstances in which minor treatment can be performed in the absence of consent. Specifically, they suggest that, to give minor treatment without consent, the patient should not be objecting and the treatment should be intended to promote the person’s health and wellbeing. Consistent with this suggestion, it is proposed that the Act confirm that minor treatment can be performed without consent where it promotes the person’s health and wellbeing. This approach aligns with the existing test for a person responsible to give consent to treatment, which requires the person responsible to consider that the treatment is to be carried out only to promote and maintain the patient’s health and wellbeing.\textsuperscript{1092} It is also consistent with the approach to urgent treatments, where treatment may be performed without consent where it is needed to save a person’s life, prevent serious damage to the person’s health, or (except for special treatment), where it is intended to prevent the person from suffering or continuing to suffer from significant pain or distress. It is also consistent with the existing position in relation to treatments that may be performed without consent where there is no person responsible. Section 41 of the Act provides that treatments (other than those excluded within the Regulations\textsuperscript{1093}) may be carried out without consent where ‘the treatment is necessary and is in the form of treatment that will most successfully promote that person’s health and well-being’.\textsuperscript{1094} Inclusion of this test avoids unnecessary treatment being performed, or treatments being performed for reasons other than promoting the patient’s health and wellbeing. It is appropriate that the Act provides some test before even minor treatments may be performed without consent, as part of safeguarding the rights and interests of the patient.

13.3.19 The OPMHS’s submission also raised the relevance of a patient’s objections, which is considered below.

\textsuperscript{1092} Ibid s 43(2).
\textsuperscript{1093} Ibid s 41(2).
\textsuperscript{1094} Ibid s 41(c).
Recommendation 13.5

(1) That the Act define the following treatments as ‘minor health care and treatment’:

- non-intrusive examinations made for diagnostic purposes (such as visual examination of the mouth, nasal cavity, eyes or ears);
- first-aid; and
- administration of pharmaceutical drug for which a prescription is not required and which is normally self-administered, if it is being used for its recommended purpose and dosage level.

(2) That the Act confirm that consent to minor health care and treatment is not required where the person does not have decision-making ability to give consent and the minor health care and treatment is to be carried out to promote or maintain the person’s health and wellbeing.

Where there is no person responsible

13.3.20 Certain medical and dental treatment can be carried out without consent where:

- there is no person responsible;
- the treatment is necessary;
- the treatment is in the form of treatment that will most successfully promote that person’s health and wellbeing; and
- the person does not object to the carrying out of the treatment.1095

13.3.21 The treatment cannot be classified as ‘special treatment’.1096 Under the Regulations, it may also not involve treatment that:

- is continuing or ongoing and involves the administration of a restricted substance primarily to control the conduct of the person;
- involves the administration of a drug of addiction other than in association with the treatment of cancer or palliative care of a terminally ill patient;
- is electroconvulsive therapy (ECT); or
- involves a substantial risk to the person concerned of:
  - death;
  - brain damage;
  - paralysis;
  - permanent loss of function of any organ or limb;
  - permanent and disfiguring scarring; or
  - extreme pain or distress; or
- is intended, or likely, to result in the removal of all or a substantial number of teeth.1097

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1095 Guardianship and Administration Act 1995 (Tas) s 41(1).
1096 Ibid s 41(1)(a).
In any these cases, if there is no person responsible, then the Board must consent to the treatment.

13.3.22 To lawfully carry out treatment without consent in these circumstances, the treating medical practitioner or dentist must certify in the patient's clinical records that the treatment is necessary, it is in the form that will most successfully promote the person’s health and wellbeing and that the patient does not object.1098

13.3.23 The Institute asked whether the Act should require medical practitioners to enquire about the existence of an ACD or person responsible before performing treatment without consent. The rationale is that, if a relevant valid ACD existed which conveyed a patient’s advance refusal to consent to the proposed treatment, then it would be inappropriate to perform the treatment. Similarly, if a person responsible or guardian were able to give consent to the treatment, then it becomes unnecessary to rely on the default provision enabling treatment to be performed without consent. The Issues Paper posed the following question:

| Should medical practitioners be required to make attempts to locate a person responsible and/or advance care directive before giving treatment without consent? |

13.3.24 There were eight responses with most endorsing a need for ‘reasonable’ or ‘realistic’ enquiries, and two specifically noting that it may not be realistic in cases of an emergency. In relation to enquiries in an emergency, MIGA submitted:

Except in an emergency, reasonable attempts should be made to locate an ACD or person responsible, reflecting existing practice.

In an emergency, unless an ACD is immediately accessible or a person responsible immediately present, there should be no obligation on medical or other health practitioners to take additional steps to locate an ACD or person responsible.

Guidance should be developed with input from MIGA and other professional organisations to clarify what reasonable efforts to locate an ACD or person responsible should include.

13.3.25 The OPMHS commented that, in their experience:

some nursing homes are also not very mindful of checking who decision makers are, documenting current administration and guardianship orders and consulting the respective person. It is currently at times necessary for health professionals to clarify the legal situation and contact the GAB to obtain the relevant paperwork, and sometimes correct false assumptions of the nursing home. There should be an obligation of a nursing home to keep their documentation up to date re this and ensure that appointed decision makers are appropriately included …

13.3.26 Associate Professor Wallace made similar observations.

13.3.27 Recommendation 5.9(1) proposes that, except in relation to urgent health care and treatment, health practitioners must make reasonable enquiries in the circumstances to ascertain whether a patient who does not have decision-making ability to give consent has an ACD or

1097 Guardianship and Administration Act 1995 (Tas) s 41(2); Guardianship and Administration Regulations 2017 (Tas) reg 12.
1098 Guardianship and Administration Act 1995 (Tas) s 41(3).
1099 TLRI, above n 69, Question 10.4(ii).
instrument. Consistent with this proposal, it is recommended that the Act require reasonable efforts to be taken to locate a person responsible before proceeding to provide health care and treatment without consent. The rationale is that, if it is reasonably convenient to obtain substitute consent, then this should be sought rather than proceeding without consent. The involvement of a representative provides a level of protection for the patient and advances understanding of, and promotion of, their views, wishes and preferences. This is consistent with the approach in Victoria.\textsuperscript{1100}

13.3.28 The Institute further recommends that, in order to provide health care or treatment in the absence of consent, the treating health practitioner be required to document in a patient’s medical records their reasonable efforts to locate an ACD and person responsible for the patient. This is consistent with requirements in Victoria,\textsuperscript{1101} and was endorsed by the Board in its submission. It also aligns with present requirements under s 41 which require medical practitioners to certify in a patient’s clinical records that the treatment is necessary and in the form that most successfully promotes the patient’s health and wellbeing, and that the patient did not object.\textsuperscript{1102} This reform would therefore not involve a substantially increased workload for a health practitioner in these circumstances, as the Act already requires them to certify two matters in a patient’s clinical records — this reform would increase that requirement to including information about a third matter within the patient’s clinical records for the health care and treatment.

**Recommendation 13.6**

That s 41 of the Act remain but it be revised to also provide that, to perform health care and treatment without consent:

(a) before the health practitioner administers the health care and treatment, they must make reasonable efforts in the circumstances to ascertain whether the patient has a person responsible; and

(b) the health practitioner who carries out or supervises the health care and treatment must document in the clinical records relating to the health care and treatment the reasonable efforts taken in the circumstances to locate an advance care directive and person responsible for the patient.

**Relevance of a patient’s objections**

13.3.29 Section 41 of the Act provides that treatment which is not special treatment (or any other treatment excluded under the Regulations) may only be performed in the absence of consent where the person does not object to the treatment.\textsuperscript{1103} If the person objects, then consent must be obtained in accordance with the Act. This approach requires a patient to express an objection. There may be situations where a patient does not communicate their objection, but this may not necessarily mean that they do not object, or that they consent. In Queensland, generally, a patient’s objection to treatment results in any substitute consent to that treatment being ineffective.\textsuperscript{1104} Exceptions apply where the patient has minimal or no understanding and the treatment will cause them no distress, or

\textsuperscript{1100} Medical Treatment Planning and Decision Act 2016 (Vic) s 50(1)(b).

\textsuperscript{1101} Ibid s 56(3).

\textsuperscript{1102} Guardianship and Administration Act 1995 (Tas) s 41(3).

\textsuperscript{1103} Ibid s 41(1)(d).

\textsuperscript{1104} Guardianship and Administration Act 2000 (Qld) s 67(1). The NSWLRRC has recently made a similar recommendation: NSWLRRC, above n 24, Recommendation 10.17(2)(a).
that the distress would be reasonably tolerable and temporary.\(^{1105}\) In New South Wales, the Tribunal may authorise a guardian to consent where a patient is objecting.\(^{1106}\) In Tasmania, under the *Mental Health Act*, treatment can only be carried out either with informed consent or if authorised by a treatment order.\(^{1107}\) The effect is to require treatment to be authorised in all instances, irrespective of whether a patient is objecting.

13.3.30 Noting the different approaches to this issue, the Issues Paper asked whether treatment ought to be able to be performed where a patient is expressing their objection.

<table>
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<tr>
<th>If a patient objects to treatment, should substitute consent still be able to be given, and if so, when?(^{1108})</th>
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13.3.31 Ten respondents addressed this question. There were a range of views expressed, with most commenting that there may be circumstances where treatment is appropriate despite a patient’s objections and that the Act should not preclude treatment being performed in these situations. The Board noted that the Convention does not preclude substitute consent where a patient is objecting. It commented about the practical difficulties that arise in trying to balance competing considerations in these circumstances:

While Article 12 of the UN Convention lists a number of appropriate safeguards for consent to treatment, balancing the competing right of personal choice with the right to equal access to necessary and appropriate medical treatment is, in practice, a difficult exercise for medical practitioners and substitute decision makers when a person objects to treatment.

13.3.32 Advocacy Tasmania submitted that a patient’s clearly expressed will and preference about treatment should never be overridden. Both Speak Out advocates and Advocacy Tasmania commented that people deemed capable of making their own decisions have the right to have their objection to treatment respected and that the same principle should apply under the Act.

13.3.33 Most observed that this question needs to be addressed on an individual basis, dependent upon the nature of the objection and the patient’s ability to understand relevant matters relating to a decision. The OPG commented:

Our view is that if the person is objecting to the treatment but is unable to understand the risks and repercussions associated with not receiving the treatment, there needs to be a regime of substitute consent to ensure the person is not deprived of necessary health care resulting in unacceptable risk or detriment to their health and well-being.

13.3.34 Speak Out advocates commented that the focus should be upon supporting a person to understand issues relevant to the decision and that there needs to be time taken to try to understand the underlying reasons for a patient’s objections. Advocacy Tasmania also commented:

The focus needs to be on the decision support needs of the person and their understanding of, and views around, the treatment in question.

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\(^{1105}\) *Guardianship Act 1987* (NSW) s 46(4); *Guardianship and Administration Act 2000* (Qld) s 67(2).

\(^{1106}\) *Guardianship Act 1987* (NSW) s 46A. The NSWLRC has endorsed this approach: NSWLRC, above n 24, Recommendation 10.16. The tribunal can also give directions to the person responsible in Queensland: *Guardianship and Administration Act 2000* (Qld) s 81(1)(d).

\(^{1107}\) *Mental Health Act 2013* (Tas) s 16(2).

\(^{1108}\) TLRI, above n 69, Question 11.1.
13.3.35 The OPG submitted that treatment should not be performed where the person has previously declined consent in an ACD or via a direction in an instrument. MIGA also commented that an ACD should be taken into account. This factor is included within the Decision-Making Process for Health Care and Treatment outlined below.\(^{1109}\)

13.3.36 Three submissions\(^{1110}\) stated that a patient’s views should be taken into consideration, including their objections. MIGA noted that the guiding principles of the Act already require a person’s wishes to be carried into effect if possible. The OPG submitted that the risks and benefits of treatment should also be considered. In the context of providing palliative care, PCT submitted that a patient’s objections are particularly relevant:

> Palliative care is about neither prolonging life, nor hastening death, but providing the best quality of life (as defined by the person concerned) for a dying person. This makes the objection to treatment very relevant, particularly if the dying person experiences emotional distress if forced to undergo treatment.

13.3.37 Recommendation 13.14 proposes that decision-makers first consider the need for a representative decision about health care and treatment, before making a decision based on what they believe is consistent with the person’s wishes, views and preferences (a substituted judgment test). Recommendation 6.4(2) also provides that the Act confirm that a person may not be considered unable to make their own decision unless all practical steps have been taken to provide the person with support to make and communicate a decision. This approach necessarily requires a decision-maker to take into consideration the relevance of a patient’s expressed objection. Consistent with the views of respondents, and a person’s right to necessary and appropriate treatment, it is not proposed that the Act prohibit substitute consent to health care or treatment where a patient is objecting. The ability to appeal or seek review of a person responsible’s consent to treatment is considered in Part 14. It remains appropriate, however, that the Act continue to require consent in circumstances where a patient is objecting, consistent with the existing approach.

How an objection may be communicated

13.3.38 The Act does not clarify how a patient can communicate their objection. This raises the following issues:

- that whether a patient is objecting may be interpreted subjectively. Different individuals might have differing views about conduct that comprises an objection; and
- it might sometimes be difficult for a patient to indicate their objection.

13.3.39 Some jurisdictions confirm that objections can be indicated by whatever means and include circumstances where a patient has previously indicated in similar circumstances that they did not want the treatment and they have not subsequently indicated to the contrary.\(^{1111}\)

13.3.40 The Issues Paper asked whether it would assist if the Act provided clarification about how a patient is able to communicate their objection to treatment.

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\(^{1109}\) Recommendation 13.14.

\(^{1110}\) OPG, MIGA, PCT.

\(^{1111}\) Guardianship Act 1987 (NSW) s 33(3); Guardianship and Administration Act 2000 (Qld) sch 4 – definition of ‘object’. 
Should the Act confirm how a patient can indicate an objection?\textsuperscript{1112}

13.3.41 Three responses addressed this issue. The Board supported the Act containing legislative guidance about how a person may communicate their objection, with the OPG’s submission implicitly endorsing this approach. The Board submitted:

To prioritise the right of a person and to have their wishes acted upon in the medical domain, the adoption in the Act of criteria to identify what constitutes an objection is important. If a person lacks the capacity to understand or evaluate the information necessary for the decision which is required, then there can, it would seem, be no valid objection. The terminology set out in the Issues Paper at Part 11 paragraph 11.2.6 from the NSW legislation for the identification of an objection could be adopted, with the specific addition, perhaps, of any wishes expressed in an advance care directive.

13.3.42 The OPG also stated that the Act should confirm that a previously expressed objection, for example, in an ACD, should be taken as a valid objection:

A patient should be able to communicate their objection by any means available to them. Previously indicated objections to similar treatment in similar circumstances — obviously by way of an advance care directive but also by less formal means — should be accepted as an objection.

13.3.43 MIGA, on the other hand, submitted that ‘[t]he Act should not set out any requirements as to how a patient can or should indicate an objection.’

13.3.44 The Institute proposes that the Act confirm that a patient may communicate their objection by any means. This promotes an inclusive and flexible approach and supports an individual being able to communicate their objection by any means that best suits them. This is not intended to be prescriptive, but instead reinforces that a person may communicate in a variety of ways, including non-verbal communication. Recommendation 5.6 proposes that the Act confirm that directions expressing a refusal to consent to treatment in a valid ACD that applies to the circumstances is binding. For the avoidance of doubt, it is proposed that the Act confirm that, for the purpose of determining whether a patient is or has communicated their objection, an objection may be validly contained and communicated in advance, including (but not limited to) in an ACD.

**Recommendation 13.7**

That the Act confirm that a person can indicate an objection to health care and treatment by whatever means, including:

\begin{itemize}
  \item having indicated on a previous but similar occasion that they did not want the health care and treatment; or
  \item having previously communicated their objection to the health care and treatment, including in an advance care directive,
\end{itemize}

and they have not subsequently indicated to the contrary.

\textsuperscript{1112} TLRI, above n 69, Question 11.1.
13.4 Treatment where consent is needed

13.4.1 In all other circumstances other than those described previously, the Act provides that substitute consent to treatment is needed — either from a person responsible or the Board. This section considers when and how persons responsible can give consent. Following paragraphs then review when and how the Board can give consent.

Health care and treatment permitted with the consent of a ‘person responsible’

13.4.2 The Act authorises certain individuals to give substitute consent to some medical treatment on behalf of a patient who is unable to consent. The person authorised is called the ‘person responsible’. The person responsible only has authority over medical treatment decisions and does not have power to make personal or financial decisions. Classifications of people eligible to be a person responsible are outlined in Part 14. The powers and functions of the ‘person responsible’ are important because only a small portion of the Tasmanian community has a registered enduring guardian. The majority of people will therefore have a default statutory person responsible making decisions on their behalf.

What should a person responsible be able to consent to?

13.4.3 A person responsible can consent to all medical and dental treatment that is not defined as ‘special treatment’. Only the Board can consent to special treatment. Special treatments are explained and discussed later in this Part.

13.4.4 The Institute asked for views about what matters a person responsible should have power to consent to.

What should a person responsible be able to consent to?

13.4.5 There were eight responses to this question. Five expressed support for persons responsible continuing to have the ability to consent to ‘medical treatment’. Five supported persons responsible also having power to consent to ‘health care’. Recommendation 9.4 provides a single definition and classification of ‘health care and treatment.’ This has the effect of extending a person responsible’s authority to consent to health care in addition to treatment, consistent with the views of these respondents.

13.4.6 Three submissions referred to and endorsed the existing approach of classifying certain treatments as ‘special treatments’ that are beyond the scope of a person responsible’s authority. National Seniors Australia, Tasmanian Policy Advisory Group submitted that there was no need to change existing arrangements. One respondent endorsed a person responsible having the ability to

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1113 Guardianship and Administration Act 1995 (Tas) s 43.
1114 Ibid s 4, definition of ‘person responsible.’
1115 See [14.5.8].
1116 As at 30 June 2017, there were 28 844 registered enduring guardians in Tasmania: Guardianship and Administration Board, above n 235, 20. See also Ashby and Thornton, above n 258.
1117 See [14.5.8].
1118 TLRI, above n 69, Question 10.7.
1119 The definition of ‘special treatment’ is considered later in this Part.
consent to ‘anything and everything’, expressing concern that there would otherwise be delay and potential pain and suffering for a patient whilst awaiting substitute consent from another source.

13.4.7 Both the Board and the OPMHS responded that a person responsible should not be permitted to consent to detention, including at the Roy Fagan Centre (RFC). The OPG, on the other hand, submitted ‘that the person responsible should be able to provide formal consent to uncontentious decisions about where the person is to reside.’ The issue of whether a person responsible should be able to consent to the admission of a patient within a secure facility is dealt with separately below.\textsuperscript{1120}

13.4.8 One respondent submitted that there is currently a lack of clarity about what is included within the scope of authority of a person responsible. Another respondent made a similar comment in answering a separate question in the Issues Paper.

13.4.9 One response stated that there should be power to cease medical treatment following specialist medical advice recommending that approach. This submission raises the issue of consent to the withdrawal and withholding of treatment, which is discussed below.\textsuperscript{1121}

13.4.10 In summary, responses received indicate broad support for retention of the existing powers of a person responsible aside from certain matters which are addressed elsewhere in this Part.

*What if there is no eligible person responsible?*

13.4.11 If there is no person responsible and consent to treatment is required, then an application must be made to the Board. The Board then has power to give consent to treatment, or alternatively, it might decide it more appropriate to appoint a guardian with power to consent to treatment.\textsuperscript{1122}

13.4.12 In Queensland, if there is no one who meets the criteria to be the person responsible, then the Public Guardian is automatically appointed as the person responsible as a ‘last resort’.\textsuperscript{1123} This means that there will always be a person responsible able to consent to treatment that is not special treatment. It avoids the need for an application to the tribunal with the resulting delay, and avoids the need for a guardian. The Issues Paper commented that this would seem to align with the principles of proceeding in a manner that is least restrictive of a person’s freedom of decision and action, and the desire to only appoint a representative as a last resort. The VLRC recommended this approach.\textsuperscript{1124} Under Victoria’s subsequent legislative reforms, the Public Advocate may act as medical treatment decision-maker if the treatment is ‘significant treatment’ (as defined\textsuperscript{1125}) and the health practitioner has been unable to locate a relevant ACD or another decision-maker.\textsuperscript{1126}

13.4.13 Currently the Act takes this approach when dealing with forensic procedures.\textsuperscript{1127} It enables the Public Guardian to act as a ‘person responsible of last resort’ rather than needing to apply to the Board where there is no person responsible. The Issues Paper noted that one option for reform

\textsuperscript{1120} See [14.6].

\textsuperscript{1121} See [13.7.43].

\textsuperscript{1122} Guardianship and Administration Act 1995 (Tas) s 45.

\textsuperscript{1123} Powers of Attorney Act 2000 (Qld) s 63(2).

\textsuperscript{1124} VLRC, above n 24, Recommendation 209.

\textsuperscript{1125} Medical Treatment Planning and Decision Act 2016 (Vic) s 3.

\textsuperscript{1126} Ibid s 63.

\textsuperscript{1127} Guardianship and Administration Act 1995 (Tas) s 4(1)(d).
would be to extend these provisions to apply to all treatments (other than special treatments) to avoid the need to apply to the Board for it to consent to treatment where there is no person responsible. One of the questions that the Issues Paper posed is whether this amendment would be appropriate and desirable.

If consent is required and there is no person responsible, should the Public Guardian have power to act as the person responsible of last resort to consent to treatments other than special treatment?!

13.4.14 Four submissions endorsed the Act providing the Public Guardian as decision-maker of last resort where there is no other person eligible to act as the person responsible. Whilst endorsing this approach, PCT also commented that decisions ‘in relation to a person with a life limiting illness, should be made based on an ACD (if available) and information about the person provided by family, friends, and medical professionals.’ Other recommendations in this Report address this submission.

13.4.15 The Board’s submission noted advantages and disadvantages to this option:

Sometimes there is more than one carer or close friend eligible to act, and in the case of dispute, or where there is no person responsible, there must be an application to the Board for the appointment of a guardian to give consent. Less cumbersome alternatives to this could be for the Public Guardian to have the power to mediate between disputing candidates or possibly even be the default person responsible — as is currently the case with forensic procedures. Against this, is the concern that little effort may be made to locate a person responsible if the easy default position, is that the Public Guardian becomes person responsible.

13.4.16 The OPMHS also commented that there could be advantages to enabling the Public Guardian to act as person responsible of last resort, but also expressed the view that there can also be advantages to instead appointing a guardian with power to consent to treatments:

For individual treatments this would avoid a protracted process for consent. It would be beneficial to have a mechanism to prevent serial use of the PG in cases where an appointed Guardian could act in the interest of the RP in a more co-ordinated way with greater continuity. Continuity of care is extremely valuable in health, and a Guardian can make better decisions with a longer engagement with the PR.

13.4.17 The OPG submitted that the present situation works well, but that there is merit to considering reform to enable the Public Guardian to act as person responsible as a last resort where it would otherwise be necessary to apply to the Board:

the current provisions of section 41, whereby treatment can be undertaken without consent if there is no person responsible and the person is not objecting, work well and should continue. However, if these provisions were discontinued, the OPG believes the Queensland model of the Public Guardian acting as the statutory health attorney of last resort has merit and should be considered. This would seem a more streamlined process that that of seeking the Board’s consent or seeking a guardianship order.

Regulation 12 specifies various cases where medical or dental treatment cannot be carried out without consent under section 41. The OPG acting as statutory health attorney of last

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1128 TLRI, above n 69, Question 10.10.
1129 MIGA, PCT.
1130 Recommendations 3.3, 5.7.
resort is worthy of consideration as a means of providing consent to treatment in those categories.

13.4.18 In summary, all responses to this question either endorsed this approach or considered that there was some merit to this alternative in certain circumstances. No respondents rejected the approach.

13.4.19 The Institute proposes revision to the Act to enable the Public Guardian to act as person responsible of last resort where consent is required and there is no one else who would otherwise be eligible to consent as the person responsible. This retains the existing position under s 41 enabling certain health care and treatment to be performed without consent where there is no person responsible. Where, however, the Act requires consent, this reform would enable the Public Guardian to act, avoiding the need to apply to the Board for the appointment of a guardian, or for it to consent. The Public Guardian already functions as a guardian for individuals and thus has expertise in this area suited to this increased role.

13.4.20 This approach avoids the need to appoint a representative and is therefore a least restrictive and more efficient alternative to resolve situations where consent is required and there is no other person responsible. It would minimise delay, noting that the Board must generally give at least 10 days’ notice to conduct a hearing and that the appeal period must generally have expired before the treatment may be performed (although the Board can waive this requirement if the treatment is urgent). This reform intends to streamline processes and improve responsiveness particularly when health care or treatment is time critical or necessary outside of business hours. This, in part, addresses concerns raised by the OPMHS that there are presently issues that arise when consent is required outside of business hours when the Board is not sitting in what might be perceived as ‘non-urgent’ circumstances such that an application for an emergency order is not considered appropriate.

13.4.21 The Board’s concern that this could lead to inadequate enquiries being made to find another eligible person responsible is noted. It is agreed that it is important to avoid this potential consequence which could lead to decision-making being removed from those otherwise more appropriate to act in the role. There would remain the ability for a person to apply to the Board to be appointed as the patient’s guardian with power to consent to some or all health care and treatment. It is also recommended that guidelines be developed to outline circumstances where it may be more appropriate to apply to the Board. As the OPMHS commented, one of the relevant considerations could be whether there is a likely need for ongoing decisions to be made. It should also be possible for individuals to apply to the Board where they consider that they are eligible to act as the person responsible but it has been determined that they are ineligible.

13.4.22 Recommendation 14.1 would have the effect of granting the Public Guardian power to mediate matters where there is a dispute about whether a person is eligible to act as the person responsible, or where there are multiple individuals eligible to act as the person responsible. Noting

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1131 It should be acknowledged, however, that on average over the last five years, only 3.8 applications for consent to treatment have been made to the Board: Guardianship and Administration Board, above n 235, 24.

1132 Guardianship and Administration Act 1995 (Tas) s 76(3).

1133 Ibid (Tas) ss 45(3)–(4).

1134 Refer to [15.3] below.

1135 Refer to [14.4.54] below and Recommendation 14.6.
the potential for a perceived or actual conflict of interest when resolution of a matter could result in the Public Guardian becoming the default person responsible, it is important that there be an avenue to contest a decision via an application to the Board. Consistent with adopting the least restrictive approach, the Institute endorses revision to the Act to enable the review of a health practitioner’s opinion that an individual is ineligible to act as the person responsible without this needing to be resolved by a formal appointment as guardian. This issue is addressed in Part 14.\textsuperscript{1136}

When should the Board’s consent then be needed?

13.4.23 The OPG’s submission indicated a need for clarity about the circumstances in which the Board may consent to treatment because s 39 provides that consent may be given by the Board or by a person responsible. The OPG stated:

The OPG is concerned about recent practice which has seen the Board providing consent to particular medical treatment when a guardian (and therefore a person responsible) is already in place. The OPG believes this is problematic in a number of ways: it creates uncertainty about how consent should be sought by medical practitioners or other applicants; the appropriate source of consent for subsequent treatment arising out of complications from the original treatment to which the Board has consented is blurred, particularly in cases where there is a ‘domino effect’ of side-effects and delayed consequences; the role of a person responsible is ambiguous, when they need clarity as to the scope and carrying out of their functions; and it is unnecessarily burdensome on applicants and the Board.

The OPG’s view is that the legislation should clarify when the Board’s consent should be sought, and require that it only provides consent to treatment (other than special treatment) if there is no person responsible and consent is required. This would be consistent with the principle of the least restrictive alternative and the priority that ought to be given to less formal arrangements. As discussed in chapter 11 the OPG has concerns about delays associated with the provision of treatment when the Board’s consent is sought.

13.4.24 In addressing a separate question in the Issues Paper, the OPG also submitted that:

Until very recently it was highly unusual for the Board to provide consent to medical treatment. Historically, this provision of the Act was used for consent to psychiatric treatment for people with mental illnesses detained under the old Mental Health Act, as that Act did not have provisions for involuntary treatment.

Where there has not been a person responsible and consent for treatment has been required, the usual practice had been to seek the appointment a guardian with powers to make health care decisions rather than applying for the Board to consent to medical treatment. In our view, this generally works well and is the preferred approach from a ‘best interests’ point of view due to the delays associated with seeking the Board’s consent. Delays are associated with the required 10 days’ notice of a hearing, and the appeal provisions which could potentially amount to a 56 day delay (someone has 28 days to seek reasons for decision, and a further 28 days to lodge an appeal) before treatment can commence, although the Board can consent to the treatment being carried out immediately in urgent situations.

In addition, the appointment of a guardian offers far greater flexibility if further or additional treatment is needed. A common scenario for a person with a severe disability

\textsuperscript{1136} Ibid.
who requires an anaesthetic for a routine dental check, for instance, is for other
examinations or investigations for which anaesthesia is also required (e.g., a pap smear,
taking of bloods, scans and x-rays) to be ‘added in’ and performed at the same time. This
makes practical and medical sense and is certainly in the best interests of the patient for
trips to hospital and the use of anaesthetic to be minimised. However multiple procedures
or investigations entails multiple applications to the Board for consent to each procedure,
even if they are all to be conducted at the same time under the same anaesthetic. In these
situations the appointment of a guardian would appear to be much more straightforward
and clear cut.

13.4.25 The Institute agrees that the Act should better articulate circumstances where the Board
may give consent to health care and treatment. Currently, the Act provides that the Board may issue
and make available to members of the public guidelines specifying situations in which applications
should be made to the Board for its consent to medical or dental treatment, although no
guidelines exist. It is recommended that the Act confirm that the Board may consent to health care
and treatment:

- classified as special treatment; or
- where consent is needed and there is otherwise no other eligible person responsible and no
valid ACD that applies to the circumstances.

The effect is to provide a dual arrangement where either the Public Guardian or the Board may
consent to health care or treatment where there is otherwise no one falling within the definition of
person responsible and no relevant ACD. The development of guidelines would assist to clarify
whether it is more appropriate to proceed with consent from the Public Guardian, the Board, or via
the appointment of a guardian with power to consent to some or all health care and treatment.

13.4.26 A related issue is that the Board must have the ability to appoint a guardian upon hearing
an application for it to consent to health care and treatment. This issue was raised by the OPG in its
response to a question asked about the functions, duties and powers of the Board. The Act currently
enables the Board to make an emergency guardianship or administration order upon hearing an
application for it to consent to health care and treatment. The section, however, requires a higher
standard of proof for the Board to make an emergency order in those circumstances — requiring the
Board to be satisfied that the test to appoint a guardian or administrator is met. This conflicts with
s 65(1) which already enables the Board to make an emergency order of its own motion and only
requires the Board to be satisfied that there may be grounds for making a guardianship or
administration order (emphasis added).

13.4.27 The Act does not enable the Board to treat an application for consent to health care and
treatment as an application for a guardianship order. The Board may only appoint a guardian for a
person in respect of whom an application has been made for an order appointing a guardian or
administrator. This enables an application for an administration order to be treated as an
application for a guardianship order. Similarly, an application for a guardianship order may be treated

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1137 Guardianship and Administration Act 1995 (Tas) s 44(3).
1138 Ibid s 46A.
1139 Under ibid ss 20(1), 51(1).
1140 Ibid ss 65(2)–(3).
1141 Ibid s 20(1).
as an application for an administration order.\textsuperscript{1142} It is appropriate that an application for the Board to consent to health care and treatment be able to be treated as an application for a guardianship order, to enable the Board to make an order appointing a guardian (other than pursuant to an emergency order) upon hearing an application for consent. It is unnecessary to make further provision in relation to the making of an administration order, noting that the Board already has power to make emergency orders irrespective of whether it has received an application.

**Recommendation 13.8**

(1) That the Public Guardian be able to give consent to health care and treatment as a person responsible of last resort where consent is required and there is no valid advance care directive that applies to the decision and no one falling within the definition of person responsible.

(2) That the Act provide that the Board may consent to health care and treatment:
   - classified as special treatment; or
   - where consent to health care and treatment is required and there is no valid advance care directive that applies to the decision and no one falling within the definition of person responsible.

(3) That guidelines be developed to outline circumstances where it may be appropriate to request the Public Guardian to consent as the person responsible of last resort, or instead apply to the Board for either it to give consent or appoint a guardian with power to consent to some or all health care and treatment.

(4) That s 46A of the Act be deleted and that, in its place:
   a. the Act provide that the Board may treat an application for it to consent to the carrying out of health care and treatment on a person as an application for a guardianship order; and
   b. the Board be permitted to make a guardianship order at a hearing of an application for consent to health care and treatment if the Board is satisfied that the test to appoint a representative is met.

**How is a request to a person responsible made?**

13.4.28 It is important that decision-makers have access to relevant information when deciding whether to consent to a particular treatment. The Act does not set out any special process that must be followed when making a request of a person responsible, but medical professionals have duties under other legislation to ensure that fully informed consent is obtained.\textsuperscript{1143}

13.4.29 In South Australia, provisions within legislation governing consent to health care confirm that medical practitioners have a duty to explain to a patient, or their representative, as far as is practicable and reasonable in the circumstances, the nature, consequences and risks of the proposed treatment, the likely consequences of not undertaking the treatment, and any alternative treatments or courses of action that might be reasonably considered.\textsuperscript{1144} In New South Wales and the ACT, requests must be in writing, unless it is not practicable. Requests must specify certain information

\textsuperscript{1142} Ibid s 51(1).

\textsuperscript{1143} Civil Liability Act 2002 (Tas) s 21 provides a duty for medical practitioners to warn of risks.

\textsuperscript{1144} Consent to Medical Treatment and Palliative Care Act 1995 (SA) s 15.
relevant to the decision of whether to consent.\textsuperscript{1145} The Institute queried whether there would be any benefit gained from the Act containing specific provisions that govern the way that requests of a person responsible are made.

**Should the Act set out how a request for consent is made to a person responsible?\textsuperscript{1146}**

13.4.30 There were six responses to this question, with half supporting and the other half rejecting legislative reform. The Board endorsed this reform to ensure that persons responsible have all relevant information to make decisions and because it would provide consistency with other jurisdictions. The OPG also supported this reform on the basis of its observations that current processes are ‘are variable and inconsistent and may sometimes be glossed over.’ The OPG also submitted that the Act should require health professionals to confirm and document consent and the source of consent.

13.4.31 In answering this question in the negative, both MIGA and the OPMHS commented that obligations in relation to obtaining consent to treatment should be the same, irrespective of whether consent is from the patient themselves or a person responsible. MIGA, for example, commented that existing professional obligations and health professionals’ duty of care at common law sufficiently address this matter. The OPMHS also commented:

> Adding further requirements which aren’t normally necessary (e.g. in writing), could make the process excessively bureaucratic, and also create an impediment and potentially different or delayed treatment for the RP [represented person] (compared with for someone consenting for themselves).

13.4.32 The Institute is not satisfied of the need for reform to the Act to require health practitioners to explain certain matters or take certain steps prior to and as part of seeking a person responsible’s consent to a particular treatment. Existing obligations adequately address this issue.

### 13.5 Test to consent to health care and treatment

13.5.1 To consent to treatment, a person responsible must be satisfied that:

- the person is incapable of giving consent; and
- the treatment is in their best interests.\textsuperscript{1147}

To assess what is in a person’s best interests, a person responsible must consider:

- the wishes of the person;
- the consequences if the treatment is not carried out;
- any alternative treatments available;
- the nature and degree of any significant risks associated with the proposed treatment, or any alternative treatment; and

\textsuperscript{1145} *Guardianship and Management of Property Act 1991* (ACT) s 32G; *Guardianship Act 1987* (NSW) s 40(2).

\textsuperscript{1146} TLRI, above n 69, Question 10.11.

\textsuperscript{1147} *Guardianship and Administration Act 1995* (Tas) s 43(1). Note that when the Board gives consent, it must also be satisfied that the treatment is otherwise lawful.
that the treatment is to be carried out only to promote and maintain the person’s health and wellbeing.\footnote{Ibid s 43(2).}

13.5.2 For the Board to give consent to treatment, it must be satisfied that:

- the person is incapable of giving consent;
- the treatment is otherwise lawful;\footnote{This is not part of the test that applies to persons responsible.} and
- the treatment would be in the person’s best interests.\footnote{Guardianship and Administration Act 1995 (Tas) s 45.}

In determining whether the proposed treatment would be in a person’s best interests, the Act provides that the Board must take into account:

- the wishes of the person, so far as they can be ascertained;
- the consequences if the proposed treatment is not carried out;
- alternative treatments available; and
- whether the proposed treatment can be postponed on the basis that a better treatment may become available and whether the person is likely to become capable of providing consent.\footnote{Ibid s 45(2).}

The result is differing tests for persons responsible and the Board to apply when deciding whether to consent to treatment.

13.5.3 The Board and persons responsible also have an overriding duty to perform their role in accordance with the guiding principles of the Act. These principles were discussed in Part 3. Recommendation 3.3 proposes that one of the revised guiding principles of the Act be that the views, wishes, preferences and rights of a person who may require decision-making support must direct decisions that affect their lives. Other recommendations made in this Report are also relevant to the present discussion. Recommendation 11.2 sets out a proposed decision-making process for representatives to follow when making decisions. This process emphasises the need to give all practicable and appropriate effect to a person’s views, wishes and preferences, or likely views, wishes and preferences and that a representative may only depart from these where it is necessary to prevent unacceptable harm, or it would be unlawful. Recommendation 5.6(4) proposes that the Act confirm that, where a patient has a valid ACD that applies to the relevant circumstances, any refusal to consent has the same effect as if the person made the decision whilst they had the decision-making ability to do so.

13.5.4 In Victoria, medical treatment decision-makers must make a decision that they reasonably believe is the decision that the person would have made if they had decision-making capacity.\footnote{Medical Treatment Planning and Decision Act 2016 (Vic) s 61(1).} Effectively, this amounts to a ‘substituted judgment’ based on what the decision-maker considers the person would decide for themselves. The Victorian Act provides that, to make a decision that they
consider the person would have made if they had the ability to make their own decision, a decision-
maker must:

- first, consider any valid and relevant values directive;
- next, consider any other relevant preferences that the person has expressed and the circumstances in which those preferences were expressed;
- if the decision-maker is unable to identify any relevant preferences, they must give consideration to the person’s values, whether expressed other than by way of a values directive or inferred from the person’s life;
- also consider:
  - the likely effects and consequences of the medical treatment, including the likely effectiveness of the treatment, and whether these are consistent with the person’s preferences or values; and
  - whether there are any alternatives, including refusing treatment, that would be more consistent with the person’s preferences or values; and
- act in good faith and with due diligence.\textsuperscript{1153}

The decision-maker must also consult with any person who they reasonably believe the person would want to be consulted in the circumstances.\textsuperscript{1154}

13.5.5 If the decision-maker is unable to ascertain or apply the person’s preferences or values, the decision-maker must act in good faith and with due diligence and make a decision that promotes the personal and social wellbeing of the person, having regard to the need to respect the person’s individuality. This includes consideration of:

- the likely effects and consequences of the medical treatment, including the likely effectiveness of the treatment, and whether these promote the person’s personal and social wellbeing, having regard to the need to respect the person’s individuality; and
- whether there are any alternatives, including refusing medical treatment, that would better promote the person’s personal and social wellbeing, having regard to the need to respect the person’s individuality.\textsuperscript{1155}

Again, the decision-maker must consult with any person who they reasonably believe the person would want to be consulted.\textsuperscript{1156}

\textsuperscript{1153} Ibid s 61(2).
\textsuperscript{1154} Ibid s 61(4).
\textsuperscript{1155} Ibid s 61(3). A similar approach has recently been endorsed by the NSWRLC which recommend that persons responsible and the tribunal need to give effect to a patient’s will and preference (referring to their Recommendation 5.4) whilst having regard to: the patient’s condition, courses of health care available, the general nature and effect of those courses of health care, the nature and degree of any significant risks associated with those courses of health care, and the reason why the health practitioner making the request for consent considers that the particular course of health care ought to be carried out: NSWLRC, above n 24, Recommendations 10.22, 10.23, 10.24.
\textsuperscript{1156} Ibid s 61(4).
13.5.6 Under the current framework articulated in the Act, a person responsible must consider the patient’s wishes, but does not need to make a decision that the patient would have been likely to have made if they were capable of giving their own consent. This permits decision-making that is not consistent with the patient’s wishes, if the person responsible considers that consent (or withdrawal or refusal of consent) is in the person’s best interests.

13.5.7 Given these considerations, the Issues Paper asked what test should apply for a person responsible to give consent to treatment.

What test should a person responsible need to apply when deciding whether to consent to treatment?

13.5.8 There were five responses to this question with the OPG and MIGA endorsing the current approach to decisions about treatment. The Board noted the link to earlier submissions about the decision-making principles of the Act (discussed in Part 3), noting the need to give primacy to a person’s likely wishes and taking into account any ACD of the patient. The OPG’s submission also commented that persons responsible should also need to make decisions in accordance with the guiding principles of the Act and that decisions should be consistent with any ACD. The Board and OPG both endorsed consistency between the tests that the Board and persons responsible must apply when deciding whether to consent to treatment.

13.5.9 The OPMHS submitted:

A Person Responsible should apply only the same questions that a reasonable person would apply when providing consent for themselves. The test should not be more difficult; the standard should not mean that a represented person will miss out on treatment due to their incapacity to consent.

13.5.10 Another submission endorsed decisions being based upon what the person would want if making the decision themselves.

13.5.11 The Institute asked a separate question about what test the Board should apply when deciding whether to consent to treatment.

What test should the Board need to apply when deciding whether to consent to treatment?

13.5.12 Three submissions addressed this question, with all endorsing an equivalent approach to that applying to persons responsible.

13.5.13 This Report has already made several recommendations relevant to giving substitute consent to proposed health care or treatment. These include:

- Recommendation 11.2 which proposes that decision-makers follow a Decision-Making Process, emphasising the need to make decisions based on a person’s wishes, views and preferences. The decision-making process also provides that decision-makers should

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1157 In South Australia, a person responsible must make a decision that, as far as is reasonably practicable, reflects the decision that the patient would have made for themselves in the circumstances: Consent to Medical Treatment and Palliative Care Act 1995 (SA) s 14C. A similar provision applies in the Northern Territory: Advance Personal Planning Act 2016 (NT) s 22.

1158 TLRI, above n 69, Question 10.12.

1159 Ibid Question 10.14(i).
consider whether a representative decision is needed, or whether the decision could be deferred to a time when the patient can make their own decision; and

- Recommendation 5.6 which confirm that there is no need for a representative decision if the patient has made a valid ACD applying to the circumstances.

13.5.14 Most submissions endorsed existing factors for decision-makers to consider and thus it is proposed that the substance of the existing tests remain. Consistent with recommendations made in this Report, it is proposed that the existing tests that persons responsible and the Board apply be revised as follows:

- to provide consistency between the tests that apply to each; and

- to incorporate a will, preferences and rights approach, consistent with the Decision-Making Process articulated in Recommendation 11.2, and consistent with legislative provisions in Victoria and recommendations in New South Wales outlined at [13.5.4]–[13.5.5].

Where a patient is likely to soon be able to consent

13.5.15 The Act does not provide any different test that must be applied where a patient is likely to be able to consent themselves within a reasonable time. It is a factor that the Board (not a person responsible) must take into account.\(^\text{1160}\) In Victoria, where the patient is likely to become capable of giving their own consent within a reasonable time, a person responsible can only consent to the treatment where the treating practitioner reasonably believes that delay would significantly deteriorate the patient’s condition.\(^\text{1161}\) This matter was also considered in Part 11 when outlining the proposed Decision-Making Process.\(^\text{1162}\)

13.5.16 The Issues Paper asked whether any special provisions should apply to the giving of consent in these circumstances.

| Should any special test apply where the patient is likely to shortly gain capacity to consent? |  
|---|---|

13.5.17 Five respondents addressed this question with most endorsing a provision similar to that in Victoria.\(^\text{1164}\) Consistent with responses, the Institute proposes that this revision is made to the Act. This approach is incorporated into the Decision-Making Process articulated in Recommendation 11.2.

13.5.18 The intention is to facilitate representative decisions only being made where necessary, as a last resort. If a decision can be deferred until the person is able to make their own decision, without that delay causing any harm to the person, then a representative decision is unnecessary. This is consistent with adopting the least restrictive alternative. The Act already requires the Board to consider this factor when deciding whether to give consent to treatment.\(^\text{1165}\) This reform would strengthen this requirement to provide that, rather than it only being a factor that is considered, it is

\(^{1160}\) Guardianship and Administration Act 1995 (Tas) s 45(2).

\(^{1161}\) Medical Treatment Planning and Decision Act 2016 (Vic) s 59.

\(^{1162}\) See [11.4.10].

\(^{1163}\) TLRI, above n 69, Question 10.15.

\(^{1164}\) Four supported this approach, and one expressed views either way noting that the emphasis should be upon assessing what the patient would likely do and want.

\(^{1165}\) Guardianship and Administration Act 1995 (Tas) s 45(2).
the threshold test to establish whether a representative decision should be made. The reform would also require persons responsible to make this assessment, rather than presently where only the Board must take this into account.

**Recommendation 13.9**

(1) That the Act confirm that a person responsible and the Board may only give consent to health care and treatment where the person does not have the decision-making ability to make a decision about that health care or treatment.

(2) That the Act contain a separate section outlining the test for both persons responsible and the Board (decision-makers) to apply to make decisions about consent to health care and treatment.

(3) That the Act require decision-makers, when making decisions about consent to health care and treatment, to:

(i) adopt the Decision-Making Process outlined in Recommendation 11.2; and

(ii) consider the following:

- the consequences if the health care and treatment is not carried out;
- any alternative health care and treatment available;
- the nature and degree of any significant risks associated with the proposed health care and treatment, or any alternative health care and treatment;
- whether the proposed health care and treatment can be postponed on the basis that a better health care and treatment may become available; and
- that the health care and treatment is to be carried out only to promote and maintain the person’s health and wellbeing.

### 13.6 Special treatment

13.6.1 Only the Board may consent to treatment classified as ‘special treatments’. These decisions are treated differently because of their nature — they are generally treatments that are serious, invasive or have irreversible consequences. The Act defines ‘special treatment’ as:

- any treatment intended, or reasonably likely, to have the effect of rendering the person permanently infertile;
- termination of pregnancy; and

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1166 Ibid ss 39(1), 3, definition of ‘special treatment’.

1167 Note *Criminal Code 1924 (Tas)* s 178E:

A person who intentionally or recklessly performs a termination on a woman without the woman’s consent, whether or not the woman suffers any other harm, is guilty of a crime.

Charge: Termination without woman’s consent.

(2) No prosecution is to be instituted against a medical practitioner who performs a termination on a woman if the woman is incapable of giving consent and the termination is —

(a) performed in good faith and with reasonable care and skill; and

(b) is for the woman’s benefit; and

(c) is reasonable having regard to all the circumstances.
any removal of non-regenerative tissue for transplantation.\textsuperscript{1168}

13.6.2 The Regulations also declare the following to be special treatment:\textsuperscript{1169}

- psychosurgery, including neurological procedure carried out for the relief of Parkinson’s disease; and
- any treatment involving the use of an aversive stimulus, whether mechanical, chemical, physical or otherwise.\textsuperscript{1170}

13.6.3 It is important that the classifications of treatment as ‘special treatment’ are appropriate, unambiguous and exhaustive. The Institute therefore asked firstly, what the community considers ought to be included within the class of ‘special treatments’, and secondly, whether there needs to be any changes made to the existing descriptions.

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<thead>
<tr>
<th>What ‘special treatment’ should the Board need to consent to?</th>
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<tr>
<td>Do any of the current descriptions or classifications of treatments need to be revised, and if so, how?\textsuperscript{1171}</td>
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13.6.4 Eight respondents addressed these questions with most endorsing the existing classifications of ‘special treatments’. One respondent submitted that there should be no treatments classified as special treatments where only the Board’s consent is permitted. The two submissions that suggested revision commented that they should perhaps deal with gender reassignment treatment\textsuperscript{1172} and restrictive interventions.\textsuperscript{1173} Gender reassignment is considered below, and restrictive interventions in Part 17.\textsuperscript{1174}

13.6.5 This next Part reviews the existing classes of special treatment.

**Termination of pregnancy**

13.6.6 Termination of pregnancy is included in the class of ‘special treatments’ requiring the Board’s consent.\textsuperscript{1175} It is a crime under the Criminal Code to intentionally or recklessly perform a termination on a woman\textsuperscript{1176} without their consent, whether or not they suffer any other harm. It also provides that no prosecution is to be instituted against a medical practitioner who performs a termination on a woman if they are incapable of giving consent and the termination is performed in good faith and with reasonable care and skill, is for the woman’s benefit and is reasonable having regard to all the circumstances.\textsuperscript{1177} Comprehensive consideration of the provisions of the Criminal Code falls outside of the scope of this review.

\textsuperscript{1168} Guardianship and Administration Act 1995 (Tas) s 3.
\textsuperscript{1169} Ibid s 3, definition of ‘special treatment’.
\textsuperscript{1170} Guardianship and Administration Regulations 2017 (Tas) reg 11.
\textsuperscript{1171} TLRI, above n 69, Question 10.13.
\textsuperscript{1172} OPG.
\textsuperscript{1173} National Seniors Australia, Tasmanian Policy Advisory Group.
\textsuperscript{1174} See [17.4].
\textsuperscript{1175} Guardianship and Administration Act 1995 (Tas) s 3, definition of ‘special treatment’.
\textsuperscript{1176} Defined to mean female person of any age: Criminal Code Act 1924 (Tas) s 178E(1).
\textsuperscript{1177} Ibid s 178E(2).
13.6.7 The Convention provides that there must not be discrimination of people with disability in relation to family.\textsuperscript{1178} This is stated to include the right to decide freely and responsibly on the number and spacing of children, and to have access to information, reproductive and family planning education.

13.6.8 There is no special test that applies for the Board to consent to termination of pregnancy. The test that it must apply is the same as the test for other treatments.\textsuperscript{1179} The Issues Paper noted that some jurisdictions provide a special test to give substitute consent to the termination of a pregnancy. In South Australia, substitute consent to the termination of a pregnancy is only permitted if there is no likelihood of the woman acquiring the capacity to give consent within the period that is reasonably available for the safe carrying out of the termination.\textsuperscript{1180} There must also be no knowledge of any advance refusal having been communicated to a medical practitioner whilst the patient was capable of consenting.\textsuperscript{1181} These approaches are captured within other recommendations in this Report, notably Recommendation 13.9 which proposes that the test for the Board (and persons responsible) to consent to health care and treatment require the decision-maker to be satisfied that the person is unlikely to have the ability to consent themselves within a reasonable time, and Recommendation 5.6 which confirms that a refusal of treatment in a valid ACD applying to the circumstances is binding.

**Sterilisation**

13.6.9 ‘Treatment that is likely or intended to render a person infertile’ is also included within the definition of ‘special treatment’.\textsuperscript{1182} The Act does not provide any special test that the Board must apply to consent to treatment likely or intended to render the patient infertile. The test is the same as consent to any other form of treatment.\textsuperscript{1183}

13.6.10 The Convention provides that people with disabilities, including children, must have the right to retain their fertility on an equal basis with others.\textsuperscript{1184} The World Health Organisation has stated that any procedures that result in sterilisation must only be undertaken where there is ‘full, free, and informed consent.’\textsuperscript{1185} The Human Rights Committee has recently commented that it ‘remains concerned about the compatibility of the practice of involuntary non-therapeutic sterilisation of women and girls with intellectual disability and/or cognitive impairment with the [International Covenant on Civil and Political Rights], in particular the prohibition against cruel, inhuman and degrading treatment, the right to privacy and equality before the law.’\textsuperscript{1186} It stated that Australia should abolish the practice of involuntary non-therapeutic sterilisation of women and girls with intellectual disability and/or cognitive impairment.\textsuperscript{1187} The Commonwealth Senate Community

\textsuperscript{1178} Convention on the Rights of Persons with Disabilities art 23.
\textsuperscript{1179} Guardianship and Administration Act 1995 (Tas) s 45.
\textsuperscript{1180} Guardianship and Administration Act 1993 (SA) s 63(3)(b).
\textsuperscript{1181} Ibid s 62(3).
\textsuperscript{1182} Guardianship and Administration Act 1995 (Tas) s 3, definition of ‘special treatment’.
\textsuperscript{1183} Ibid s 45.
\textsuperscript{1184} Convention on the Rights of Persons with Disabilities art 23.
\textsuperscript{1186} Human Rights Committee, Concluding observations on the sixth periodic report of Australia, UN Doc CCPR/C/AUS/CO/6 (9 November 2017) 23.
\textsuperscript{1187} Ibid 24.
Affairs Reference Committee delivered a report into involuntary or coerced sterilisation in 2013.\textsuperscript{1188} The Reference Committee recommended:

- that where a person has capacity to consent, including where they have capacity to consent with support, sterilisation must only be undertaken with that person’s consent;\textsuperscript{1189}
- sterilisation should not be undertaken where it is reasonably possible that a person might have capacity to consent in the future;\textsuperscript{1190}
- legislation should explicitly state that the tribunal does not have authority to hear an application for an order approving special treatment, including sterilisation, where the person has legal capacity;\textsuperscript{1191}
- States should ensure that people with disability have independent representation in sterilisation matters.\textsuperscript{1192} Costs of legal representation should be paid by legal aid funding;\textsuperscript{1193} and
- that it be made an offence to take, attempt to take, or knowingly assist a person to take, a person with a disability overseas for the purpose of obtaining a sterilisation.\textsuperscript{1194}

13.6.11 The Issues Paper summarised the Commonwealth Senate Community Affairs References Committee’s statements that the following factors must never considered as part of approving sterilisation:

- pregnancy risks associated with sexual abuse;
- eugenic arguments; and
- assessments about the person’s capacity to care for children.\textsuperscript{1195}

13.6.12 The Institute also has regard to the protocol developed by the Australian Guardianship and Administration Council (AGAC) which sets out detailed processes and procedures to follow for a tribunal (including the Board) to give consent to a sterilisation procedure. The AGAC’s Protocol for Sterilisation provides that, before an application for sterilisation is made, ‘all other alternative treatments should be considered, and, if appropriate, tried, before bringing an application for sterilisation.’\textsuperscript{1196} The rationale is that:

\begin{itemize}
  \item \textsuperscript{1188} Senate Community Affairs References Committee, above n 398.
  \item \textsuperscript{1189} Ibid Recommendation 6.
  \item \textsuperscript{1190} Ibid Recommendation 7.
  \item \textsuperscript{1191} Ibid Recommendation 9.
  \item \textsuperscript{1192} Ibid. That representative should not be their family or carer: Recommendation 13. Legal representation for sterilisation matters is provided in the ACT: see Guardianship and Management of Property Act 1991 (ACT) s 70(2).
  \item \textsuperscript{1193} Senate Community Affairs References Committee, above n 398, Recommendations 14, 22.
  \item \textsuperscript{1194} Ibid Recommendation 28. Presently, the Criminal Code Act 1924 (Tas) provides that a person who takes, or arranges for a child to be taken, overseas with the intention of performing female genital mutilation of that child is guilty of a crime: Criminal Code Act 1924 (Tas) s 178B. An exception applies where it is for genuine therapeutic purposes or a sexual reassignment procedure: ibid s 178C.
  \item \textsuperscript{1195} Senate Community Affairs References Committee, above n 398, Recommendations 5, 19.
  \item \textsuperscript{1196} AGAC, Protocol for Special Medical Procedures (Sterilisation) (6 May 2009) [5.16]–[5.17].
\end{itemize}
The significant developments in the area of reproductive technology, including contraception and menstruation management, mean that there are a range of treatments and procedures available, all of which are less invasive and less permanent than sterilisation.

13.6.13 This is consistent with the views of the High Court in *Marion's Case* where it was stated that sterilisation should be a last resort.\(^{197}\)

13.6.14 The Issues Paper asked whether there were any treatments for which a special test should apply to give substitute consent. It was also asked whether there were any matters for which substitute consent ought never to be permitted. Only the OPG’s response to these questions raised the matter of consent to sterilisation, commenting that there could be merit to the Act setting out a specific test to consent to sterilisation, consistent with the policies developed by the AGAC.

13.6.15 The Institute observes that the AGAC’s Protocol sets out in some detail (11 pages) the process that the Board should take in relation to applications received seeking consent to sterilisation. Given the level of detail in this document and that no submissions raised issues or concerns about the present legislative framework, the Institute has not made specific recommendations for reform. The revised test to give consent to treatment that has been formulated\(^{198}\) requires the Board to adopt the Decision-Making Process, providing a rights-based approach to decision-making. This test more directly focuses upon the patient’s view, wishes and preferences, rather than the existing test to consent to sterilisation (and other special treatments) which requires the Board to adopt what it considers to be in the patient’s best interests.

13.6.16 Sterilisation matters are rare in Tasmania, with no approvals having been granted since January 2016.\(^{199}\) The last reported decision was in 2014.\(^{200}\) In addressing a separate question in the Issues Paper, the Interim Children’s Commissioner stated as follows in relation to substitute consent to the sterilisation of children:

> While I understand that applications for authority to perform sterilisation on children are becoming increasingly rare, there remains a question of whether involuntary sterilisation of children can ever be appropriate at all. The UN Committee on the Rights of Persons with Disabilities has expressed ‘deep concern’ that the Senate Committee referred to above fell short of recommending prohibition of sterilisation of children in the absence of their prior, fully informed and free consent. This is not a matter which I intend to express a view on at this time …

*Gender Dysphoria*

13.6.17 Earlier sections of this Part explained treatment for gender dysphoria.\(^{201}\) ‘Stage 2’ treatment for gender dysphoria is irreversible and can include long-term infertility. Under the current definition

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\(^{197}\) *Marion’s Case* (1992) 175 CLR 218, 73 (Mason CJ, Dawson, Toohey and Gaudron JJ).

\(^{198}\) Recommendation 13.9(3).


\(^{200}\) NC (Medical Consent) [2014] TASGAB 15 (21 July 2014) 6.

\(^{201}\) See [13.2.14].
of ‘special treatment’, Stage 2 treatment fits within the class of special treatments as a treatment likely to render the person infertile, requiring the Board’s consent.

13.6.18 The Full Court of the Family Court has recently considered the issue of consent to Stage 2 treatment for a 17-year-old child.\textsuperscript{1202} The Full Court commented that judicial understanding of Gender Dysphoria and its treatment have fallen behind the advances in medical science.\textsuperscript{1203} It noted that Gender Dysphoria is a recognised mental disorder, and noted the risks associated with not treating a young person with Gender Dysphoria.\textsuperscript{1204} Stage 2 treatment was therefore seen as therapeutic in nature. The Full Court concluded that ‘[t]he treatment can no longer be considered a medical procedure for which consent lies outside the bounds of parental authority and requires the imprimatur of the Court.’\textsuperscript{71205} The Court noted, however, that court authorisation continues to be required where a person is under the care of a state government department, or where there is a genuine dispute or controversy about whether the treatment should be administered — for example, if parents or medical professionals are unable to agree.\textsuperscript{1206}

13.6.19 The decision aligns with the comments of the Human Rights Committee which recently commented that ‘[i]t is concerned that the delays and costs associated with obtaining court authorisation may compromise the success of such hormonal treatment for individuals concerned and cause them psychological harm, and welcomes the State party’s willingness to reconsider the role of the Family Court in such matters.’\textsuperscript{1207} It recommended that Australia should ‘[c]onsider ways to expedite access to stage two hormone treatment for gender dysphoria, including by removing the need for court authorisation in cases featuring uncontested agreement among parents or guardians, the child concerned and the medical team, provided that the treatment is provided in accordance with the relevant medical guidelines and standards of care.’\textsuperscript{1208}

13.6.20 The Act does not presently distinguish between therapeutic and non-therapeutic sterilisations with both falling within the class of special treatment. This raises the question of whether there should be an exception to the definition of ‘special treatment’ when Stage 2 treatment is performed for therapeutic purposes to treat Gender Dysphoria. If the Act permitted a person responsible or guardian to consent to Stage 2 treatment on the basis that it is therapeutic, a further question is then whether the same approach should be adopted for other treatments that are therapeutic in nature.

13.6.21 The Issues Paper asked for feedback about whether there needs to be any changes to the existing definition and classification of ‘special treatments’. The OPG commented:

\begin{itemize}
\item Re: Kelvin [2017] FamCAFC 258 (30 November 2017).
\item Ibid 152 (Thackray, Strickland, and Murphy JJ).
\item See discussion at ibid 152–163. Note that the Mental Health Act excludes treatments intended to render a person permanently infertile from the definition of ‘treatment’ governed by the Act: see Mental Health Act 2013 (Tas) s 4 for definition of mental illness and s 6 for definition of treatment. The Guardianship and Administration Act 1995 (Tas) therefore applies rather than the Mental Health Act.
\item Re: Kelvin [2017] FamCAFC 258 (30 November 2017) 164 (Thackray, Strickland, and Murphy JJ). This altered the prior decision of the Full Court of the Family Court in the case of Re Jamie [2013] FamCAFC 110 which provided that court authorisation was required where a child is not Gillick competent to give informed consent.
\item Re: Kelvin [2017] FamCAFC 258 (30 November 2017) 167 (Thackray, Strickland, and Murphy JJ).
\end{itemize}
The OPG proposes that gender reassignment treatment should be added to the current list of special treatment. Those aspects or phases of gender reassignment treatment that are likely to render the person infertile would currently be included as special treatment, however the OPG suggests it would be prudent to consider adding it as a separate item. Having said that, the OPG has no expertise in this area – consultation with staff of THS's Sexual Health Service would be obviously be appropriate.

This submission suggests that gender reassignment treatment not be a matter falling within the authority of a person responsible or guardian.

13.6.22 EOT also submitted that consent to medical interventions for intersex children intended to modify sex characteristics should require Board approval:

In February 2016, the former Anti-Discrimination Commissioner released a discussion paper on Legal recognition of sex and gender diversity in Tasmania: Options for amendments to the Births, Deaths and Marriages Registration Act 1999. Among other matters the paper considered issues related to surgical intervention on infants with an intersex variation.

This matter is of considerable concern to the intersex community and one that has been the subject of consideration and report by the Senate Community Affairs References Committee.

A key recommendation of the Senate Committee was:…

that all medical treatment of intersex people take place under guidelines that ensure treatment is managed by multidisciplinary teams within a human rights framework. The guidelines should favour deferral of normalising treatment until the person can give fully informed consent, and seek to minimise surgical intervention on infants undertaken for primarily psychosocial reasons

To give effect to its recommended approach, the Committee proposed all medical interventions relating to intersex children aimed at modifications of sex characteristics for psychosocial reasons be authorised by a civil and administrative tribunal in each state or territory or the Family Court (whose child welfare jurisdiction under the Family Law Act applies also to the application for the sterilisation of children without disabilities and exists concurrently with state and territory jurisdictions).

Responsibility for determining the mechanism for expanding the jurisdiction of relevant tribunals was referred to the Standing Committee on Law and Justice for consideration.

In line with the recommendations of the Senate report, the former Anti-Discrimination Commissioner recommended in her paper related to the functions of the Guardianship and Administration Board:

'That treatment or any intervention primarily undertaken to modify or “normalise” the visible or apparent sex characteristics of children for psychosocial reasons be classified as “special medical procedures”, and require consent of a Tasmanian board or tribunal such

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1210 Senate Community Affairs References Committee, above n 398.
1211 Ibid Recommendation 3.
1213 Ibid Recommendation 7.
1214 Recommendation 11.
as the Guardianship and Administration Board informed by experts on gender and sex diversity.’

Part 6 of the Guardianship Act gives authority to the Board to provide consent to medical treatment where there is evidence a person, by reason of disability, is unable to given informed consent or refusal to medical treatment unless the procedure is required in urgent circumstances to save a person’s life or to prevent serious damage to a person’s health.

Contravention of these provisions may result in criminal prosecution and proceedings for civil remedies. For the purposes of the Guardianship Act, medical treatment includes any treatment intended or is reasonably likely to have the effect of rendering permanently infertile the person on whom it is carried out.

Medical intervention in relation to an intersex child (other than that required for emergency purposes) is likely to be irreversible and risks long-term adverse consequences.

It is for this reason that EOT recommends that consideration be given to the appropriate mechanism for granting approval for any ‘normalising treatment’ prior to the child being sufficiently mature to make informed decisions of their own. There are strong grounds for considering whether the child will acquire the capacity to make a decision regarding surgical intervention in the future and, if so, the presumption should be against performing the procedure until that time.

13.6.23 The Terms of Reference did not require recommendations about these areas as part of this review. These matters have broader relevance beyond children and adults with disability to which the Act presently applies. Specifically, it involves a broader discussion about the consent regime for children who are unable to understand matters relevant to the giving of consent due to age and maturity (ie children without Gillick competence). These are acknowledged to be important issues and it is appropriate that they be considered separately. It is noted that, at the time of writing, the Australian Human Rights Commission is presently undertaking community consultation in relation to medical interventions involving people born with variations in sex characteristics. A consistent approach is desirable and this may necessitate reform to the Act depending upon whether the Act continues to apply to children and if so, whether specifically to children with disability. This issue was discussed earlier in this Part.  

**Other matters**

13.6.24 The Issues Paper asked a broad question about whether any particular treatment decisions should require a special test to give consent.

Are there any types of treatments that should involve a special test for the giving of consent? If so, what?

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1216 See [13.2].

1217 TLRI, above n 69, Question 10.14(ii).
13.6.25 There were three submissions addressing this question. One commented that consideration should be given to the extent of a person’s incapacity and the need to promote a person’s wishes. These matters have been addressed in Parts 3, 6, and 11, as well as throughout this Report.

13.6.26 EOT made submissions about surgical intervention on infants with an intersex variation, which were addressed in the previous paragraph. OPG submitted that there could be merit to the Act setting out specific tests for consent to sterilisation and termination of pregnancy, consistent with the policies developed by the AGAC about consent to treatment in these circumstances. These matters have also been considered in earlier paragraphs.

13.6.27 The Institute also sought submissions about whether the community considered there were any treatments where substitute consent ought not be permitted in any circumstances.

Are there any matters where substitute consent should never be permitted?\(^\text{1218}\)

13.6.28 Three respondents answered this question, with two indicating that there should not be any automatic preclusion within the Act. The OPMHS commented that euthanasia (ie with the explicit intention of terminating life) should not be able to be the subject of substitute consent, noting that ‘this is to be distinguished from removing treatment which is burdensome or futile.’ The Institute notes that euthanasia falls outside of the scope of this reference and is governed by other legislation.\(^\text{1219}\)

Legal representation for matters involving applications for consent to special treatment

13.6.29 The Issues Paper noted that, given that decisions relating to substitute consent to special treatment involve invasive or serious procedures that are likely to have an irreversible effect, it is important that patients’ rights and interests are protected and promoted. One way that that could be achieved is through a legislative requirement compelling legal representation for patients the subject of an application to the Board for consent to special treatment. In practice, it is already within the scope of the Board’s powers to obtain separate representation for a patient.\(^\text{1220}\) The AGAC Protocol in relation to Sterilisation also provides that the Board should ensure that a person the subject of an application for consent to sterilisation is legally represented. The question is therefore whether existing mechanisms enabling legal representation in these circumstances are sufficient, or if the community expects legislative measures that compel legal representation for patients. Part 15 also considers ways that a person the subject of a Board hearing might be better engaged in the process.

13.6.30 The Issues Paper asked whether the Act should compel the Board to arrange independent representation for a patient at a hearing involving an application for consent to special treatment.

Should the Act require mandatory legal representation for people for whom consent to special treatment is sought?\(^\text{1221}\)

13.6.31 There were five responses to this question, with two answering in the affirmative, one answering in the negative, and the OPG commenting that this should be required where the patient

\(^{1218}\) Ibid Question 10.16.

\(^{1219}\) Criminal Code 1924 (Tas) s 163.

\(^{1220}\) Guardianship and Administration Act 1995 (Tas) s 73(3).

\(^{1221}\) TLRI, above n 69, Question 10.17.
is opposed to the special treatment. The OPMHS answered that they defer to ethicists and the views of the Institute.

13.6.32 Representation of a person the subject of a Board hearing is considered more fully in Part 15.\textsuperscript{1222} The Institute does not propose any special legislative response for applications relating to consent to special treatment and refers to discussions later in this Report.

**Continuation of special treatment**

13.6.33 The Board can authorise a person’s guardian to consent to the continuation of special treatment or further special treatment of a similar nature.\textsuperscript{1223} This may be done at the guardian’s request, or with their consent.\textsuperscript{1224} The guardian’s authority can be revoked, or conditions or directions given.\textsuperscript{1225} Similar provisions apply in other jurisdictions.\textsuperscript{1226}

13.6.34 The Institute asked for community feedback about whether there is need for reform of the provisions of the Act addressing consent to continuation of special treatment that has been approved.

| (i) What improvements could be made to the way in which consent to the continuation of special treatment can be given? |
| (ii) How could the Act better deal with the giving of consent to long-term or indefinite treatment?\textsuperscript{1227} |

13.6.35 Only the OPG answered the first question, commenting that it considers the current arrangements adequate. On this basis, the Institute does not propose any legislative reform.

13.6.36 In relation to the second question, the OPG made the same submission. The OPMHS commented:

Further tests to allow a long-term or indefinite consent could be considered. Review could be triggered by changes in circumstances such as changes in the condition, the Represented Person, side effects, or significant changes, evidence, or advances, in available treatment.

13.6.37 The Institute notes that this is the only submission raising this alternative and it is thus not proposed as a matter for reform. The Institute observes that the Convention requires interventions that are subject to review, proportional, and operate for as short a time period as possible. These obligations support retention of existing requirements.

\textsuperscript{1222} See [15.4.16].

\textsuperscript{1223} Guardianship and Administration Act 1995 (Tas) ss 39(2), 46.

\textsuperscript{1224} Ibid s 46(2).

\textsuperscript{1225} Ibid s 46(3).

\textsuperscript{1226} See for example, Guardianship and Administration Act 2000 (Qld) s 74; Guardianship Act 1987 (NSW) s 45A.

\textsuperscript{1227} TLRI, above n 69, Question 10.18.
13.7 Particular matters

13.7.1 This next section reviews other health care and treatment matters not dealt with previously in this Part.

Participation in research

13.7.2 The Act does not provide any special test when giving substitute consent to participation in medical research. Decision-makers must therefore apply the same tests that apply to give consent to any other treatment. The Issues Paper noted that the ‘best interests’ test might be difficult to apply in all situations dealing with substitute consent to participation in research, for example, where:

- a person receives a placebo — receiving, or the potential of receiving a placebo may not improve the patient’s outcomes; or
- treatment is experimental in nature — the benefits of a particular treatment may be the purpose of the research; or
- the reason for wanting to participate in research is for altruistic purposes, rather than to treat any particular condition that the patient has — the research might be in the ‘best interests’ of the community at large, but it might be difficult to establish that the treatment is specifically in the patient’s best interests.

Recommendation 13.9 proposes that the Act require decision-makers to make a decision in accordance with the Decision-Making Process, focussed on a person’s values, preferences and wishes. The approach removes the ‘best interests’ basis of decision-making for people unable to give their own consent. This reform would improve some of the challenges listed above.

13.7.3 Participation in medical research involves balancing competing issues. On one hand, participating in research could have direct benefit for the participant. Research also serves a public benefit and can lead to medical and technological advancements. Restricting the ability of people with disability to participate as subjects in research can limit the veracity of the research. On the other hand, participants with support needs should not be exploited.

13.7.4 The Convention provides that no one must be subjected to medical or scientific experimentation without their free consent. The National Health and Medical Research Council (NHMRC) ethical guidelines which govern research in Australia provide that, where a participant does not have capacity to consent, the ‘person authorised to consent’ may consent. There are special provisions dealing with consent to participation in research in the majority of other Australian jurisdictions.

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1231 Guardianship Act 1987 (NSW) div 4A; Guardianship and Administration Act 2000 (Qld) s 72, sch 2 s 13; Medical Treatment Planning and Decisions Act 2016 (Vic) pt 5; Powers of Attorney Act 2006 (ACT) pt 4.3A.
13.7.5 There was broad support for the Act including provisions dealing with consent to participation in research where a person is unable to provide their own consent. Both Associate Professor Jo Dickinson\(^{1232}\) and Professor James Vickers\(^{1233}\) commented that the current lack of provisions in the Act creates uncertainty. They commented that this will be an increasing issue as research continues in relation to the prevention and treatment of dementia. The Board made a similar observation.

13.7.6 Dr Lisa Eckstein\(^{1234}\) made the following observations:

Whether and in what circumstances a surrogate decision-maker can enrol a person in research is an ongoing challenge in Tasmania. As identified in the issues paper, the provision of surrogate consent depends on a research project satisfying both the definition of ‘health care’ and/or ‘medical treatment’ and the ‘best interests’ criterion. Both of these can be unclear in the context of medical research. Consider, for example, a longitudinal study on the activity levels of older persons, which may involve providing participants with a fitbit and correlating their activity level with a health outcome such as falls/injury presentations. Would this fit within a definition of health care for which a ‘person responsible’ could provide consent?\(^{1235}\)

If research falls within the definition of ‘health care’ and/or ‘medical treatment’, a person responsible also must consider the trial to be in the person’s best interests. This can be very difficult to establish in the context of most clinical trials, which typically involve a placebo arm and/or an intervention whose benefits are currently unclear. In limited circumstances—for example, where there is no currently accepted treatment for a condition—a clinical trial might satisfy this criterion. However, more commonly, ‘best interests’ will be equated with standard medical care.

And yet it would be a travesty to prevent any medical research on persons without capacity to consent. This would render whole areas of disease incapable of progressing (e.g., dementia—noting especially Tasmania’s research strengths in this area, including work by the Wicking Dementia Research and Education Area) and foreclose an important component of broader research groups, such as older persons. Precluding surrogate consent for research also can fail to respect a person’s previous wishes if they have previously made clear that they would like to participate in research or consented on their own behalf at a time when they had capacity. Notably, paragraph 4.5.3 of the NHRMC National Statement on Ethical Conduct in Human Research (‘National Statement’) provides that ‘persons with a cognitive impairment, an intellectual disability, or a mental illness are entitled to participate in research, and to do so for altruistic reasons’.

13.7.7 Dr Rick McAllister made similar observations:

Research is conducted to gain a benefit or potential benefit for research participants in a study and potentially a direct benefit to future patients. What underpins research is that

\(^{1232}\) Chair, Tasmania Health and Medical Human Research Ethics Committee.

\(^{1233}\) Director, The Wicking Centre, Menzies Centre for Medical Research.

\(^{1234}\) Lecturer in law and medicine at the University of Tasmania and Deputy Chair of the Tasmanian Health and Medical Human Research Ethics Committee (HREC). Submission lodged in Dr Eckstein’s personal capacity and not on behalf of the HREC.

\(^{1235}\) Associate Professor Jo Dickinson and Professor James Vickers also gave another example, commenting that physiotherapy does not currently fit within the existing definition of ‘medical treatment’ in the Act. It is noted that Recommendation 9.4 would resolve this, proposing that the term ‘health care and treatment’ be used, with the term defined to include a range of health professions including physiotherapy.
'No Harm' is experienced by a participant. Safety is always the first priority. Health and Medical Human Research Ethics Committees ensure research submissions meet the National Statement on Ethical Conduct in Human Research and researchers abide by the Australian Code for the Responsible Conduct of Research.

13.7.8 The Board’s submission also made the following observations and comments:

There is currently no legislative framework to regulate substitute consent to participate in research which may mean that people with decision making incapacity are missing out on treatment that may be of benefit to them. The Board would support the incorporation of this within the Act.

13.7.9 The OPG’s submission also expressed support for the Act containing separate provisions dealing with the substitute consent to participation in medical research and experimental health care.

13.7.10 One respondent commented that there should be no research conducted on participants without the ability to provide their own consent. Another respondent submitted that research should only be permitted where the individual has given their own advance consent to participate in that particular research activity.

13.7.11 Given the issues identified above, and that it has broad support, the Institute proposes that the Act be revised to make special provision in relation to consent to research.

**Recommendation 13.10**

That the Act contain special provisions dealing with the substitute consent to the participation in research for adults who do not have the decision-making ability to provide their own consent.

13.7.12 The Issues Paper asked for feedback about what components should be included within the legislative framework for substitute consent to participation in research. The following questions were posed:

If the Act incorporates special provisions in relation to research:

(i) How should ‘research’ be defined?
(ii) What, if any, research should be able to be performed without consent?
(iii) What, if any, research should a person responsible be able to consent to?
(iv) What, if any, research should the Board need to consent to?
(v) What test(s) should apply to the giving of consent to participation in research?

13.7.13 Answers are outlined in the following paragraphs:

**How should research be defined?**

13.7.14 The first question was what should be classified as ‘research’. Acts in other jurisdictions generally distinguish between experimental research and clinical trials, although no distinction is made in Victoria.\(^{1237}\) In the Northern Territory and Victoria, non-intrusive examinations, observing a

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\(^{1236}\) TLRI, above n 69, Question 10.20.

\(^{1237}\) *Medical Treatment Planning and Decisions Act 2016 (Vic)* s 3.
person’s activities and collecting information are excluded from the definitions of medical research.\textsuperscript{1238}

13.7.15 The Board’s submission supported consistency across jurisdictions. The OPG commented that it supports legislative provisions dealing with ‘medical research and experimental health care’, although did not articulate what these terms should be defined to mean. It suggested, however, that ‘provisions should differentiate between low and high risk research.’

13.7.16 Professor James Vickers suggested that there should be a distinction between medical research that is likely to cause harm, versus environmental research which is unlikely to have a detrimental impact on the person. He suggested this could be framed in terms of a ‘low’ or ‘high’ risk distinction, or refer to ‘interventions’ compared to the administering of drugs.

13.7.17 Dr Rick McAllister submitted that:

New guardianship legislation should clearly distinguish between a ‘medical research procedure’ that is an adjunct to ‘medical treatment’ and a ‘medical research procedure’ that is undertaken for the purposes of medical research and not primarily for the purpose of providing a medical intervention to treat a person’s current condition.

When a ‘medical research procedure’ is carried out as an adjunct to ‘medical treatment’, the procedures dealing with substitute consent to ‘medical treatment’ should govern legal authorisation for the treatment and the requirements of the relevant ethics committee should govern ethical authorisation for the ‘medical research procedure’.

New definitions

New guardianship legislation should indicate that:

(a) Research that is carried out as an adjunct to ‘medical treatment’ is not a ‘medical research procedure’ for the purposes of requiring authorisation when a person is unable to consent to that research.

(b) A procedure is not a ‘medical research procedure’ unless it is approved by an ethics committee.

13.7.18 The OPMHS suggested the following as a possible definition:

• Investigation which does not, or is unlikely to, confer benefit to the patient, but is being used to better the understanding of conditions or their treatments and management.

• Treatment which is being given only or largely for the benefit of research.

• Treatment where the choice of treatment is dictated by the research project protocol, rather than through informed consent.

What, if any, research should be able to be performed without consent?

13.7.19 The Issues Paper asked whether there were any research procedures that ought to be permitted without consent in circumstances where the participant was unable to give their own consent.

\textsuperscript{1238} Guardianship of Adults Act 2016 (NT) s 8(4); Medical Treatment Planning and Decisions Act 2016 (Vic) s 3.
13.7.20 Dr McAllister suggested that the Victorian approach could be adopted,\textsuperscript{1239} enabling a patient to be given an experimental drug that they could potentially benefit from where there is no person responsible able to provide consent. Dr McAllister commented:

In the event that a researcher discovers that the eligible patient does not have an identified Responsible Person, the GAAT should have provision for the eligible patient to be afforded the right to participate in the research study/trial.

Section 42T is utilized in Victoria with positive outcomes for the eligible patient, researchers and the Guardianship Administration Board.

13.7.21 The OPMHS commented that this could occur: ‘Where there is little or no risk of harm, including the harm of significant distress. Provided there is ethics approval by the relevant authority.’

13.7.22 Another respondent commented that research should only be able to be performed with the advanced written consent of the person and not otherwise.

\textit{What, if any, research should a person responsible be able to consent to?}

13.7.23 The next question asked was what authority a person responsible ought to have in relation to giving consent to participation in research.

13.7.24 In other jurisdictions, a person responsible is generally able to consent to experimental research.\textsuperscript{1240} In Victoria, substitute consent to participation in research cannot be provided where the person is likely to gain decision-making capacity to provide their own consent within a reasonable time.\textsuperscript{1241} If a person has given a direction in an ACD, then that operates as valid consent.\textsuperscript{1242} These provisions are built into the proposed Decision-Making Process.\textsuperscript{1243}

13.7.25 In Victoria and the ACT, a person responsible can consent to a person participating in a clinical trial without the tribunal’s consent where the trial has ethics committee approval.\textsuperscript{1244} The tribunal then acts as a dispute resolution and review venue. In New South Wales and Queensland, the tribunal must consent to participation in clinical research.\textsuperscript{1245} The NSWLRC has recently recommended that a person responsible be able to consent to any medical research procedure, including clinical trials.\textsuperscript{1246}

13.7.26 Dr Eckstein submitted:

\begin{quote}
a person responsible should be able to consent to participation in research that has been approved by a Human Research Ethics Committee (HREC). The HREC should specifically consider whether the research is suitable for surrogate decision-making, in accordance with the provisions set out in Chapter 4 of the National Statement. This
\end{quote}

\textsuperscript{1239} Referring to the Guardianship and Administration Act 1986 (Vic) s 42T.
\textsuperscript{1240} In Victoria, a person responsible can apply to the tribunal for directions: Medical Treatment Planning and Decisions Act 2016 (Vic) s 83.
\textsuperscript{1241} Ibid s 72(2).
\textsuperscript{1242} Ibid s 75(b)(i).
\textsuperscript{1243} Recommendation 13.9(3)
\textsuperscript{1244} Guardianship and Management of Property Act 1991 (ACT) s 32D; Medical Treatment Planning and Decision Act 2016 (Vic) s 77.
\textsuperscript{1245} Guardianship and Administration Act 2000 (Qld) s 72.
\textsuperscript{1246} NSWLRC, above n 24, Recommendation 11.2(b).
includes an assessment under paragraph 4.5.4 that ‘the risks and any burden involved in the proposed research are justified by the potential benefits of the research’. For research for which an HREC has approved a waiver of consent, this waiver should also apply for persons without decision-making capacity, unless specified otherwise by the HREC.

13.7.27 Dr McAllister submitted:

A personal guardian or an enduring personal guardian with ‘medical research procedure’ powers or a health decision maker should be permitted to authorise participation in a ‘medical research procedure’ for the principal when the principal lacks the capacity to make their own decision about the matter.

The Public Advocate should be permitted to authorise participation in a ‘medical research procedure’ which is a ‘significant procedure’ for a person who does not have the capacity to authorise their own participation and who does not have a personal guardian, an enduring personal guardian or a health decision-maker to make that decision for them.

13.7.28 The OPMHS stated that a person responsible should be able to consent to participation in the following research:

Research which is not burdensome for the patient. If there might be minor and transient discomfort, and minimal risk, e.g. radiological examination, blood tests, non-invasive examination including psychological testing or psychiatric evaluation.

13.7.29 One respondent commented that research should only be able to be performed with the advanced written consent of the person and not otherwise.

What, if any, research should the Board need to consent to?

13.7.30 The Institute asked whether there was any research that should only be performed with the substitute consent of the Board rather than a person responsible.

13.7.31 Dr Eckstein submitted:

It is unclear what review by the Tribunal of individual research proposals would add to this process in terms of protection of vulnerable persons.

13.7.32 The OPMHS suggested that the Board might be appropriate to consent to: ‘Research which might be burdensome for the patient to experience. Research where there is significant risk of harm.’

13.7.33 Associate Professor Dickinson commented that, if Board approval were required for a clinical trial rather than a person responsible or guardian, it would seem more efficient for the Board to approve a particular clinical trial, rather than each individual participant’s participation in that trial. This is the current approach in New South Wales where the Tribunal approves of the participation of people with disability in a clinical trial.\textsuperscript{1247} The Tribunal then decides whether a person responsible can consent to an individual participant participating in the trial, or if the tribunal needs to approve each participant’s participation.\textsuperscript{1248} ‘The QLRC endorsed this approach on the basis that it avoids the need for the tribunal to hear multiple applications for consent to the participation of each adult in

\textsuperscript{1247} That complies with the NHMRC guidelines and has ethics approval.

\textsuperscript{1248} Guardianship Act 1987 (NSW) s 45AB.
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the research. Some criticise this approach, however, because the research has already received independent approval from a specialist ethics committee, and requiring further approval from a tribunal adds another layer of complexity and duplicates processes.

What test(s) should apply to the giving of consent to participation in research?

13.7.34 Noting that the existing ‘best interests’ test does not fit neatly with matters involving requests to give substitute consent to participation in research, the Institute asked what test the Act should require representatives to apply when deciding whether to give consent.

13.7.35 The OPG submitted that the test should ‘take into account the wishes (or likely wishes) of the person, and where there is not likely to be any direct benefit to the represented person to weigh up the potential benefits to society against any risks to the person.’ Dr Eckstein submitted that the test should be consistent with the test provided under the National Statement. She commented that the Act should facilitate participation in research despite it not necessarily benefiting the individual, but instead having benefit to society. Dr Eckstein noted that the existing test in New South Wales limits research in this regard. Their present test requires a particular drug or technique to be ‘intended to cure or alleviate a particular condition from which the patients suffer’:

How would such a test fit, for example, with a low-risk trial assessing optimal sleeping environments? It’s hard to argue that sleeping conditions are a ‘particular condition from which the patients suffer’ and yet this research is likely to be low risk and might be highly valuable for many nursing home residents.

13.7.36 Dr Eckstein referred to the Wisconsin Social Services Chapter 54.25. Duties and Powers of Guardian of the Person as a useful example upon which legislative reform could be based. She supported the Act providing that, where a person’s capacity fluctuates, consent should be sought when they have capacity, consistent with the approach under the National Statement.

1251 Paragraph 4.5.6 of the National Statement: ‘Where the impairment, disability, or illness is temporary or episodic, an attempt should be made to seek consent at a time when the condition does not interfere with the person’s capacity to give consent.’

1252 Paragraph 4.5.11 of the National Statement: ‘Refusal or reluctance to participate in a research project by a person with a disability, or a mental illness should be respected.’

1253 Guardianship and Administration Act 2000 (Qld) s 72(3)(a).

1254 Guardianship Act 1987 (NSW) ss 46, 46A.
13.7.37 Dr McAllister commented:

A substitute decision maker should only be permitted to authorise participation in a medical research procedure if they believe that it would not be contrary to the patient’s personal and social wellbeing to participate in that procedure. When determining whether the procedure would not be contrary to the patient’s personal and social wellbeing, the following are relevant considerations:

a) the decision that the person might have made in the circumstances
b) the extent to which the procedure is likely to benefit the patient, or a class of people to which the patient belongs
c) the matters set out in section 42U(1) of the *Guardianship and Administration Act 1986* (Vic).

He also stated that the ‘focus should be upon whether the patient won’t be harmed.’

13.7.38 On the other hand, Associate Professor Dickinson raised potential issues with legislation referring to the term ‘risk’ as, in a research environment, many matters are considered risks — for example, taking up a person’s time — meaning that there is ‘risk’ involved in seemingly straightforward procedures like taking blood or performing an ultrasound. She suggested that, instead, the Act should distinguish between low risk research and research where there is significant risk of adverse health outcomes. Both Associate Professor Dickinson and Professor Vicker commented that there should be consideration given to the benefits that the research may have for society as a whole, in addition to considering the ‘best interests’ of the participant.

13.7.39 The OPMHS suggested that the test include:

- Whether the research is burdensome for the patient
- Whether there is risk of enduring discomfort
- Whether there is significant risk of significant harm.

Other matters

13.7.40 Dr McAllister’s submission also expressed a desire for national consistency in relation to laws dealing with substitute consent to participation in research, and mutual recognition of laws:

a patient in Tasmania may require interstate transport from time to time for ongoing medical specialist treatment. For patients who are randomised or enrolled into a research study/trial general recognition of the legislation allowing enrolment to a research study/trial should be mutually recognised.

It was also noted that there is a need for applications to be dealt with within reasonable timeframes ‘taking into consideration the specific study Protocol inclusion criteria.’ The desirability of nationally consistent laws is discussed in further detail in Part 18.1256

*The Institute’s view*

13.7.41 The Terms of Reference for this review did not require specific consideration of the way that research is treated under the Act. The Institute considered it appropriate to raise the issue of

1256 See [18.2.32].
consent to research in its Issues Paper, observing that most guardianship legislation in other jurisdictions contains provisions dealing with research which may otherwise not neatly fit within the substitute consent regime for other treatment decisions.

13.7.42 Answers to questions outlined in the preceding paragraphs highlight that there are a range of views about the way in which the Act should deal with consent to participation in research. It is appropriate that the details of legislative reform be the subject of separate detailed consideration and consultation. The Institute instead adopts a principled approach when making the following recommendations in relation to how the Act might better address substitute consent to participation in research.

**Recommendation 13.11**

(1) That non-intrusive examinations, observing a person’s activities and collecting information be excluded from the definition of medical research.

(2) That the Act confirm that a person can give advance consent or refusal to consent to participation in research including in a valid advance care directive.

(3) That a donor of an instrument be able to confer authority upon their enduring guardian to make decisions about consent to participation in research where the donor does not have decision-making ability to give their own consent.

(4) That the Board be able to confer authority upon guardians to make decisions about consent to a represented person’s participation in research where a represented person does not have decision-making ability to give consent.

(5) That the Board have authority to make decisions about consent to participation in research for a person who does not have decision-making ability to give consent.

(6) That, if any research decisions are reserved as matters for the Board only, there be clear distinction between the role of the Board and the relevant Human Research Ethics Committee, avoiding duplication of functions.

(7) That the Act provide that, where a person’s decision-making ability fluctuates, an attempt should be made to seek their consent to their participation in research at a time when the person has decision-making ability to consent.

(8) That the Act provide that, for a decision-maker to give consent to a person’s participation in research, that research must have the approval of a Human Research Ethics Committee.

(9) That the Act enable decision-makers to give consent to a person without decision-making ability participating in research that is not intended to treat a condition that the person has.

(10) That a person’s objection to participate in research be respected.

(11) That there be an ability to apply to the Board for the review of a decision to consent or refusal to consent to participation in research.

**Withdrawal or withholding of life sustaining measures**

13.7.43 The Act does not specifically refer to the giving of substitute consent to the withdrawal or withholding of life sustaining measures. The Issues Paper commented that confirming when and how life sustaining measures may be withdrawn or withheld may provide greater clarity. It was noted that several Australian jurisdictions have specific provisions that address substitute consent to the
withdrawal of life sustaining measures. In Queensland, South Australia, the ACT and the Northern Territory, definitions of health care include withholding or withdrawal of life-sustaining measures.\textsuperscript{1257} In Queensland and the ACT, this is limited to circumstances where the commencement or continuation of the measure for the patient would be inconsistent with good medical practice.\textsuperscript{1258} The NSWLRC recommended that New South Wales legislation also confirm that a person responsible or the tribunal can consent to the withdrawal or withholding of life sustaining measures if starting or continuing the measure would be inconsistent with good medical practice and the decision gives effect to the patient’s will and preference.\textsuperscript{1259}

13.7.44 The Institute asked for feedback about whether the Act deals adequately with substitute consent to the withholding and withdrawal of life sustaining measures.

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<th>(i) Should the Act provide separate provisions dealing with withholding or withdrawing life sustaining measures?</th>
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13.7.45 There were eight responses to this question, with three\textsuperscript{1261} endorsing the Act containing specific reference to the role and powers of persons responsible to give consent to the withdrawal or withholding of life prolonging/sustaining treatment, with the OPMHS also commenting that ‘[p]rotections for medical practitioners in withholding burdensome or futile treatments needs to be considered.’ MIGA submitted that confirming the powers of a person responsible to consent to the withdrawal or withholding of life sustaining measures would provide certainty and protection for medical practitioners and persons responsible:

To avoid confusion, it is better to include withholding or withdrawing life sustaining treatment within the general definition of healthcare which a person responsible, a guardian or the Board can consent to.

The present position, particularly around the powers of a person responsible, is uncertain and does not reflect the realities of end of life care …

It is concerning that both practitioners treating such patients and persons responsible, each acting in good faith, could potentially be committing offences under the Act because of uncertainty around the powers of a person responsible. This potential scenario must be avoided.

Although it is open for practitioners to rely on the doctrine of futility in withholding or refusing treatment, this is a question of interpretation often involving complex considerations. It does not of itself provide a sufficient basis to guide those involved in end of life care decision-making.

13.7.46 Both the Board and the OPG’s submissions indicated that they had not observed any issues with the current legislative framework. The Board stated:

\textsuperscript{1257} Guardianship and Administration Act 2000 (Qld) sch 2, cl 5(2); Advance Care Directives Act 2013 (SA) s 4; Consent to Medical Treatment and Palliative Care Act 1995 (SA) s 4A; Powers of Attorney Act 2006 (ACT) Dictionary definition of ‘health care’; Guardianship of Adults Act 2016 (NT) s 3 definition of ‘health care action’.

\textsuperscript{1258} Guardianship and Administration Act 2000 (Qld) sch 2, cl 5(2); Powers of Attorney Act 2006 (ACT) Dictionary definition of ‘health care’.

\textsuperscript{1259} NSWLR above 24, Recommendation 10.14.

\textsuperscript{1260} TLRI, above n 69, Question 10.21(i).

\textsuperscript{1261} PCT, MIGA, Professors Ben White and Lindy Willmott.
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The Board does not wish to comment except to say that these are largely medical decisions, as treating doctors may only ethically offer treatment which is not futile or burdensome.

In practice the Board has received very few applications of this nature.

13.7.47 Whilst the OPG stated that it had not observed problems with the current framework, it submitted that it ‘is not opposed to the inclusion’.

13.7.48 One submission did not support the Act containing specific provisions dealing with substitute consent to the withdrawal or withholding of life sustaining measures, whilst another did not express a concluded view either way.

13.7.49 As noted previously, most Australian jurisdictions confirm that withdrawing or withholding treatment (including life sustaining measures) comprises ‘health care’, meaning that it falls within the ambit of the authority of persons responsible, guardians and the Board. For the sake of clarity, and noting MIGA and the OPMHS’s statements about the confusion that the present situation can create, it is proposed that the definition of health care includes the withholding or withdrawal of life-sustaining health care.

Recommendation 13.12

That ‘health care and treatment’ be defined to include the withdrawal or withholding of health care and treatment, including life sustaining measures.

13.7.50 In circumstances where the Act did contain specific reference to the withdrawal and withholding of life sustaining measures, the Institute also asked about key components of those provisions.

(ii) If so, who should be able to consent and when?

(iii) Should a patient’s advance directions about withdrawing or withholding life sustaining measures be binding? Should there be any exceptions?

13.7.51 There were six responses to the first question, with all endorsing any representative, including persons responsible, guardians and the Board, having the power to consent to the withdrawal or withholding of life sustaining measures.

13.7.52 Recommendation 13.12 has the effect of proposing that the withdrawal and withholding of health care falls within the definition of ‘health care and treatment’. Other recommendations in this Report provide that persons responsible, guardians with specific powers in relation to health care and the Board may give made decisions about ‘health care and treatment’.

By defining the withdrawal or withholding of health care within the definition of health care, it becomes unnecessary to make further recommendations confirming who ought to be able to give consent. The effect is that withdrawing and withholding of health care, including life sustaining measures, are dealt with in the same way as any other health care or treatment that is not ‘special treatment’.

13.7.53 Seven respondents addressed the second question, which asked what effect a direction in an ACD giving advance consent to the withdrawal or withholding of life sustaining measures should

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1262 TLRI, above n 69, Question 10.21(ii), (iii).
1263 See Recommendations 9.4, 13.9, 14.3.
have. Six endorsed valid ACDs that apply to the situation at hand and which are clear and unambiguous being binding and unable to be overruled by a representative. The OPMHS commented that individuals may not always be realistic or able to predict future circumstances. In particular, it commented that ‘[a]n ACD directive should not direct a doctor or health practitioner to engage in unethical or inappropriate treatment.’

13.7.54 The nature and effect of ACDs were discussed in detail in Part 5. Responses to this question all support and reinforce the effect of the recommendations made in that part which, in summary, provide that advance refusal to consent to health care or treatment in a valid ACD must be binding if it applies to the situation at hand.\textsuperscript{1264} The Institute does not propose any further reforms to address these matters.

\section*{13.8 Other issues?}

13.8.1 The Institute called for any other submissions about how else the Act could be improved in relation to consent to treatment.

\textbf{How else can the Act be improved in relation to consent to treatment?}\textsuperscript{1265}

13.8.2 There were eight submissions addressing this question. Answers can be grouped into the following themes:

- a need for education for medical practitioners and the public more broadly;\textsuperscript{1266}
- the importance of the Act being understandable and there being simple processes that do not detract clinical time from patients;\textsuperscript{1267}
- issues relating to chemical restraint. This is addressed elsewhere in this Report;\textsuperscript{1268}
- that service providers need to know who a person’s person responsible is;\textsuperscript{1269}
- that people ‘should be able to sign to stop treatment’.

This issue was considered in the previous paragraph where it was noted that, the effect of Recommendation 5.6 is that any direction in a valid ACD consenting to the withdrawal or withholding of life sustaining measures must be binding if they apply to the situation at hand; and

- a desirability to formalise processes for persons responsible, for example, having them complete documents.

Under the existing legislative framework, individuals are able to formally designate a decision-maker for medical treatment matters via an instrument. This was discussed in Part 5, with it being proposed that this situation continue.\textsuperscript{1270}

\textsuperscript{1264} See in particular Recommendation 5.6.
\textsuperscript{1265} TLRI, above n 69, Question 10.22.
\textsuperscript{1266} Four submissions raised the need for education.
\textsuperscript{1267} OPMHS.
\textsuperscript{1268} See Part 17.
\textsuperscript{1269} Recommendation 5.9 proposes that health care professionals and operators of health facilities have a duty to make reasonable enquiries to ascertain whether a patient has an ACD or instrument.
13.8.3 In relation to the role of education in relation to health care and medical treatment, Professors White and Willmott submitted:

Doctors’ knowledge of the law in this area should be recognised as an important part of effective legal regulation of guardianship and end-of-life matters. …

accurate knowledge of the law on the part of doctors is an important component of effective legal regulation of guardianship matters. Our research has shown that significant knowledge gaps exist among medical professionals practising in the end-of-life field, and we have argued this can have consequences for patient care and the legal liability of medical professionals …

Our view is that knowledge of ethics and law in this area should be integrated in medical education to provide doctors with the ability to apply knowledge of the law in clinical decision-making and understand its role and significance in practice.

13.8.4 Further discussion about the important role of education is contained in Part 18.1271 Similarly, the need for the legislation and processes to be simple is addressed in Part 18. Recommendations throughout this Report have considered the need for the law to be accessible and appropriately responsive to the needs of the community.

13.8.5 In summary, all matters raised in response to this final question have been addressed elsewhere in this Report.

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1270 See [5.5.44].
1271 See [18.2.19].
Part 14

Safeguards for Consent to Health Care and Treatment

14.1 Introduction

14.1.1 The Terms of Reference asked the Institute to address the appropriateness of current measures that address poor conduct of persons responsible and guardians not acting in the best interests of a person with impaired capacity. In this Report, we call these types of protections ‘safeguards’. Part 12 considered safeguards in relation to personal and financial decisions. This Part considers how the Act provides safeguards for decision-making about health care and treatment.

14.1.2 The Convention requires safeguards that are proportionate, appropriate and effective. The aim should always be to prevent abuse and neglect, rather than placing an over-reliance upon punishment. Representatives and supporters play a vital role in the community and can be instrumental in advancing the interests of the person they are supporting. There is therefore a need for balance, so that the role does not become unnecessarily burdensome, or the risk of personal liability too great, resulting in well-intentioned and suitable individuals being reluctant to accept these roles if required. On the other hand, with these roles comes a high degree of trust and confidence that the person has as their paramount consideration the desire to uphold the rights and interests of the represented person. There can be serious consequences where a representative exceeds their power, with the potential for that conduct resulting in a denial of a person’s human rights or endangering their health and wellbeing. In the context of consent to health care and treatment, the legislation in Queensland describes this balance as one between ensuring that people are not deprived of necessary health care because of an impaired capacity, whilst ensuring that the health care that people receive is necessary and appropriate to maintain or promote their health and wellbeing.

14.1.3 Whilst this Part focuses on specific safeguards for consent to health care and treatment, other parts of this Report are also aimed at strengthening the rights of people who do not have the ability to make decisions about consent to health care and treatment. Part 13 considered reform to the Act to better strengthen the rights and interests of people receiving health care and treatment. Part 7 proposes that a legislated supported decision-making framework apply to decisions about consent to health care and treatment. Parts 15 and 16 consider the role and functions of the Board and Public Guardian which are also relevant to those provisions in the Act dealing with substitute consent to health care and treatment. Proposed reforms to the overriding guiding principles of the Act are also intended to promote a greater rights-based approach to decision-making and the operation of the Act as are reforms proposed in Part 7, providing greater recognition and facilitation of the role of support for decision-making.

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1273 See Guardianship and Administration Act 2000 (Qld) s 61.
14.2 The ALRC’s Safeguards Guidelines

14.2.1 The ALRC’s Safeguards Guidelines were explained in Part 12. The Safeguards Guidelines provide:

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<th>ALRC Safeguards Guidelines</th>
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<tr>
<td><strong>(1) General</strong></td>
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<tr>
<td>Safeguards should ensure that interventions for persons who require decision-making support are:</td>
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<tr>
<td>(a) the least restrictive of a person’s human rights;</td>
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<tr>
<td>(b) subject to appeal; and</td>
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<tr>
<td>(c) subject to regular, independent and impartial monitoring and review.</td>
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<tr>
<td><strong>(2) Support in decision-making</strong></td>
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<tr>
<td>(a) Support in decision–making must be free of conflict of interests and undue influence.</td>
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<td>(b) Any appointment of a representative decision-maker should be:</td>
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<td>(i) a last resort and not an alternative to appropriate support;</td>
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<tr>
<td>(ii) limited in scope, proportionate, and apply for the shortest time possible; and</td>
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<td>(iii) subject to review.</td>
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14.2.2 This Part evaluates current safeguarding provisions relating to consent to health care and treatment against the ALRC’s Safeguards Guidelines.

14.3 Least restrictive interventions

14.3.1 The first of the ALRC’s Safeguards Guidelines provides that safeguards should ensure that interventions for people who require decision-making support are the least restrictive of a person’s human rights. The need to adopt the least restrictive intervention has been considered throughout this Report, including Part 3 (‘Guiding Principles of the Act’), and Part 6 (‘Decision-Making Capacity’).

14.4 Appeal provisions

14.4.1 The second of the ALRC’s Safeguards Guidelines provides that safeguards must ensure that interventions for people who require decision-making support are subject to appeal. The following paragraphs considers how the Act approaches appeals of decisions about consent to health care and treatment.

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1274 ALRC, above n 3, Recommendation 3-4.
**Appeals against decisions of the Board**

14.4.2 Part 12 reviewed how the Act deals with appeals against Board decisions. Recommendation 12.1 proposes that the Act enable internal reviews of Board decisions. It also recommends that the process of external appeal to the Supreme Court be free and simple. Part 12 also looked at the use of alternative dispute resolution, with revision to the Act to incorporate the use of mediation being endorsed. It was also suggested that the Public Guardian play a role in mediating matters. This approach is considered later in this Part in the context of consent to health care and treatment.

**Appeals in relation to decisions of persons responsible**

14.4.3 The Board does not have express power to review the decisions of a person responsible unless they are appointed as a guardian. If someone does not agree with a person responsible’s decision, then the person could:

- request the Public Guardian’s advice;
- apply to the Board for the appointment of a guardian. Any appointed guardian would then act as the person responsible.

These approaches may assist where a person responsible is refusing to consent to health care or treatment. However, they may be of limited benefit where a person responsible consents to health care or treatment which is carried out before an application is made or determined. The Board’s submission explained:

> There is currently no formal mechanism in the Act for objecting to a person responsible’s decision, or for that matter a guardian’s or administrator’s decision and the Board has no direct power to review such decisions. However under the Act the Board has the power to hear a review of a guardianship or administration order which may result in consideration of the appropriateness of decisions made by a guardian and/or administrator. As there is no formal appointment of a person responsible there is no ability to review a person responsible’s appointment and therefore decisions they have made. There is some benefit in directly addressing this in the Act.

The Board notes the appointment of a guardian upon application may come too late given the necessary notice period and appeal period.

14.4.5 The OPG also commented that:

> Currently, the only real option open to someone objecting to decisions of a person responsible is to make an application for guardianship to the Board. This allows the

1275 See [12.4].
1276 See Recommendation 12.3.
1277 Recommendation 12.4.
1278 The Board can deal with disputes about the activities of a guardian when acting as the person responsible in the same manner as dealing with other complaints in relation to guardians.
1279 Guardianship and Administration Act 1995 (Tas) s 15(1)(j).
1280 Ibid s 4(1)(c)(i).
1281 Whilst the Board has power under s 44(4) of the Act to direct that treatment not be started, or be stopped pending it hearing an application, this only applies to situations ‘where the treatment cannot be performed without that consent’.
Board to appoint a guardian, including the Public Guardian under an emergency order, which provides a measure of protection to represented persons (particularly where the person responsible is not making decisions in the best interests of the person) but can amount to a somewhat heavy-handed solution. Guardianship appointments are not an appropriate mechanism when it is the person themselves objecting to the decision: they might be objecting to both the decision and to being deprived of the right to make their own decision. In such cases the more restrictive alternative of a guardianship order is no solution.

14.4.6 Recommendation 14.2 proposes that the Board be empowered to give persons responsible advice and directions, consistent with the approach in relation to guardians and administrators. In several jurisdictions, the Public Advocate/Public Guardian plays a role in mediating disputes. This was discussed in Part 12, with Recommendation 12.4 proposing that the Public Guardian have power to attempt to resolve disputes, consistent with the approach in South Australia.

14.4.7 The Institute called for submissions about whether and how a person responsible’s decisions should be able to be reviewed or appealed.

Should the Act provide a mechanism to object to a person responsible’s decision? How could this work? 1282

14.4.8 Most respondents endorsed there being some mechanism to object to a person responsible’s decision, with one commenting that, whatever the approach, there should be consistency with the approach adopted for enduring guardians. Three respondents 1283 endorsed the Public Guardian playing a role in attempting to resolve disputes.

14.4.9 Recommendations 5.7 and 12.4 propose an extended role for the Public Guardian to mediate disputes about ACDs or between representatives. It is appropriate, for the reasons articulated in those parts, that the Public Guardian have equivalent authority to mediate disputes in relation to persons responsible. This provides the Public Guardian complementary powers to resolve disputes that can arise in each area of a person’s life.

Recommendation 14.1

That Recommendation 5.7 be extended to enable the Public Guardian to attempt to resolve disputes involving persons responsible and consent to health care and treatment.

14.5 Safeguards in relation to persons responsible

14.5.1 The ALRC’s Safeguards Guidelines provide that interventions for people who require decision-making support must be subject to regular, independent and impartial monitoring and review. 1284 The Guidelines also require support in decision-making to be free of conflict of interest and undue influence. 1285

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1282 TLRI, above n 69, Question 11.3.
1283 Board, OPG, MIGA.
1284 ALRC, above n 3, Recommendation 3-4.
1285 Ibid.
14.5.2 There is no mandated oversight or monitoring of a person responsible’s activities. Unlike Board-appointed guardians, persons responsible are not required to periodically report to the Board about a person’s circumstances. Their appointment is not fixed for a certain term or their suitability assessed by the Board. The main circumstance where the Board might be called upon to review the activities of a person responsible is where a person applies to the Board, for example, for the appointment of a guardian. An applicant might do this where they hold concerns that a person responsible is not acting in a patient’s interests. If the Board considers that the test for the appointment of a guardian is met, then it may appoint another person (or the Public Guardian) as a guardian, granting them powers to consent to health care and treatment. The effect is to remove the authority of the individual otherwise eligible to act as the person responsible.

14.5.3 Discussion in Part 13 included formulating reforms intended to safeguard the rights and interests of people without decision-making ability to give their own consent to health care and treatment. This includes prescribing that some health care and treatment fall outside of the scope of the authority of a person responsible. The following paragraphs evaluate and outline recommendations about other safeguards that should be adopted to minimise the risk of a person responsible acting improperly and remedying situations where they have.

Advice to persons responsible

14.5.4 Enduring guardians, guardians and administrators can apply to the Board for advice or direction. There is no equivalent provision enabling a person responsible to request the Board’s advice or enabling the Board to give them directions. Section 35 of the Act provides, for example, in relation to enduring guardians, that:

• an enduring guardian may apply for advice or direction by the Board on any matter relating to the scope of their role or the exercise of any power;
• the Board may approve or disapprove of any act proposed to be done by the enduring guardian;
• the Board has the power to give such advice or direction as it considers appropriate; and
• the Board may, of its own motion, direct or offer advice to an enduring guardian.\footnote{Guardianship and Administration Act 1995 (Tas) s 35(1).}

14.5.5 The Issues Paper commented that the ability to seek guidance from the Board might act as a preventative strategy and avoid situations where a person responsible intentionally, or unintentionally acts outside of their powers. In Victoria, for example, a person responsible can apply for advice.\footnote{Medical Treatment Planning and Decisions Act 2016 (Vic) ss 70(1), 83(1).} Responses were sought about whether the Act should enable a person responsible to apply to the Board for advice and directions.

Should a person responsible be able to apply to the Board for advice?\footnote{TLRI, above n 69, Question 11.2.}

14.5.6 Eight submissions addressed this issue, with all supporting persons responsible having the ability to apply to the Board for advice. Both MIGA and the OPG submitted that the Public

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\footnote{A person who is a guardian can do so.}

\footnote{Guardianship and Administration Act 1995 (Tas) s 35(1).}

\footnote{Medical Treatment Planning and Decisions Act 2016 (Vic) ss 70(1), 83(1).}

\footnote{TLRI, above n 69, Question 11.2.}
Guardian should have a role to provide advice and attempt to resolve disputes involving persons responsible, with an application to the Board only being necessary if this first step is unsuccessful. This was addressed in the previous paragraph.

14.5.7 Consistent with the views of respondents, it is proposed that there be consistency with those parts of the Act which enable representatives to apply to the Board for advice and directions. As the OPG observed, this approach is consistent with adopting the least restrictive alternative as it may avoid the need for a guardianship order.

**Recommendation 14.2**

(1) That a person responsible be able to apply to the Board for advice or direction on any matter relating to the scope of their role or the exercise of any power.

(2) That the Board be empowered to:

   (i) approve or disapprove of any act proposed to be done by a person responsible;

   (ii) give such advice to a person responsible as it considers appropriate; and

   (iii) direct or offer advice to a person responsible of its own motion.

**Eligibility to act as a person responsible**

14.5.8 Assessing the suitability of a person to act as a representative or decision-maker can act as a safeguard, by promoting the likelihood that those who have authority to make decisions are most appropriate to act in that role. Suitability was considered in Part 12 in relation to eligibility to be a guardian and administrator.1290 This Part reviews how the Act addresses criteria to be a person responsible.

14.5.9 A patient’s person responsible is determined by reference to a person’s relationship with the patient. A hierarchical list determines priority.1291

Giving classes of individuals priority to be the person responsible

14.5.10 The Institute asked for feedback about whether the list of persons responsible should continue to be expressed in a hierarchy and, if so, whether the current order is appropriate.

Should there be an order of priority to determine the person responsible? If so, should the current order be revised?1292

14.5.11 Eight respondents addressed this question with mixed views expressed. Three expressed support for retaining an order of priority on the basis that it provides clarity and avoids potential conflicts and disputes. The OPG’s submission, however, stated that it did not consider the hierarchical list avoids or reduces the risk of conflict:

The intention of creating this ‘hierarchy’ is, presumably, to avoid conflict by specifying who out of various people with different relationships, should have authority. However

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1290 See [12.8.32].
1291 Guardianship and Administration Act 1995 (Tas) s 4.
1292 TLRI, above n 69, Question 10.8(ii).
there is still plenty of room for conflict, and the order of priority does not help at all if, for example, there is no spouse but multiple children and/or close friends.

14.5.12 Three responses indicated support for removing the priority ranking.\textsuperscript{1293} Carers Tasmania observed that the hierarchy does not necessarily reflect those closest to the patient or those most suitable to make decisions about treatment:

\begin{quote}
it may be person is much better supported by a close friend or sibling than their spouse, or an aunty or uncle rather than a parent, dependant on family dynamics.
\end{quote}

14.5.13 The OPG also commented that:

\begin{quote}
In reality, many (if not most) medical practitioners are not aware of the order of priority and will seek the consent of the person who is presenting as the ‘logical’ source of consent. This might be the sibling who attends with the patient, or the daughter when the husband is overwhelmed and stressed, or the close neighbour when the only child lives overseas …

The OPG believes the health practitioner seeking substitute consent is capable of identifying the most appropriate person responsible where there are multiple contenders. Mostly, there is a ‘stand out’ or logical choice.
\end{quote}

14.5.14 Two responses, including the Board, did not express a concluded view about this issue.

14.5.15 Three submissions contained suggestions about how to address potential disputes, for example, where there are multiple adult children of a patient. The Board stated:

\begin{quote}
Sometimes there is more than one carer or close friend eligible to act, and in the case of dispute, or where there is no person responsible, there must be an application to the Board for the appointment of a guardian to give consent. Less cumbersome alternatives to this could be for the Public Guardian to have the power to mediate between disputing candidates or possibly even be the default person responsible — as is currently the case with forensic procedures. Against this, is the concern that little effort may be made to locate a person responsible if the easy default position, is that the Public Guardian becomes person responsible.
\end{quote}

14.5.16 The OPG and MIGA also commented that there could be a role for the Public Guardian to mediate disputes about who has authority to act as the person responsible where there are multiple contenders. This is the effect of Recommendation 14.1.

14.5.17 MIGA also suggested that the Act clarify that, if there is more than one person falling within the class of individuals eligible to be the person responsible, it should be the first available who has authority to act. This raises the relevance of a person’s willingness and availability to act, a matter addressed below.\textsuperscript{1294}

14.5.18 MIGA also suggested that public education could assist, stating:

\begin{quote}
The health professions and the community need further, practical advice about how to deal disputes over who should act as person responsible. This is to try and avoid initial disputes escalating to a point where more formal resolution mechanisms are required.
\end{quote}

\textsuperscript{1293} Carers Tasmania’s submission is taken as implicit support for this option.

\textsuperscript{1294} See [14.5.43].
The Institute endorses preventative strategies to minimise and mitigate the severity of potential disputes arising in this area. Recommendations about the use and benefits of community education are outlined in Part 18.\footnote{Recommendation 18.1.}

14.5.19 On balance, the Institute does not propose revision to the existing approach of listing those classes of individuals eligible to be the person responsible in a hierarchy. This is because it provides an objective means to identify the person responsible. The alternative would be to provide third parties the role of determining subjectively who they consider is most appropriate. That individual may not have sufficient information upon which to decide who is most appropriate to act. There would be the risk of that decision being based on misinformation or itself causing disputes between competing eligible individuals. At worst, this could lead to delay in the provision of health care and treatment whilst these matters were being resolved. Instead, it is suggested that the Act provide some parameters around which to assess an individual’s eligibility (discussed below).

14.5.20 One respondent stated that there is a need for legislative clarity about the effect of substitute consent being obtained from a person who is later established to not have the highest priority to act as the person responsible. The Institute is unaware of whether this is considered more broadly to be an issue requiring resolution, and so has not made any recommendations to this effect. Recommendations outlined below are likely to at least in part address this issue, by requiring a person to be available to be a patient’s person responsible.\footnote{Recommendation 14.5(1).}

Priority of a Guardian

14.5.21 The Act states that if a person has a guardian, that guardian is the represented person’s person responsible.\footnote{Guardianship and Administration Act 1995 (Tas) s 4(c).} The wording does not distinguish between full and limited guardians. The Board has interpreted this to mean that guardians with only limited powers are the person responsible irrespective of only having limited powers (for example, to only make decisions about where a person lives).\footnote{BND (Review of Administration) [2012] TASGAB 3.} This extends the powers of limited guardians and removes the ability of family members who would otherwise be the person responsible. The Public Guardian has commented that ‘[t]his is hardly the least restrictive option, and difficult to see that it is in the represented person’s best interests.’\footnote{OPG, Annual Report 2015–2016, 11 (‘OPG 2016’).}

14.5.22 New South Wales and Victorian legislation provides that a guardian only has priority as a person responsible if they have authority to make the relevant decision.\footnote{Medical Treatment Planning and Decisions Act 2016 (Vic) s 55(2); Guardianship Act 1987 (NSW) s 33A(4)(a).} A similar provision applies in the Northern Territory and South Australia.\footnote{Guardianship of Adults Act 2016 (NT) s 23(1); Consent to Medical Treatment and Palliative Care Act 1995 (SA), definition of ‘person responsible’ s 14(1)(a).} A different approach is adopted in South Australia, where the list defining the person responsible is not expressed to be in any order of priority.\footnote{Consent to Medical Treatment and Palliative Care Act 1995 (SA) s 14B(3).} The effect is to allow individuals fitting within a lower listed class to be the person responsible.
14.5.23 The Institute enquired whether the Act should provide that a guardian is only a represented person’s ‘person responsible’ where they have been given the express power to consent to treatment. That power could be conferred in the instrument (in the case of an enduring guardian), or by the Board (in the case of a Board-appointed guardian).

Should a guardian only be the person responsible if they have been given express authority to make treatment decisions?\(^{1303}\)

14.5.24 Six submissions addressed this question with five\(^{1304}\) endorsing revision to the wording of the Act to provide that a guardian is only a represented person’s person responsible where they have been given explicit powers in relation to health care and treatment. Rationales included that extending the powers of a guardian where it is intended that they have only limited powers is not usually the least restrictive option. It was also observed that the effect can be to exclude others who might be more appropriate or suitable to act as the person responsible, for example a spouse or adult child. The OPMHS commented that it has observed this causing confusion.

14.5.25 MIGA submitted that, whilst they endorsed this reform, they considered it important that, procedurally, the Board should raise this during a hearing whilst appointing a guardian, so that it can consider whether the guardian should be given powers in relation to health care and treatment matters. The OPG also submitted that a guardian should also be the person responsible where there is no one else to act in that capacity.

14.5.26 Sandra Taglieri SC did not support this reform and endorsed retention of the existing position that a guardian becomes the represented person’s person responsible. It was commented that this may avoid the need for a guardianship order and that it is appropriate that guardians ‘trump’ other decision-makers. It was noted that a guardian is appointed based on suitability and that if a person wishes to make treatment decisions for their family member, then it is open to them to apply to be their guardian. She submitted that, if an order is silent on the powers of a guardian to consent to treatment, then this ought to be implied where a need to give consent to treatment arises as this may limit multiple applications being made to the Board (except in the types of cases where there was a potential for conflict between a limited guardian and the person’s represented person, there is confusion on the part of a limited guardian about what power he/she has, or where a limited guardian was concerned about acting outside of their powers, so refuses or delays in giving consent, or the medical professional involved in the anticipated treatment will not provide treatment because of fear of committing an offence\(^{1305}\)).

14.5.27 The Institute is persuaded by comments that conferring powers by implication or by default is not the least restrictive alternative. Reflecting the need to adopt the least restrictive alternative, Recommendation 8.3 proposes that the Board be required to tailor orders and only give representatives powers where they are satisfied that the test for appointment of a representative is satisfied in relation to each function conferred. The Board would be unable to do this if legislation continued to provide default powers to a guardian to make health care and treatment decisions as the person responsible irrespective of whether the Board intended to confer those powers.

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1303 TLRI, above n 69, Question 10.9.
1304 The Board, OPG, OPMHS, MIGA, Keith Anderson.
1305 Referring to Guardianship and Administration Act 1995 (Tas) s 39, despite the terms of s 40.
14.5.28 A further factor supporting this reform is observations that the present approach can create angst in emergency situations where the Public Guardian is appointed as a temporary or limited guardian to make a particular decision under an emergency order, with the consequential effect being that they then become the person responsible with power in relation to medical treatment decisions. This has the potential to further escalate distress felt by family members, particularly where an emergency order has been required in urgent circumstances. In urgent circumstances, family members do not have an opportunity to apply to be appointed as the guardian, and only the Public Guardian may be appointed. This Report does not recommend any revision to that arrangement.\textsuperscript{1306}

14.5.29 There may, however, be situations where a guardianship order is made in non-urgent circumstances where the patient’s spouse, or someone who would otherwise be the default person responsible, is not appointed as a guardian. This might be for reasons including that the Board has determined that they are unsuitable to act in that capacity, or that they did not nominate themselves for the role. Both of these situations could arguably justify them being equally unsuitable to act as person responsible with power to make health care and treatment decisions. Nevertheless, in these circumstances, the Board retains the ability to confer upon the appointed guardian powers to consent to health care and treatment, removing the otherwise default authority of that family member.

14.5.30 It is proposed that reform be achieved in line with the approach in Victoria and New South Wales, where legislation confirms that a guardian is the person responsible if they have authority to make the relevant decision.\textsuperscript{1308}

\begin{center}
\textbf{Recommendation 14.3}
\end{center}

That the definition of ‘person responsible’ in the Act provide that a person’s guardian is their person responsible only if the order or instrument appointing the guardian authorises the guardian to make a decision about that particular health care and treatment or all health care and treatment matters.

\textit{Classes of persons responsible}

14.5.31 The hierarchy of those eligible to be an adult’s person responsible (after their guardian) is as follows:

- their spouse;
- the person having the care of the other person; and
- a close friend or relative of the person.\textsuperscript{1309}

14.5.32 ‘Spouse’ is defined to mean a person who is in a significant relationship with a person under the \textit{Relationships Act}.\textsuperscript{1310} This means that they have a relationship as a couple, and are not

\textsuperscript{1306} Guardianship and Administration Act 1995 (Tas) s 65(2).
\textsuperscript{1307} See [15.3.30].
\textsuperscript{1308} Medical Treatment Planning and Decisions Act 2016 (Vic) s 55(2); Guardianship Act 1987 (NSW) s 33A(4)(a).
\textsuperscript{1309} Guardianship and Administration Act 1995 (Tas) s 4(1)(c).
\textsuperscript{1310} Relationships Act 2003 (Tas) s 3(1).
married. The Relationships Act does not require a relationship to last any particular length of time to be a ‘significant relationship’, although the duration of the relationship is relevant. Under the Act, for a spouse to be a person responsible, there must be a ‘close and continuing relationship’. What is a ‘close and continuing relationship’ is not explained. In New South Wales, the definition of ‘spouse’ clarifies that where there is more than one person who would fall within the definition, the last person to qualify as a ‘spouse’ is taken to be the spouse. A similar clarification is included in the Coroners Act 1995 (Tas).

14.5.33 The Act does not give priority to any particular category of family and friends. In Western Australia and Victoria, nearest relatives are given priority over close friends. Some jurisdictions specifically recognise Aboriginal and Torres Strait Islander concepts of family and relationship within their definitions. For example, in the Northern Territory, ‘relative’ is defined as including ‘a person who is related to the adult in accordance with customary law or tradition (including Aboriginal customary law or tradition).’ Similar provisions are included in South Australia. In Tasmania, the Coroners Act 1995 also recognises family relationships according to Aboriginal and Torres Strait Islander customs and traditions.

14.5.34 The Issues Paper asked for feedback about whether there needs to be any changes made to these definitions.

Should there be any changes made to the definition of the person responsible?

14.5.35 Several responses raised matters considered elsewhere in this Part, for example, issues relating to the priority of a guardian.

14.5.36 One respondent commented that there are differences between the hierarchy of those eligible to give consent under the Human Tissue Act 1985 (Tas) and the Act which create inconsistency and confusion. Another respondent made a similar observation in addressing a separate question in relation to participation in research.

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1311 Ibid s 4(1). If they have registered their relationship, then that registration is proof of their relationship: s 4(2). If they have not registered their relationship, then whether they are in a significant relationship is assessed in light of a range of relevant factors: s 4(3).
1312 Ibid s 4(3)(a).
1313 And not themselves under guardianship: Guardianship and Administration Act 1995 (Tas) s 4(5)(a).
1314 To be a ‘spouse’ for the purposes of intestacy (where a person dies without a valid Will), a spouse must have been in a relationship with the deceased for a continuous period of at least two years, or the relationship resulted in the birth of a child: Intestacy Act 2010 (Tas) s 6(c).
1315 Definition of ‘spouse’, Guardianship Act 1987 (NSW) s 3(1).
1316 Guardianship Act 1995 (Tas) s 3A(b).
1317 Medical Treatment Planning and Decisions Act 2016 (Vic) s 55(3); Guardianship and Administration Act 1990 (WA) s 110ZSD(5).
1318 Guardianship of Adults Act 2016 (NT) s 7(1)(j). The NSWLRC has recently made the same recommendation: NSWLRC, above n 24, Recommendation 10.21.
1319 Definition of ‘prescribed relative’, Guardianship and Administration Act 1993 (SA) s 3(1); Consent to Medical Treatment and Palliative Care Act 1995 (SA) s 14(1).
1320 Guardians Act 1995 (Tas) s 3A(j).
1321 TLRI, above n 69, Question 10.8(o).
14.5.37 The Human Tissue Act 1985 (Tas) provides the following order of priority of those who may act as the ‘senior available next of kin’ with certain powers to consent to organ donation following an adult’s death:

- a spouse or other person in a significant relationship with the deceased within the meaning of the Relationships Act, if they are available;
- where there is no spouse or partner available, then their adult son or daughter who is available;
- where there is no adult son or daughter available, then their parent who is available;
- where there is no parent available, then their adult brother or sister who is available; or
- where the deceased is an Aboriginal person, then a person who is an appropriate person according to the customs and tradition of the community or group that the deceased person belonged to.\textsuperscript{1322}

The effect is to prioritise certain family members over others and to prioritise family over close friends.

14.5.38 MIGA submitted that the current definition ‘works well where there are no disputes between persons responsible of equal status, as long as the term “close friend or relative” acknowledges the diversity of cultural relationships.’ It suggested that this could be achieved through guidelines. It also commented that disputes could be addressed through granting powers to the Public Guardian to mediate. This is the effect of Recommendation 14.1.

14.5.39 Both the Board and the OPG raised whether the term ‘person responsible’ is the most appropriate term to describe the role. The Board observed that the term is not widely understood and suggested that the role could be better explained using the name ‘health decision-maker’ or similar, consistent with the VLRC’s recommendations and subsequent legislative reforms.\textsuperscript{1323} The OPG also stated that consideration could be given to adopting the title of ‘health decision-maker’ as a more descriptive name. It commented, however, that the term could be inadequate if the scope of authority of the traditional person responsible were broadened to other areas such as uncontentious accommodation decisions.

14.5.40 The Institute does not propose major revision to the definition of ‘person responsible’. It does, however, recommend reform to provide greater clarity to the definition and to reflect more contemporary concepts of family and relationships. The first recommendation is that the definition clarify what is to occur in situations where a patient has more than one spouse. Consistent with the Coroners Act 1995 (Tas),\textsuperscript{1324} it is suggested that the Act clarify that, where a person has more than one person fitting within the description of ‘spouse’, then it is the most recent spouse who is the person responsible. This reduces the risk of conflicting views or disputes.

\textsuperscript{1322} Human Tissue Act 1985 (Tas) ss 26(2)(a), s 3(1) definition of ‘senior available next of kin’.

\textsuperscript{1323} See Medical Treatment Planning and Decision Act 2016 (Vic), adopting the term ‘medical treatment decision-maker’.

\textsuperscript{1324} Coroners Act 1995 (Tas) s 3A(b).
14.5.41 The second proposal also creates greater alignment with the *Coroners Act 1995*, providing that the Act acknowledge and respect relationships recognised under Aboriginal customary law. This aligns with more contemporary Acts which recognise relationships existing under customary law.

14.5.42 The Institute has not made recommendations to revise the name ‘person responsible’, although is not opposed to that change. Apparent lack of awareness of the term or role may be improved through community education rather than legislative revision to the name. There is also a risk that reforming the title could be confusing for those stakeholders who are familiar with the term.

**Recommendation 14.4**

That the definitions of ‘person responsible’ in s 4 of the Act be revised as follows:

- to provide that, where there is more than one person falling within the definition of ‘spouse’ then it is the most recent person to qualify as the spouse who is the ‘spouse’ for the purposes of this section; and
- for the term ‘relative’ to include any person who is related to the person in accordance with customary law or tradition (including Aboriginal customary law or tradition).

**Other Eligibility Criteria?**

14.5.43 Currently, the Act only provides that a person is the person responsible if they rank highest in priority by virtue of their relationship to the patient. The Act does not require any subjective assessment of the person responsible’s relationship with the patient. Their suitability is not part of the test to be the person responsible in the way that a proposed guardian or administrator must satisfy the Board that they are suitable to act in order to be appointed to the role. By contrast, in Queensland, a person must be culturally appropriate to be a person responsible. In the ACT, a health professional can choose the person responsible that they believe is best able to represent the views of the person.

14.5.44 Similarly, the Act does not explain what ought to happen where a person, who would otherwise be the person responsible, declines to act, or is incapable of acting. In Victoria, Queensland, Western Australia and South Australia, the definition of ‘person responsible’ requires the person to be reasonably available and willing and able to act. As explained earlier in this Part, the definition of ‘senior next of kin’ under the *Coroners Act 1995 (Tas)* also requires the person to be available to act in that role.

14.5.45 In the Northern Territory, for a person responsible to be ‘willing and able’ to consent, they must have unimpaired decision-making capacity, be reasonable available, willing to make the decision, understand their obligations to act in accordance with the principles of the Act, have all the

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1325 Consistent with the Coroners Act: *Coroners Act 1995 (Tas)* s 3A(6).
1326 *Powers of Attorney Act 2000 (Qld)* s 63(1).
1327 *Guardianship and Management of Property Act 1991 (ACT)* s 32D(2).
1328 *Powers of Attorney Act 2000 (Qld)* s 63(1); *Guardianship and Administration Act 1990 (WA)* s 110ZD(2)(c); *Consent to Medical Treatment and Palliative Care Act 1995 (SA)* s 14(1); *Guardianship and Administration Act 1986 (Vic)* s 37(1). Equivalent requirements are imposed for medical treatment decisions makers: *Medical Treatment Planning and Decision Act 2016 (Vic)* ss 28(2), 55(1). The NSWLRRC has recently made the same recommendation. They also propose that the person is the person responsible only if they have not declined to make a decision: NSWLRRC, above n 24, Recommendation 10.18.
1329 *Coroners Act 1995 (Tas)* s 3A.
information needed, adequate time to consider that information, understand the effect of making the decision and must make the decision voluntarily and without undue influence.\textsuperscript{1330} In New South Wales, the Act provides that a person can decline in writing to act as a person responsible.\textsuperscript{1331}

14.5.46 In practice, if a third party (for example, a health practitioner or family member or friend) considers that the person is inappropriate to act in the role, then it is open to them to make an application to the Board for the appointment of a guardian. The OPG’s submission commented that they have observed that, in practice, treating practitioners may make an assessment as to who they consider most appropriate or ‘logical’ to provide consent.

14.5.47 The Institute asked for community response about whether a person responsible should have to meet any other criteria over and above their relationship to the patient.

| Should the Act provide any other test to be eligible to be a person responsible other than their relationship?\textsuperscript{1332} |

14.5.48 The Board submitted:

There are currently no provisions in the Act in respect of persons responsible:

- to ensure that they only make decisions if and when the person is incapable of doing so
- to require unimpaired decision making capacity
- to require recording or reporting to the Board about decisions made, or providing for the review of decisions
- to accept or refuse the decision making role should they become incapable of acting

The Northern Territory’s test of a person responsible being ‘able and willing to consent’ … sets out useful criteria for a person responsible’s suitability for the role.

For the sake of consistency and good practice, whatever test is adopted for a person responsible when deciding whether to consent to treatment, should be the same as the test imposed on a guardian and as far as possibly reflect the principles adopted across the jurisdictions to implement and meet international law obligations.

14.5.49 Social Work Services RHH also commented that persons responsible should need to meet similar tests to those applying to guardians. MIGA similarly endorsed additional criteria of persons responsible being reasonably available, willing and able to act in that role.

14.5.50 The OPG submitted:

A person responsible who has not been appointed by the Board or the individual themselves (e.g., under an enduring guardian appointment) should be required to have a close and continuing relationship with the individual such that they have an understanding of what the person’s wishes might be and can consider ‘best interests’ in a broader sense than purely medical.

\textsuperscript{1330} Advance Personal Planning Act 2016 (NT) s 43.
\textsuperscript{1331} Guardianship Act 1987 (NSW) s 33A(5)(a).
\textsuperscript{1332} TLRI, above n 69, Question 10.8(iii).
14.5.51 Both PCT and Carers Tasmania submitted that there should be flexibility to adequately address situations where a person who would otherwise be eligible to be the person responsible is deemed unsuitable, for example, in instances of domestic violence. PCT submitted that this could be achieved by enabling a person to appoint a substitute decision-maker in an ACD without having to undertake the formal process of appointing an enduring guardian.\footnote{Another submission\footnote{Dr Rick McAllister, Clinical Research Coordinator, Department of Critical Care Medicine, Royal Hobart Hospital.} made similar observations, commenting that there can be practical difficulties where a partner might be subject to a family violence order and restricted from visiting the patient. One submission commented that there may be no need for additional criteria to determine the eligibility of the person responsible if the list defining the person responsible were not expressed to be in any order of priority.} Another submission\footnote{Dr Rick McAllister, Clinical Research Coordinator, Department of Critical Care Medicine, Royal Hobart Hospital.} made similar observations, commenting that there can be practical difficulties where a partner might be subject to a family violence order and restricted from visiting the patient. One submission commented that there may be no need for additional criteria to determine the eligibility of the person responsible if the list defining the person responsible were not expressed to be in any order of priority.

14.5.52 Consistent with responses received and approaches in other jurisdictions, it is proposed that the Act contain additional criteria for individuals to meet to become a person responsible. The primary aim is to promote decision-makers being appropriate for the role. This acts as a safeguard and promotes the interests of the patient. It provides greater consistency with requirements for Board-appointed representatives who are assessed for suitability. It also facilitates the timely provision of consent where there might otherwise be delay in identifying and locating a person responsible.

14.5.53 The Institute endorses providing means for individuals to easily renounce from their otherwise default position as a person responsible. This was also discussed in Part 4, with Recommendation 4.15 proposing that the Act provide a simple method for enduring guardians to resign. As discussed in that part, this approach provides a quicker and more reliable method to identify a decision-maker. People should not feel that they have to accept the role, and there should be an easy way for them to communicate this to third parties.

**Recommendation 14.5**

(1) That the definition of ‘person responsible’ in s 4 of the Act require a person to:
- be reasonably available;
- have decision-making ability in relation to the particular matter;
- be willing to act; and
- be in a close and continuing relationship with the person.

(2) That the Act provide a simple, non-mandatory form for individuals to complete and register with the Board to indicate their refusal to act as person responsible.

14.5.54 The next question posed was, if eligibility is assessed based on criteria other than a person’s relationship to a patient, who should make that assessment. In Victoria, an eligible applicant may apply to the tribunal for an order dealing with the authority of a person to act as person responsible.\footnote{Medical Treatment Planning and Decision Act 2016 (Vic) ss 65, 66.} The tribunal may also make an order on its own motion. The Act enables the tribunal to declare that a person is not the person responsible\footnote{Ibid s 66(2).} and, if it does so, it may either affirm or set

\footnote{This alternative has been considered elsewhere in this report, see [5.5.40].}
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aside the person’s decision.\textsuperscript{1337} Similarly, in Western Australia, a person with a proper interest in the matter\textsuperscript{1338} may apply to the tribunal for a declaration as to the relevant decision-maker.\textsuperscript{1339} In Queensland, if there is a disagreement about who is the patient’s person responsible, and the disagreement cannot be resolved by the Public Guardian mediating the matter, then the Public Guardian may make a decision.\textsuperscript{1340} If the Public Guardian exercises this authority, then it must advise the tribunal, providing relevant information as prescribed.\textsuperscript{1341}

Who should assess whether a person responsible is ineligible or incapable of acting?\textsuperscript{1342}

14.5.55 Four submissions addressed this question. The OPG submitted that it ought to be the treating health practitioner seeking consent who should evaluate a person’s ability to act as the person responsible. MIGA also stated that it did not support any test upon the health profession to determine whether a person is ineligible or incapable of acting as person responsible. It commented that any disputes could be referred to the Public Guardian to mediate, and ultimately to the Board if required. Another submission also stated that this could be resolved by the Board.

14.5.56 The OPMHS submitted that the approach should be consistent with the approach to the assessment of a proposed represented person or represented person. It commented that there should be a presumption of capacity until there is evidence raising concerns. The OPMHS also submitted that:

\begin{quote}
It should also be possible to ask the Board for a review if it is felt that there is a possible conflict of interest and doubts about this influencing decisions of the PR, or if the PR does not appear to be acting in the represented person’s interest.
\end{quote}

14.5.57 It is proposed that the Act be revised to require a person to be available, willing and able to act as a person responsible.\textsuperscript{1343} Alternatives would be for either the Board or Public Guardian or the relevant treating health practitioner to make an assessment against this criteria. The Board and Public Guardian provide a level of independence and it is the Board who performs this role in evaluating the suitability of representatives for personal or financial matters. On the other hand, health practitioners are experienced in making assessments about a person’s ability to give consent to health care and treatment. If a treating health practitioner does not consider that a patient has the ability to give consent to a particular treatment, then they defer to the patient’s person responsible to seek that consent. This process does not require the Board or Public Guardian’s involvement. If a health practitioner were required to obtain the Board or Public Guardians’ determination about the person responsible’s ability to act in the role, then this raises the question of whether the Board or Public Guardian should be involved in making the initial determination about the patient’s ability to themselves consent. This would impact the efficiency and effectiveness of the system and likely risk negative health outcomes for patients. On this basis, the Institute does not propose that any different situation apply to assessing an individual’s ability to act as a person responsible.

\textsuperscript{1337} Ibid s 66(3).
\textsuperscript{1338} Guardianship and Administration Act 1990 (WA) s 110ZM.
\textsuperscript{1339} Ibid s 110ZN.
\textsuperscript{1340} Guardianship and Administration Act 2000 (Qld) s 42.
\textsuperscript{1341} Ibid s 42(2).
\textsuperscript{1342} TLRI, above n 69, Question 10.8(iv).
\textsuperscript{1343} Recommendation 14.5(1).
14.5.58 It is proposed, however, that the Board have jurisdiction to make an order in relation to who is a patient’s person responsible if a dispute cannot be resolved by more informal means. This enables the Board to declare who a patient’s person responsible is, without having to appoint a guardian who would then, under the current model, have authority to consent to health care and treatment as the person responsible.

**Recommendation 14.6**

That the Board be able to make a declaration about the authority of a person to act as another person’s person responsible upon application from an interested party, or of its own motion.

### 14.6 Admission or detention of patients within secure facilities

14.6.1 The Terms of Reference asked the Institute to address the question of how long-term or indefinite medical treatment in institutional and non-institutional settings should be dealt with. Some patients admitted to secure treatment and care facilities are admitted under the *Mental Health Act*. Other patients fall within the Act’s jurisdiction where they are unable to give their own consent to admission for reasons other than mental illness.

14.6.2 There is debate about whether a person responsible can consent, or should be able to consent, to a patient’s admission to a secure facility. The Public Guardian reports that it is the practice of the THS to apply to the Board for the emergency appointment of a guardian to consent to the admission of patients at the Roy Fagan Centre (RFC) who do not fall under the *Mental Health Act*. The Institute understands that this approach is adopted on the basis that a person responsible is not appointed to the role, but is appointed ‘by default’, by virtue of their relationship to the patient. Their suitability or otherwise is not assessed and their decisions are not ordinarily subject to the Board’s oversight in the way that a guardian is appointed and supervised. There is no review or appeal mechanism for the decisions of a person responsible and they may have conflicting interests. The Institute notes that some of these matters have been considered elsewhere in this Report, with recommendations made for reform. Notably, this includes proposals requiring persons responsible to have a close and continuing relationship with the person, and that they be willing, able and available to act, as discussed earlier in this Part.\(^{1347}\)

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\(^{1344}\) The Roy Fagan Centre is a secure treatment and care facilities for older persons with dementia, cognitive disabilities and mental health issues.

\(^{1345}\) OPG, above n 1299, 5.

\(^{1346}\) Anita Smith, former President of the Board, has commented that: ‘The practice at the Roy Fagan Centre reflects national, if not world’s, best practice because it (a) recognises the residents as being ‘subjects of rights’ rather than ‘objects of care’, (b) provides a clear source of lawful authority for the detention of all residents, (c) gives an opportunity for external scrutiny of the decision to detain, (d) gives the resident and their families and friends an opportunity to attend a hearing to put their perspective regarding the detention and (e) sets in place an automatic system for review and monitoring by an external person or agency regarding the ongoing detention of people with dementia. In other words, it does not take advantage of the residents’ lack of understanding of their detention and it does not ‘take the risk’ that no-one will complain. The practice of the Roy Fagan Centre is highly consistent with criminal, civil and human rights laws.’: Anita Smith, *Detention of people with dementia in secure facilities in State care in Tasmania*, Guardianship and Administration Board, 4 <https://www.guardianship.tas.gov.au/__data/assets/pdf_file/0009/203967/Detention_of_people_with_dementia_in_secure_facilities.doc_-_Updated_31.8.17.pdf>.

\(^{1347}\) See Recommendation 14.5.
14.6.3 Responses to the Issues Paper suggest that differing views are influenced by whether admission within a secure facility is considered an ‘admission’ like any other admission of a patient to a place for medical treatment, or whether it is viewed as ‘detention’. On one hand, some consider the ‘admission’ of a patient within a secure facility to be incidental to the treatment itself, and so closely linked that both matters should fall under the single banner. It was also viewed as an admission where the patient is indicating their willingness to be admitted, or at least not expressing their objection. On the other hand, some viewed the admission of a patient within a secure facility as a deprivation of that person’s liberty and that their lack of objection does not necessarily indicate their consent. Applying that perspective, the admission within a secure facility was described as ‘detention’ rather than an ‘admission’. Given the impact of detention upon a person’s human rights, some submitted that it is appropriate that there be safeguards to protect and promote the person’s interests, including having that decision subject to monitoring and review.

14.6.4 The OPG’s submission explained:

It seems the purpose of the admission is construed as not being primarily for medical treatment, but rather assessment, monitoring and management. In addition, it seems there are concerns that any admission is deemed to be ‘detention’ — regardless of the views of the patient, whether or not they are objecting, and whether the patient is deemed safe to take leave from the facility — due to the RFC being a secure facility.

14.6.5 The OPMHS’s submission demonstrates its contrary view:

To call the detention component of management ‘treatment’ is inaccurate and misleading. It is often not done purely for the best interests of the RP [represented person] (e.g. it may be for the safety of others), and by definition it is never done for the Will and Preference for the RP.

14.6.6 Currently, issues arise particularly where an urgent appointment of a guardian is required pursuant to an emergency order. Only the Public Guardian can be appointed as guardian under an emergency order. If the Public Guardian is appointed as a patient’s guardian, the Public Guardian then becomes the person responsible by virtue of that appointment. It is immaterial whether the Public Guardian has only been appointed for limited purposes, for example, to restrict visits on behalf of the represented person.

14.6.7 This Report does not propose any change to who can be appointed under an emergency order, specifically to extend those eligible for appointment to private representatives. It is, however, proposed that a guardian only be a person’s person responsible if they have been granted specific powers in relation to health care and treatment matters. This would resolve the current issue of the Public Guardian’s appointment as guardian under an emergency order having the automatic effect of overriding any otherwise prior right of a family member or close friend to act as the represented person’s person responsible.

14.6.8 Coroner McTaggart has recently recommended that the RFC implement a written policy and system to ensure that persons admitted to RFC who are incapable of giving informed consent to

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1348 Guardianship and Administration Act 1995 (Tas) s 65. See [15.3].
1349 See Part 8.
1350 See discussion at [14.5.21].
1351 See discussion at [15.5.30].
1352 See Recommendation 14.3.
their admission, residency and/or treatment at RFC are identified and only admitted, treated and/or continue residence with the substitute consent of a guardian, or pursuant to a power or order under the *Mental Health Act*.\textsuperscript{1353} Coroner McTaggart commented that:

it has been recognised that there are reasons against voluntary admission, particularly where capacity for informed consent is doubtful. These include: the potential for patient coercion and abuse, fewer opportunities for discharge, the patient’s lack of access to legal advice, a lack of legal process or determination; and the patient is not free to leave.

14.6.9 Coroner McTaggart expressed concern that, in the absence of an appointed guardian, admission was ‘unchecked, not scrutinised by a legal guardian and not subject to the formal processes of the law or amenable to challenge.’

14.6.10 The Issues Paper outlined a range of options that could be considered to deal with the giving of substitute consent to the admission of a patient in a secure facility. These included:

- **Consent only permitted by a Guardian**: requiring an application to the Board for it to appoint a guardian (in circumstances where the person does not have an enduring guardian). This would involve the Act providing that consent in these circumstances falls outside of the scope of a person responsible’s powers;

- **Consent permitted by a person responsible, unless the patient is objecting**: providing that a person responsible can consent so long as the patient is not objecting. If a patient indicates their objection, then consent would fall outside of the authority of the person responsible and the appointment of a guardian would be required;

- **Consent permitted by a person responsible, but with that consent able to be appealed**: giving power to persons responsible to consent to admission, with that decision able to be appealed in certain circumstances. This was the recommendation of the VLRC which recommended that the restriction upon the liberty of a person in a supported residential care facility require the approval of all three of: the person in charge of the facility, the medical practitioner and the substitute decision-maker.\textsuperscript{1354} If the patient is consistently resisting or opposing the restriction, then an application should be made to the tribunal to consent.\textsuperscript{1355} It proposed that the person, or someone concerned for their welfare, should be able to apply to the tribunal or Public Guardian for a review of the decision to consent\textsuperscript{1356} and that a consent be able to last for a maximum of 12 months before review;\textsuperscript{1357} or

- **Consent only by the Board**: reserving power to consent to detention as a matter for the Board. This is the effectively the approach in South Australia.\textsuperscript{1358}

14.6.11 In South Australia, a separate section is included within guardianship legislation dealing with how a patient may be detained within a secure facility.\textsuperscript{1359} In broad terms, this section enables a

\textsuperscript{1354} VLRC, above n 24, Recommendation 241.
\textsuperscript{1355} Ibid Recommendation 252.
\textsuperscript{1356} Ibid Recommendation 253.
\textsuperscript{1357} Ibid Recommendation 254, for its rationales, see Chapter 15, 318–348.
\textsuperscript{1358} *Guardianship and Administration Act 1993* (SA) s 32.
\textsuperscript{1359} Ibid.
14.6.12 Noting these options, the Institute asked for stakeholders’ views about who should have power to consent to the admission of patients to secure treatment facilities.

Who should be able to consent to the admission of patients to secure treatment and care facilities where the provisions of the Mental Health Act do not apply?\[1364\]

14.6.13 There were five submissions that addressed this question. One respondent submitted that these decisions should be referred to the Board. The OPMHS and Social Work Services RHH supported the position that it should only be an appointed guardian that is able to consent. The OPMHS confirmed that, where a patient does not have an existing guardian, it makes application to the Board for the appointment of a guardian to provide consent to the admission of a patient at the RFC. It commented that state-run facilities can have a conflict of interest in these situations:

One salient point in this debate is the need for independent oversight and safeguards for patients at the facility. Oakden\[1365\] in South Australia is an exemplar of failure of oversight ultimately leading to poor care.

It went on to comment:

facilities have conflict of interest in providing adequate care. Care is expensive, and in limited budgets, decisions are not necessarily made with the Best Interests or Will and Preferences of those in the care as the only priority … It would be a folly to believe that a state run facility would always simply ‘do the right thing’. Underpinning all of this, it is extremely easy for elderly or impaired people to be neglected, and psychiatry has a poor history in terms of self-regulation.

14.6.14 The OPMHS did not agree that whether a patient is objecting is an adequate measure of whether safeguards are required:

objection to detention is not an appropriate measure of the safeguards required. A Persons capacity to object is commonly impaired by their disability, for example due to aphasia, inertia, impulsivity, memory impairment, and emotional lability.

14.6.15 Social Work Services RHH made similar comments:

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1360 The section enables an application under the relevant section to be heard at the same time as an application for the appointment of a guardian: ibid s 32(1a).
1361 Other than a correctional institution or other place in which persons charged with or convicted of offences may be detained or any part of an approved treatment centre under the Mental Health Act: ibid s 32(3).
1362 Ibid s 32(2).
1363 Ibid s 32(5).
1364 TLRI, above n 69, Question 10.19.
We need to ensure people’s rights are protected and their detention of a person against their will is weighed up against what is in their best interests. Depriving a person’s liberty and autonomy (detention) is serious and deserves clear and explicit consideration, from a human rights point of view. Many patients of secure facilities also fluctuate a lot in their views, often agreeable one day and demanding to leave the next. For some patients they are unable to express their objection to detention due to communication difficulties (e.g. aphasia), fluctuating mood, impulsiveness, inertia or other reasons.

14.6.16 The OPMHS submitted that persons responsible might not necessarily be appropriate to act and may not act in a patient’s best interests, particularly if there are conflicting interests:

Detention has various implications, including financial, and there can be inherent conflicts of interest when such a decision is made by someone who would ordinarily be a Person Responsible (for example financial implications of a person leaving their house, social implications of not having to provide care, interpersonal conflict between the RP and the PR [person responsible]).

Identifying a suitable Person Responsible is fraught with difficulties, such as conflicts of interests, elder abuse, family conflict, and frequently the emotional distress in the circumstances (e.g. anticipatory grief, i.e. anger, guilt, denial) of the Person Responsible which impairs their decision-making.

14.6.17 It noted, however, that sometimes a person responsible might be the most appropriate person to make decisions about a patient’s admission to a secure facility:

Counter to these arguments, a Person responsible is often best equipped to make decisions on behalf of the Represented Person. To ensure the human rights of the RP are maintained, if a PR were to make decisions on detention, there would need to be a mechanism for review of a Represented Person’s detention, and the adequacy of the facilities and care provided. Such a mechanism would need to be independent of both the facility in which the person is detained, and the Person Responsible.

14.6.18 The Board did not put forward an explicit position about who should provide consent in these circumstances, but observed that under any model, there must be appropriate safeguards to protect the rights and interests of the patient and that currently, consent by a person responsible does not afford those safeguards. It noted obligations under the Convention in relation to deprivation of a person’s liberty:

The Board notes that Article 14 of the UN Convention requires that people with disabilities are:

‘not deprived of their liberty unlawfully or arbitrarily, and that any deprivation of liberty is in conformity with the law, and that the existence of a disability shall in no case justify a deprivation of liberty.’

Article 14 requires that if persons with disabilities are deprived of their liberty through any process, other human rights protections will also apply …

The Board would support clarification in the Act, consistent with international obligations, to ensure adequate safeguards for people who are subject to detention in a secure facility and unable to consent to admission to such a facility, exist.

Irrespective of who is authorised to make such a decision, the Board is concerned to ensure that any decision which involves the detention of a person in a secure facility, whether against their will or otherwise, should be subject to external scrutiny and review.
That would not be the case if the decision were made by a person responsible as part of a treatment consent.

14.6.19 The Board noted, in contrast to the Act, the safeguards contained within the Mental Health Act in relation to the detention of patients:

- clear lawful authority for the detention of patients exists under the Mental Health Act 2013 (Tas). The Mental Health Act 2013 (Tas) provides that a person who does not have capacity to consent can only be detained in a facility by virtue of an assessment order or treatment order, which is subject to regular review by the Tribunal. The Mental Health Act 2013 (Tas) also provides for a formal avenue for complaints and review, through the Official Visitor scheme. It is noted that persons detained in a secure unit who are not subject to the Mental Health Act 2013 (Tas), are not subject to the scrutiny of the Official Visitor complaints scheme or any other complaint scheme.

It endorsed consistency between the Act and the Mental Health Act in relation to detention of patients:

As detention constitutes a fundamental abrogation of rights, it is important that there be best practice and consistency across Tasmanian legislation and throughout Australia. Terminology consistent, as far as possible, with the Mental Health Act 2013 (Tas) is desirable, where explicit reference is made to detention in assessment and treatment orders.

14.6.20 The OPMHS also endorsed the approach under the Mental Health Act:

Those detained under the MHA have extensive safeguards, with MHT reviews, OVS [official visitor scheme], and formal avenues for complaints and review … By removing the presence of a formally appointed substitute decision-maker in detention, the care of those under the GAA would have nothing like those protections. There would be no professional or independent review of their care, which introduces a double standard in the safeguards for detention between the MHA and GAA.

14.6.21 The Board also endorsed the approach in South Australia, commenting that ‘South Australia’s guardianship legislation dignifies the subject of detention with a separate heading setting out special powers to place and detain a person.’

14.6.22 The OPG submitted that consent ought to be permitted by a person responsible where the patient does not object to their admission. This was supported on the basis that it is consistent with the patient’s will and preferences and in their best interests as it enables family members with an existing relationship to the person to make this decision, rather than decision-making being taken away from family. The OPG stated:

The current practice in relation to RFC admissions is particularly concerning as the application for a guardianship order is generally made in ‘urgent’ circumstances requiring the Public Guardian to be appointed under the emergency provisions. This effectively displaces the role of family members, who until the point of transfer to the RFC have been providing consent to other in-patient treatment (often in other locked wards) and find, suddenly, that their authority is no longer accepted. This unreasonably and unnecessarily adds to their anguish and distress in an already stressful situation.

The practice of guardianship appointments being made when a person responsible is able to consent to these admissions is inconsistent with the principles underpinning the Act: it is not the least restrictive alternative; does not serve the best interests of the person, adding to both the represented person’s and their family’s distress and anguish; and is
commonly inconsistent with the wishes of the represented person (many or most of whom would prefer family members to support or make decisions on their behalf, and many of whom object to the sudden appointment of a complete stranger to make substitute decisions) …

The OPG considers that additional oversight and safeguards are required if restraint or force is required to convey the person to or keep them in the facility. The OPG does not contend that the consent of the person responsible alone should be sufficient to authorise substantial or ongoing restraint.

The Institute’s view

14.6.23 The Institute considers that only a guardian or the Board should be permitted to consent to the detention of a patient on the basis that it safeguards the rights and interests of the patient.

14.6.24 The right to liberty of movement and freedom to choose one’s residence is enshrined in the *International Covenant on Civil and Political Rights*.\(^\text{1366}\) The Convention Committee states that

> Liberty of movement, an adequate standard of living as well as the ability to understand and have one’s preferences, choices and decisions understood, form indispensable conditions for human dignity and the free development of a person.\(^\text{1367}\)

14.6.25 Article 18 of the Convention confirms the right to liberty of movement.\(^\text{1368}\) Article 14 confirms the equal rights of people with disability to liberty and security of the person.\(^\text{1369}\)

14.6.26 An article by former President of the Board, Anita Smith, published on the Board’s website, notes:

> Because of the importance of human liberty, the deprivation of a person’s liberty without lawful authority is an assault under criminal law and in civil law …

> As with all assaults, it is usually a defence to a charge of deprivation of liberty that such an act took place with the consent of the complainant/plaintiff. Where a person lacks capacity to understand the circumstances of their deprivation of liberty because of a disability, such as dementia, it is not a defence to say that the person consented, as the quality of their consent is impaired. Similarly, acquiescence of a person without capacity to understand what they are acquiescing to is also no defence.\(^\text{1370}\)

14.6.27 The Institute observes the following obligations under the Convention\(^\text{1371}\) that require interventions for people requiring decision-making support to:

- be free of conflict of interest – as the OPMHS commented, family members may have conflicting interests in relation to the admission of a patient within a secure facility.

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\(^\text{1366}\) *International Covenant on Civil and Political Rights* art 12.

\(^\text{1367}\) Committee on the Rights of Persons with Disabilities, General Comment No. 5; General comment on article 19: Living independently and being included in the community, UN Doc CRPD/C/18/1 (29 August 2017) [9].

\(^\text{1368}\) *Convention on the Rights of Persons with Disabilities* art 18.

\(^\text{1369}\) Ibid art 14.

\(^\text{1370}\) Smith, above n 1346, 2.

\(^\text{1371}\) *Convention on the Rights of Persons with Disabilities* art 12(3).
Conflicts of interest are assessed in relation to the appointment of a guardian. The Board is also an independent body absent conflicting interests;

- be proportional and tailored and operate for as short a time as possible – the extended detention of a patient within a secure facility for an unlimited period and without review may not be proportional to the intervention necessary to promote the individual’s health and wellbeing. The Institute proposes that the Act require consent to detention to be time limited, and subject to review and appeal; and

- be subject to regular review – a person responsible’s consent to a patient’s detention within a secure facility is not subject to periodic review. Instead, it requires an interested party to make an application to the Board for the appointment of a guardian if they are concerned. A person requiring decision-making support may not have access to support to understand their rights and the role of the Board in this regard.

The Institute proposes that approvals for a patient’s admission to be time limited and subject to regular review and appeal.

14.6.28 One concern raised by the OPG was that the appointment of a guardian results in that guardian being the person responsible with power to consent to all medical and dental treatment. This means that, if an emergency guardianship order is made for the urgent admission of a patient to the RFC, the Public Guardian becomes the patient’s person responsible by default. Recommendation 14.3 partly resolves this issue by proposing that a guardian is only a patient’s person responsible if they have been given specific powers in relation to consent to health care and treatment.

14.6.29 The Institute agrees with the Board’s suggestion that, like South Australia, the Act provide a separate section dealing with detention.

14.6.30 The Board’s submission commented that it would be useful for the Act to clarify whether the relevant decision-maker is able to, or should, take into account the potential for risk to another person. Currently the Act requires only consideration of the patient’s best interests. Conversely, the Mental Health Act enables decisions about assessment and treatment orders to take into account the safety of others. As discussed in Part 11, it is proposed that the Act provide consistency with the Mental Health Act, enabling decision-makers to take into account the risk of harm to the patient, or another person.

An Official Visitor Scheme

14.6.31 Part 14 of the Issues Paper considered the interaction between the Act and other legislation, including the Mental Health Act. A variation identified was that the Mental Health Act establishes an Official Visitor Scheme in relation to approved facilities and the secure mental health unit at Risdon, whilst there is no Official Visitors Scheme under the Act.

1372 See [12.8].
1373 Guardianship and Administration Act 1995 (Tas) ss 27(1), 57(1), 43(1)(b), 45(1)(c), 6.
1374 Mental Health Act 2013 (Tas) ss 25(b)(ii), 40(b)(ii).
1375 See Recommendation 11.2 and discussion at [11.4.31].
1376 Mental Health Act 2013 (Tas) ss 156, 157.
14.6.32 Official Visitor Schemes involve the appointment of members of the community who visit approved facilities and prisons to check how people are being treated. Their role is to make enquiries, review the adequacy and quality of facilities and receive and investigate complaints. This acts as a safeguard to oversee the promotion of a patient’s rights and interests.

14.6.33 Under the Mental Health Act, a principal official visitor is appointed whose functions include:

- to arrange for Official Visitors to visit approved facilities and any premises from which patients are provided with services under the Mental Health Act;
- to receive complaints from (or concerning) patients, including complaints referred to the Principal Official Visitor by Official Visitors;
- to assess and conduct preliminary inquiries into complaints received from (or concerning) patients, including complaints referred to the Principal Official Visitor by Official Visitors;
- to refer suspected contraventions of the Mental Health Act, or other matters that may require investigation, to the Health Complaints Commissioner or Ombudsman;
- to promote, amongst patients and administrators and in other relevant quarters, an awareness of Official Visitors and their role;
- to report on suspected contraventions of the Mental Health Act or standing orders or clinical guidelines;
- to report on the extent to which the objects of the Mental Health Act and the mental health service delivery principles are being met;
- to raise with the Minister for Health or relevant Chief Psychiatrist any matters of particular concern that come to the Principal Official Visitor’s attention; and
- any functions conferred upon it under the Mental Health Act or any other Act.

14.6.34 The prescribed functions of Official Visitors are then:

- to visit approved facilities and premises from which patients are provided with services under the Mental Health Act;
- to receive complaints from (or concerning) patients;
- to refer complaints received from (or concerning) patients to the Principal Official Visitor;
- to report suspected contraventions of the Act, or other matters that may require investigation, to the Principal Official Visitor;
- to check that patients are being informed of and accorded their rights;
- to monitor the adequacy and quality of approved facilities, with particular regard to the recreational, occupational, training and rehabilitation facilities available to patients;

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1377 Ibid s 155.
1378 Ibid s 156.
• to raise with the Principal Official Visitor any matters of particular concern that come to the Official Visitor’s attention; and
• to perform such other functions as are conferred under the Mental Health Act or any other Act.\textsuperscript{1379}

14.6.35 Official visitors are required to visit approved facilities at least once a month.\textsuperscript{1380} They have power to do all things necessary and convenient to discharge their role.\textsuperscript{1381} All individuals with responsibilities under the Mental Health Act are required to help people to make complaints, including having to notify an Official Visitor within 24 hours if a patient expresses a wish to see them, or make a complaint.\textsuperscript{1382}

14.6.36 Prison Official Visitors are also created under the Corrections Act.\textsuperscript{1383} The Senior Practitioner has a similar role of investigation of funded disability providers under the Disability Services Act.\textsuperscript{1384} The recent report following review of the Disability Services Act comments that stakeholder feedback indicated that ‘the absence of a community or authorised visitors scheme was regarded as a significant omission to ensure compliance under the Act.’\textsuperscript{1385}

14.6.37 Official/Community Visitor schemes are endorsed by the Australian Human Rights Commission (‘the Commission’) as providing an effective safeguard to protect the rights and interests of people with disability in institutional settings to ‘identify issues of concern and bring these to the attention of government and other oversight agencies.’\textsuperscript{1386} It has stated that, in the context of people with intellectual disability, ‘it may be difficult for people to self-advocate in instances of violence, abuse and neglect without the support of an independent oversight mechanism such as community visitors.’\textsuperscript{1387} Smith and Rigby also endorse consideration being given to adopting official visitor schemes in the guardianship jurisdiction, commenting that ‘it has always been recognized that people with disabilities may be inhibited from taking a complaint by their disabilities or by their dependence upon the agencies about whom they might complain.’\textsuperscript{1388}

14.6.38 At the time of writing, the Commission is consulting on how to execute Australia’s obligations following ratification of the OPCAT in December 2017.\textsuperscript{1389} The Commission describes the OPCAT as ‘an international human rights treaty that aims to prevent ill-treatment in places of

\begin{footnotes}
\item \textsuperscript{1379} Ibid s 157.
\item \textsuperscript{1380} Ibid s 160(1).
\item \textsuperscript{1381} Ibid s 159.
\item \textsuperscript{1382} Ibid s 163.
\item \textsuperscript{1383} Corrections Act 1997 (Tas) s 10.
\item \textsuperscript{1384} Disability Services Act 2011 (Tas) s 46. The NDIS Safeguarding Framework provides that there will be an evaluation of the use of community visitor programs considered by the Disability Reform Council in relation to their use under the NDIS: Department of Social Services, Government of Australia, NDIS Quality and Safeguarding Framework (9 December 2016) <https://www.dss.gov.au/sites/default/files/documents/04_2017/ndis_quality_and_safeguarding_framework_final.pdf>.
\item \textsuperscript{1385} Review of the Disability Services Act 2011, above n 106, 19.
\item \textsuperscript{1386} Australian Human Rights Commission, above n 60, 39, 52.
\item \textsuperscript{1387} Ibid 53.
\item \textsuperscript{1388} Smith and Rigby, above n 433, 188.
\end{footnotes}
detention through the establishment of a preventive-based inspection mechanism.’ It requires State parties that have ratified the OPCAT to ‘introduce a system of regular inspections to all places where people are deprived of their liberty in order to prevent torture and other cruel, inhuman or degrading treatment or punishment.’\textsuperscript{1390} It requires places of detention to be monitored through a National Preventative Mechanism (NPM) — a domestic entity or network responsible for conducting inspections and oversight of places where people are detained.\textsuperscript{1391} The Commission notes that:

The Australian Government has already indicated that the implementation of OPCAT in Australia will focus on ‘primary’ places of detention, such as prisons, juvenile detention, police cells and immigration facilities, noting that these environments pose the most ‘acute’ challenges for people deprived of their liberty.\textsuperscript{1392}

It is unclear the extent to which the implementation plan may address other contexts, including residential care facilities, hospitals, aged care facilities and secure mental health units.\textsuperscript{1393} Some stakeholders have submitted that these environments ought to be covered by OPCAT.\textsuperscript{1394} The Commission commented that: ‘Some of the more acute human rights issues arise in environments that are not traditionally considered a “primary” place of detention.’\textsuperscript{1395}

14.6.39 The Issues Paper commented that it may be useful to extend operation of an Official Visitor Scheme to those individuals without decision-making ability to consent to their own admission within a secure facility outside of the Mental Health Act.

14.6.40 The Issues Paper enquired about the level of support for this reform.

\begin{table}[h]
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\textbf{Is there merit in establishing an Official Visitor scheme for individuals without decision-making capacity who are admitted to secure facilities outside of the Mental Health Act 2013?}\textsuperscript{1396} \\
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14.6.41 There were nine responses to this question with all indicating support or strong support for introduction of an Official Visitor Scheme under the Act, with the exception of the Public Trustee which submitted that it held no view. Comments made in support of this reform included:

It is envisaged that Official Visitors can have an important oversight role receiving complaints; checking a represented person is being informed and accorded their rights; monitoring the quality and adequacy of approved facilities and the care provided; and ensuring guardians and administrators are acting within the powers of the Order. This type of oversight is very important to ensure the rights of frail or vulnerable people in aged care, mental health and the disability facilities are upheld, particularly in light of the recent Independent Commissioner against Corruption’s report into Oakden, Older Persons Mental Health Services in South Australia.\textsuperscript{1397}

We see the current lack of official visitors, other than for mental health facilities, as a significant gap in Tasmania’s safeguarding framework.

\begin{thebibliography}{99}
\bibitem{1390} Ibid 18.
\bibitem{1391} Ibid 19.
\bibitem{1392} Ibid 33.
\bibitem{1393} Ibid 33–34.
\bibitem{1394} Ibid 34.
\bibitem{1395} Ibid.
\bibitem{1396} TLRI, above n 69, Question 14.2.
\bibitem{1397} The Board.
\end{thebibliography}
An official (or community) visiting scheme is an important element in the protection of the rights of people with a disability and should enable enquiries and inspections of group homes and other supported residential facilities, to ensure compliance with the relevant standards, that care and support is provided in a way that respects the dignity and autonomy of the residents, to identify any issues of concern, and for both individual and systemic advocacy.¹³⁹⁸

Official Visitor programs have the potential to provide important safeguards for vulnerable people living in supported accommodation and other congregate-care or restrictive environments. …

They provide a particularly important avenue for safeguarding the rights of those with impaired capacity that may have difficulty making complaint or raising concerns.¹³⁹⁹

14.6.42 The OPMHS submitted:

Those with dementia are no less vulnerable than those with mental illness, and in many ways are more vulnerable due to cognitive impairment and their inability to raise objection, and, typically, physical frailty. This would provide some meaningful safeguard for instances where the facility is not properly resourced or where care has not been adequate.

Such a system would need to be tailored provide meaningful oversight, for example it should not respond only to those individuals who are objecting.

Dementia impairs a Person’s ability to object. Aphasia and inertia and memory impairment are three impairments which may prevent objection. Memory impairment, impulsivity, paranoia, and emotional instability are examples of impairments which can lead to spurious objections. In such situation, it is possible for a person who has grounds to object not being heard, while a person who may incessantly object when there is no remedy, being heard.

A system of oversight would need to review the whole facility and the care provided.

14.6.43 Social Work Services RHH also commented about some of the functions that an Official Visitor could serve:

They could be asking the questions does the person continue to lack capacity, need secure facility care, is there a least restrictive care environment and act as a safeguards to oversee the promotion of a patient’s rights and interests.

It also commented that:

When people move to secure residential aged care there should be a mandated review to ensure they still require that level of restriction of freedom.

14.6.44 The OPMHS commented that the use of an Official Visitor Scheme would be ‘absolutely critical’ if persons responsible were able to consent to a patient’s detention.

14.6.45 Consistent with responses received, the Institute considers that there is merit to extending the use of Official Visitors to those admitted to/detained within secure facilities pursuant to the Act. This provides an effective means of protecting and promoting the rights and interests of patients.

¹³⁹⁸ OPG.
¹³⁹⁹ EOT.
This scheme may have particular benefits for individuals who are socially isolated and may not have others within their social network to observe and raise issues or concerns. It also provides a method of supporting a patient to exercise and pursue their legal rights and express their views and wishes.

14.6.46 The Institute recommends that, consistent with the Mental Health Act, facilities also be required to provide patients with a statement of rights to promote awareness and understanding. This approach is consistent with the recent recommendations of the Commission, which commented that quality, safeguarding and oversight systems ‘raise awareness and capability of people with disability to understand their rights, what constitutes violence, abuse and neglect, and how to raise concerns, report violence and seek help.’

14.6.47 Work to progress implementation of Australia’s obligations under OPCAT are continuing and there is the potential for the role of NPMs under that framework to extend to monitoring and overseeing detention within hospital settings, secure mental health facilities and residential care facilities. The use of an Official Visitor Scheme under the Act will need to be monitored and further reviewed following decisions being made about these matters.

**Recommendation 14.7**

(1) That the Act contain a separate section dealing with the consent to the admission and, if necessary, detention of a patient within a secure unit where the patient does not have decision-making ability to give their own consent where the provisions of the Mental Health Act 2013 (Tas) do not apply.

(2) That the term ‘secure unit’ be defined to:

(i) exclude places of detention covered by the Corrections Act 1997 (Tas) and any approved secure health units governed by the Mental Health Act 2013 (Tas); and

(ii) include facilities as listed in the Regulations.

That the Regulations include the Roy Fagan Centre as a secure unit.

(3) That consent to the admission and, if necessary, detention of a patient without decision-making ability within a secure unit fall outside of the scope of a person responsible’s authority.

(4) That the section contain the following elements:

- that only the Board or a guardian with specific authority be permitted to consent to the admission or detention of a patient within a secure unit;
- enabling the Board to appoint a guardian with authority to consent to the admission or detention of a patient within a secure unit, including the temporary appointment of the Public Guardian in urgent circumstances;
- requiring guardians’ decisions to consent to the admission or detention of a patient within a secure unit to be subject to periodic review by the Board;
- confirming that an application can be made to the Board for the review of a decision to consent to the admission or detention of a patient within a secure unit;

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1400 Mental Health Act 2013 (Tas) s 129.
1401 Australian Human Rights Commission, above n 60, 40.
Part 14: Safeguards for Consent to Health Care and Treatment

• enabling the Board to conduct ‘own motion’ reviews of the substitute consent to the admission or detention of a patient within a secure unit;

• confirming a patient’s rights, consistent with s 63 of the Mental Health Act 2013 (Tas). Key components include (but are not limited to):
  ◦ the right to have contact with, and to correspond privately with, his or her guardian, supporter, lawyer, or any other person nominated by the patient to represent their interests; and
  ◦ the right to have contact with, and to correspond privately with, Official Visitors; and

• requiring secure units to provide patients with a statement of rights, consistent with s 129 of the Mental Health Act 2013 (Tas).

(5) That the Mental Health Act 2013 (Tas) Official Visitors Scheme be extended to the Act subject to any specific adjustments required to meet the needs of the Act.

14.7 Offences

14.7.1 The Act provides offences where treatment is performed without lawful consent, and where consent is purported to be given by a person who does not have power to consent. Where a person carries out special treatment without consent, then they are guilty of a crime under the Criminal Code. Where a person carries out any other treatment without valid consent where consent is required, then they are guilty of an offence. A period of one year imprisonment may be imposed, or a fine, or both. A person who purports to give consent, or represents to a registered practitioner that they have the power to consent, is guilty of an offence. A fine may be imposed.

14.7.2 The Issues Paper asked what the consequences should be for individuals who breach the Act in relation to consent to treatment.

What should the consequences be for breaches of the Act in relation to consent to treatment?

14.7.3 Five respondents addressed this question. Both MIGA and the OPG commented that they observed that the existing provisions in the Act are rarely used. MIGA submitted that ‘this of itself raises issues as to its utility and appropriateness.’ MIGA did not support the Act containing discrete consequences for breaches of its provisions. It commented that breaches can be dealt with under other laws, including the Health Practitioner Regulation National Law and through civil damages claims. It also commented that:

MIGA opposes what is effectively a strict liability provision under s 38 of the Act providing that provision of medical treatment which does not follow the Act’s requirements exposes the provider to criminal penalty …

The provisions in s 38 of the Act are inappropriate, unnecessary and should be removed.

1402 Criminal Code 1924 (Tas) s 38(2).
1403 Ibid s 38(3).
1404 Ibid s 42.
1405 TLRI, above n 69, Question 11.4.
14.7.4 One respondent commented that fines and potential imprisonment should be available as potential consequences. Two submissions commented that there could be criminal offences imposed.

14.7.5 One respondent commented that guardians should need to prove their authority to give consent prior to doing so. The OPG submitted as follows:

   The OPG has concerns that treatment without consent is widespread in situations where the person is not objecting but there is a person responsible available to provide substitute consent. We know this to be the case for persons who are under the guardianship of the Public Guardian: it is not uncommon for the delegated guardian to discover by chance that a represented person’s medication has been changed without any consultation, let alone formal consent. We hear, anecdotally, that family members in the role of person responsible are even more likely to be overlooked. The Act should clearly state the requirement for medical and other health practitioners to document the consent and source of consent.

   It is considered that existing professional obligations address the need for health practitioners to document consent given to perform health care and treatment.

14.7.6 In summary, only one response objected to the existing approach in the Act, whilst two endorsed criminal and civil penalties being available, implicitly endorsing the current approach. The Institute does not make recommendations for reform to the existing provisions of the Act.

**Protection for medical practitioners**

14.7.7 The Act protects medical practitioners who perform treatment where a person purports to consent without having authority to do so. In those circumstances, consent can be taken as valid if the treating practitioner did not know that the person was not authorised to consent or reasonably believed that they were authorised to consent.\(^{1406}\)

14.7.8 The Issues Paper gave the following examples of protections given to medical practitioners in other jurisdictions:

   - where they administer (or do not administer) treatment in good faith and without negligence believing on reasonable grounds that they have complied with the legislation;\(^{1407}\)
   - where they give treatment in reliance upon another health provider who states that consent has been given;\(^{1408}\) and
   - where they perform treatment relying in good faith upon the consent of a person who has impaired decision-making capacity where they did not know, and could not have been reasonably expected to know, that the person had impaired capacity.\(^{1409}\)

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\(^{1406}\) *Guardianship and Administration Act 1995 (Tas)* s 39(3). Similar protection applies in the Northern Territory: see *Advance Personal Planning Act 2016 (NT)* s 46.

\(^{1407}\) *Medical Treatment Planning and Decisions Act 2016 (Vic)* s 52.

\(^{1408}\) *Advance Personal Planning Act 2016 (NT)* s 48.

\(^{1409}\) Ibid s 49.
14.7.9 The Institute asked whether stakeholders consider there needs to be any additional protections in the Act to protect medical professionals who administer treatment upon reliance of substitute consent.

**Does the Act need to provide additional protections for health care professionals?**

14.7.10 There were five responses, with a range of issues raised. The OPG commented that it was unaware of any deficiencies with the existing approach, but ‘would be open to extending protection to include a practitioner providing treatment in good faith on reliance of another practitioner’s advice that consent has been provided.’

14.7.11 MIGA submitted that there is a need for reform to the protections afforded to medical and other health practitioners under the Act:

There needs to be protections for medical and other health practitioners from criminal, civil or disciplinary liability, other liability under an administrative process, or discrimination or other adverse action in workplace, for actions taken in good faith and in a reasonable belief of compliance with Act, or in exercising a conscientious objection outside the context of emergency treatment.

Applying any additional criteria of ‘without negligence’ to such a protection is inappropriate and confusing where a criteria of reasonable belief exists.

The existing protection, namely where person purports to consent without authority, is insufficient. There are more situations than that where good faith protections for the health professions are required.

Practitioners may inadvertently breach provisions of the Act, exposing themselves to potential penalty, claim or other adverse action. Inevitably there is considerable scope for unintentional breaches or disputes over whether requirements of the Act have been followed.

14.7.12 One respondent commented that health practitioners should be ‘exempt from any risk of penalty’ where they withhold treatment consistent with a person’s ACD or instrument. This issue has been considered and addressed elsewhere in this Report, notably Part 5 which considered the nature and effect of directions in an ACD. Recommendation 5.6 proposes that the Act confirm that directions expressing a refusal to consent in a valid ACD that applies to the circumstances must be binding and operates in the same way that a decision by a person with decision-making ability does.

14.7.13 Another respondent stated that there should be whistle-blower protections for medical practitioners. The Institute considers that this issue best addressed as part of a separate review into the merits of adult safeguarding legislation, which the Institute has recommended take place.\(^{1411}\)

14.7.14 One submission also raised issues relating to protections in relation to euthanasia. It is observed that this issue falls outside of the scope of this review and has thus not been considered further.

14.7.15 The Institute acknowledges the issues raised in MIGA’s response to this question. As this is the only submission raising these issues, the Institute is unable to form a concluded view about the need or desirability for legislative reform consistent with this submission.

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\(^{1410}\) TLRI, above n 69, Question 11.5.

\(^{1411}\) See Recommendation 12.28.
14.8 Other reforms

14.8.1 The Issues Paper concluded this Part by asking broadly whether there was a need for any additional provisions in the Act to act as a safeguard for substitute consent to treatment.

How else could the Act better safeguard the giving of consent to medical and dental treatment?\(^{2412}\)

14.8.2 Both the OPG and MIGA made submissions in response to this question. The OPG’s submission raised three matters:

- that the Board’s role in relation to giving consent to treatment be confirmed. This matter was addressed in Part 13;\(^{2413}\)
- that it was not opposed to further consideration of the Public Guardian acting as person responsible of last resort. This was also addressed in Part 13;\(^{2414}\) and
- that the Act clarify the effect of substitute consent given whilst a patient did not have decision-making ability for a matter where the patient gains or regains decision-making ability. The OPG submitted:

  The OPG believes the legislation should clarify whether or not consent for medical treatment endures beyond the period of a representative’s appointment. This is particularly relevant to OPG guardians consenting to medication under an emergency order, where the administration of the medication might continue beyond the 28 day appointment. It is unclear if the consent is still ‘valid’ after the ceasing of an order in such cases.

14.8.3 The Institute considers that this is a matter better addressed through guidelines and factsheets for the use of health practitioners, rather than legislative reform.

14.8.4 MIGA’s submission raised two matters. Firstly, that the common law position that a medical or other health practitioner is not compelled to provide futile or non-beneficial treatment should be recognised. This should include directions set out in an ACD, requested by a decision-maker or otherwise. It noted that:

  This is particularly important in the context of end of life care. It would also recognise the issues of clinical appropriateness and practicality which arise in the healthcare context.

14.8.5 MIGA also stated that health practitioners should have discretion to make a conscientious objection. In relation to this issue, it commented:

  The Australian Medical Association, in its Position Statement on End of Life Care and Advance Care Planning, addresses the issue of conscientious objection, outlining that (in cl 5):

  ‘Doctors caring for patients at the end of the patient’s life should be under no obligation to recommend or participate in a legally-recognised treatment or procedure related to end of life care to which they hold a conscientious objection … [a] doctor should always provide medically appropriate treatment in an emergency situation …’

\(^{2412}\) TLRI, above n 69, Question 11.6.

\(^{2413}\) Refer to Recommendation 13.8(2).

\(^{2414}\) Refer to Recommendation 13.8(1).
This is also consistent with cl 2.4.6 of the Medical Board of Australia’s Good Medical Practice Code of Conduct, providing that medical practitioners have a right not to provide or directly participate in treatments to which they conscientiously object, so long as the objection is not used to impede access to treatments that are legal.

Given end of life care inevitably involves a spectrum of cultural, religious or other ethical views, and bearing in mind the existing health profession codes and ethical positions on conscientious objection, MIGA submits that a provision preserving the scope for conscientious objection in relation to an ACD or end of life care generally should be set out in the Act.

14.8.6 The Institute considers that community consultation in relation to these proposed reforms is appropriate. These issues apply equally to people with decision-making ability as they do to individuals who do not have decision-making ability to consent to treatment. The scope of this reference is to consider review to the Act, dealing with substitute consent to treatment for individuals unable to give their own consent. Broader consultation is therefore appropriate, and the Institute is unable to reach a concluded view about the merits of any potential legislative reform.
Part 15

Functions, Powers and Duties of the Board

15.1 Introduction

15.1.1 The Terms of Reference asked the Institute to consider the functions, powers and duties of the Board. One of the Board’s existing duties is to perform its functions and exercise its powers in accordance with the Act’s guiding principles. These were considered in Part 3. Earlier parts of this Report also considered and made recommendations about some of the powers of the Board, including its powers to appoint, supervise and remove representatives\(^\text{1415}\) and its powers in relation to consent to health care and treatment.\(^\text{1416}\) This Part therefore focuses upon the way in which the Board functions and discreet powers not dealt with elsewhere in this Report.

15.1.2 It must be noted that the Board also has a range of powers under other legislation,\(^\text{1417}\) but this review is limited to its functions and power under the Act.

15.2 The need for a hearing

15.2.1 With some exceptions, applications to the Board typically require it to hold a hearing before making orders.\(^\text{1418}\) The making of emergency orders without a hearing is considered separately at [15.3] below.

15.2.2 The Institute asked whether there are any circumstances where stakeholders felt that a hearing should not be required for the Board to make orders.

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<th>Are there any situations where the Board should not need to hold a hearing before it can make orders?(^\text{1419})</th>
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15.2.3 Most responses highlighted the importance of the Board having flexibility to make orders in urgent circumstances without a hearing, as the Act currently provides.\(^\text{1420}\)

15.2.4 Other responses supported the Board retaining its ability to make orders without a hearing in the following circumstances:

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\(^{1415}\) Parts 8 and 12.

\(^{1416}\) Part 13.

\(^{1417}\) Disability Services Act 2011 (Tas), Powers of Attorney Act 2000 (Tas), and the Wills Act 2008 (Tas).

\(^{1418}\) See for example Guardianship and Administration Act 1995 (Tas) ss 20, 34, 45, 51.

\(^{1419}\) TLRi, above n 69, Question 8.6.

\(^{1420}\) Guardianship and Administration Act 1995 (Tas) s 65.
• where representatives apply for advice or directions, or where the Board of its own motion provides advice or directions to representatives. The OPG submitted that this should be permitted where advice and directions are required urgently;

• where an application is withdrawn;

• applications dealing with a request for release of information;

• reviews of ongoing orders in appropriate circumstances (explained below).

15.2.5 The Board raised an issue with the drafting of the relevant sections enabling representatives to apply for advice and directions:

Section 31(3)(c) and section 61(3)(c) can at times, cause some practical difficulties. In practice, the Board receives advice and direction requests from guardians (often the Public Guardian) and administrators (including the Public Trustee) who seek an enlargement of their powers due to particular circumstances that have arisen. Sometimes the Board is asked to respond quickly to these requests given time limits that may be involved. Section 31(3)(c) and section 61(3)(c) gives the Board the power to vary the Order, or make any other order that it would have made on the original application. These applications could also be dealt with by way of an Application for Review of an Order.

If the Board proceeds without holding a hearing, as it is able to do, it arguably does not afford the represented person and parties, natural justice and particularly the right to put forward their views on the amendment of an Order, or the possible increase in powers of a guardian or to ask questions. It is very difficult, if not impossible for the Board to obtain a person’s direct evidence about their wishes, without the opportunity for them to attend a hearing. Given this, the Board’s more recent practice has been to hold a hearing in respect of a request for advice and direction.

Consideration could be given to amending sections 31 and 61 by removing para (3)(c), and instead utilising the review order process and ensuring a hearing is held when an increase or amendment to powers is sought. This approach appears consistent with a number of other guardianship jurisdictions in Australia.

15.2.6 The OPG’s submission also raised issues with these sections:

The OPG’s firm view is that the Board should be able to review an order without having to conduct a hearing, where the purpose of the review is to seek revocation of the order on the ground the criteria for making an order are no longer met. Typically this would arise either because the represented person has regained capacity or because there is no longer a need for decisions to be made on behalf of the person …

This is particularly important in relation to emergency orders where a hearing is not required for the Board to make an order, but is now required to revoke the order (until recently there had been some flexibility in the approach taken by the Board). The corollary is that a much higher standard of evidence is required to revoke the order than to make it … The requirement to hold a hearing in these cases is burdensome for the Board, the OPG, the original applicant, and, importantly the represented person. The result is that generally reviews are no longer sought for emergency orders, which means

1422 Ibid s 86.
that people who clearly do not meet the criteria can remain subject to a guardianship order for some weeks …

For on-going orders, a common scenario is that the represented person’s circumstances have changed (often following the intervention of the guardian) such that there is no longer a need for substitute decision-making by a guardian … the administrative burden of holding a hearing, together with the imposition and intrusion to the represented person, should be avoided …

Guardianship legislation should and does provide important safeguards to ensure that formal orders taking away an individual’s right to make their own decisions, are only made when the person lacks the capacity for reasonable decision-making due to a disability, there is a need for someone else to make decisions on their behalf, and there is no less restrictive alternative. It is crucial that the legislation itself does not create (or prolong) unnecessary restrictions on the person with a disability, by making it difficult to get off an order or to have the powers under the order reviewed and decreased. Clear and uncomplicated provisions, devoid of unnecessary bureaucratic process, are critical to enable the revoking of orders in uncontentious circumstances, to avoid people remaining on orders when they no longer meet the criteria.

15.2.7 Whilst raising issues with the same sections, it appears that the OPG and Board’s positions do not conflict:

- the Board’s submission indicates its concern when representatives seek to invoke ss 31 and 61, applying for advice and directions for their powers to be enlarged. The Board expresses the view that the conferral of additional powers to a representative is a matter that necessitates natural justice through the usual hearing process; and

- conversely, the OPG’s submission indicates its concern that representatives cannot invoke ss 31 and 61 to request that the order appointing them as representative be revoked without a hearing.

15.2.8 The Board suggests that the issue it raised could be resolved by removing its ability to make any orders that it could have made upon hearing an original application when determining an application for advice or direction without a hearing. The effect would be to require the Board to conduct a hearing in order to confer additional powers upon a representative, unless the test for an emergency order is satisfied. This reform would effectively confirm within statute the existing policy of the Board.

15.2.9 Sections 31 and 61 do not preclude the Board conducting a hearing if it considers it appropriate, as it advises is the approach it presently adopts. It may also decide to give notice of an application to anyone it considers interested in the application.1423 The Institute therefore does not consider there is a need for legislative reform and that the matter is better addressed through internal policies and procedures. This approach provides flexibility to enable the Board to vary its original order if it considers it appropriate in the circumstances.

15.2.10 The issue that the OPG raised can be addressed through inclusion of a separate section enabling the Board to revoke an order appointing a representative without holding a hearing. The OPG’s rationale for proposing this reform in relation to the revocation of emergency orders is persuasive, and it is thus recommended that the Act be revised to enable the Board to determine an

1423 Ibid ss 31(2), 61(2).
application for the revocation of an emergency order without a hearing. The Institute considers that
the OPG’s submission proposing extension of this approach to non-emergency orders appointing
representatives has some merit but that further consultation is desirable.

15.2.11 The OPG also submitted that a HCPR should not be required when applying to have an
order revoked:

Whilst not forming part of this review, the current Guardianship and Administration
Regulations 2017 require any application to the Board (including applications for review of
an order) to be accompanied by a report by a health care professional stating that the
person has a disability that impacts on their capacity to make reasonable judgements.
Evidence about a person’s disability and capacity is irrelevant where the review is
requested on the ground that the person no longer meets the requirement of subsection
20(1)(c), i.e., that the person is in need of a guardian. Obtaining a health professional
report often involves the inconvenience of a visit by the represented person to their
doctor or psychologist, for which there might be a financial cost (in addition to the cost
to taxpayers and the health care system), and inevitable delays. It also involves the
indignity of an unnecessary focus on the person’s disability and capacity, when this is not
in question.

15.2.12 It commented that:

The corollary is that a much higher standard of evidence is required to revoke the order
than to make it … The Board only has to be satisfied that the person might lack capacity
for decision-making in order to make the order; to then hold a hearing to test evidence
that the person has regained capacity is heavy-handed and disproportionate.

15.2.13 For reasons articulated above, the Institute is persuaded that it should be unnecessary for
representatives to file a HCPR when applying for the revocation of the order appointing them as
representative.

**Recommendation 15.1**

1. That the Board not be required to conduct a hearing to revoke an order appointing a
   representative where the representative applies for the revocation of the order.

2. That applications by a representative for the revocation of an emergency order not require a
   Health Care Professional Report.

**‘Stable’ long-term administration orders**

15.2.14 The Board’s submission explained its present method of dealing with long-term
administration orders where the Public Trustee is appointed:

the Board sometimes conducts review hearings of an administration order on the
documents, but only in limited circumstances where the Public Trustee are appointed and
the administration is stable. A letter first goes out asking whether the represented person
and any of the parties wish to attend the Review Application. A hearing is listed if any
person requests this. If no request is received the hearing proceeds on the papers. This
process still requires the Board to consider evidence as to a person’s disability, incapacity
and whether there is still a need for an Order. This process is similar to that in Victoria
and ACT.

15.2.15 Legislative reform is not proposed.
15.3 Emergency orders

15.3.1 Emergencies by their very nature create stressful circumstances for the person involved and those close to them. It is critical that the Act provides appropriate and effective mechanisms to address issues that might arise in an emergency. This section deals with emergency circumstances requiring the appointment of representatives. Part 13 also considered how the Act deals with substitute consent to urgent medical treatment.\textsuperscript{1424}

15.3.2 The Act provides that the Board can make any order, or give any directions, where it considers proper by reason of urgency.\textsuperscript{1425} In 2016–2017, the Board made 213 emergency guardianship orders and 133 emergency administration orders (a total of 346 emergency orders).\textsuperscript{1426} The Board may exercise its powers of its own motion or after receiving a request from a person that the Board considers has a proper interest in the matter.\textsuperscript{1427} Requests can be made by telephone or other means the Board considers appropriate.\textsuperscript{1428} The Board does not need to hold a hearing or give notice.\textsuperscript{1429} It can receive information informally and make inquiries or investigations that it considers appropriate.\textsuperscript{1430}

15.3.3 An emergency order may continue for a maximum of 28 days. It can be extended once for a further period of a maximum of 28 days.\textsuperscript{1431} In 2016–2017, the Board extended 97 emergency guardianship orders and 86 emergency administration orders.\textsuperscript{1432} This equated to 46 per cent of the emergency guardianship orders made during the reporting period, and 65 per cent of emergency administration orders. The number of extensions to emergency guardianship orders has increased from prior years.\textsuperscript{1433}

15.3.4 The Board can make orders and give directions in relation to non-represented people.\textsuperscript{1434} The Act provides that an emergency administration order may be made even if the person is the donor of an enduring power of attorney.\textsuperscript{1435} There is no equivalent provision confirming that the Board can make a guardianship order where the person is the donor of an instrument. This is problematic as the Board also does not have powers to review an instrument of its own motion.\textsuperscript{1436}

\begin{footnotesize}
\begin{itemize}
\item[1424] See [13.3.4].
\item[1425] Guardianship and Administration Act 1995 (Tas) s 65(1).
\item[1426] Guardianship and Administration Board, above n 235, 21.
\item[1427] Guardianship and Administration Act 1995 (Tas) s 65(3). When hearing an application for consent to medical or dental treatment, the Board may also make an emergency order for the appointment of a guardian or administrator: s 46A.
\item[1428] Ibid s 65(4)(b).
\item[1429] Ibid s 65(4)(a).
\item[1430] Ibid ss 65(4)(b)–(a).
\item[1431] Ibid s 65(5). In 2016–2017, the Board extended 97 emergency guardianship orders and 86 emergency administration orders (total 183, or 53 per cent of the emergency orders made): Guardianship and Administration Board, above n 235, 22.
\item[1432] Guardianship and Administration Board, above n 235, 21–22.
\item[1433] See OPG, above n 578, 10.
\item[1434] Guardianship and Administration Act 1995 (Tas) s 65(2).
\item[1435] Ibid s 65(4)(c).
\item[1436] See [12.5.4].
\end{itemize}
\end{footnotesize}
This issue was discussed in Part 4, with it being recommended that the Board be given this power.\textsuperscript{1437} Social Work Services RHH’s submission explained the situation that can arise as follows:

Where there is an Enduring Guardian who can’t act in that role and there are urgent grounds, there should be provision to make an emergency order. Example: A patient needing transfer to the Jasmine Unit (Roy Fagan Centre) for rehabilitation who lacks capacity to consent who has an enduring Guardian and Enduring Power of Attorney who can’t be contacted despite intensive efforts to make contact. Emergency Guardianship applications have been rejected in such circumstances, with a 14 days hearing to review the enduring Guardianship, despite consent matters needing to be addressed.

15.3.5 The Board also raised concerns about this issue. It would appear to be due to oversight that this is not included within the Board’s powers. To address this, it is proposed that the Act confirm that the Board can make an emergency guardianship order where the person is the donor of an instrument.

\textbf{Recommendation 15.2}

That the Act enable the Board to make an emergency guardianship order despite the proposed represented person being the donor of an instrument, equivalent to s 65(4)(c) of the Act dealing with emergency administration orders.

\textbf{Test to appoint a representative in an emergency}

15.3.6 The Board can make any order or give any directions where it considers it proper by reason of urgency.\textsuperscript{1438} The Act does not define the phrase ‘reason of urgency’, but the Board has interpreted it to mean ‘when there is sufficient evidence that a person with a disability is at immediate risk of significant harm unless a guardian or administrator is appointed within the next 10 days to 45 days.’\textsuperscript{1439} The Board’s submission commented that:

Consideration could be given to defining ‘urgency’ or using different terminology which encompasses immediate risk to a person, unlawful detention of a person or to adopt some of the terminology in the Queensland Act such as ‘risk of harm to the health, welfare or property of the adult concerned in an application, including because of the risk of abuse, exploitation or neglect of, or self-neglect, by, the adult.’

15.3.7 The threshold to appoint a temporary representative is not as high to make an emergency order appointing a representative as it is to appoint a representative in non-urgent circumstances. The Board only needs to be satisfied that there may be grounds to appoint a representative.\textsuperscript{1440} The OPG’s submission expressed a view that a higher standard of evidence of disability and incapacity should be required:

Given many emergency applications are made by hospitals, stronger evidence as to the person’s disability and capacity and the likely length of incapacity ought to be readily available.

\textsuperscript{1437} Recommendation 12.5.
\textsuperscript{1438} Ibid s 65(1).
\textsuperscript{1440} Ibid.
15.3.8 In Queensland, the test to make an interim order in urgent circumstances requires the Tribunal to be satisfied on reasonable grounds that there is an immediate risk of harm to the person’s health, welfare, or property including because of risk of abuse, exploitation, neglect or self-neglect. New legislation proposed in Victoria adopts a similar approach, enabling the tribunal to make an urgent order appointing a representative without complying with notice requirements if the tribunal is satisfied on reasonable grounds that there is an immediate risk of harm to the health, welfare or property of a proposed represented person if an order were not made. This is clarified to include abuse, exploitation, neglect, or self neglect. It will still require the tribunal to be satisfied of the matters outlined in respect of the test to appoint a guardian or administrator. In the Northern Territory, the tribunal must reasonably believe that the proposed represented person has impaired decision-making capacity and that there is an urgent need for a guardian. The NSWLRC has recently recommended that the New South Wales Act be revised to enable an emergency order to be made where there is an unacceptable risk and urgency. It proposes that the test require the tribunal to be satisfied that there may be grounds for making an order, as the Act in Tasmania presently provides. A similar test applies in Western Australia. In South Australia, the test requires the tribunal to be satisfied that urgent action is required. In the ACT, the test requires the tribunal to be satisfied that there are special circumstances of urgency.

Use of interim orders

15.3.9 Pre-consultation with stakeholders during the drafting of the Issues Paper indicated that s 65 (Emergency Orders) may not be sufficiently flexible to deal with urgent circumstances. The Issues Paper identified one alternative for reform being to enable the Board to make short-term orders (longer than 28 days) appointing representatives without holding a hearing and/or without the need to give the required 10 days’ notice of a hearing, or giving the Board power to make interim orders. New South Wales and Queensland, for example, permit the making of short-term or interim orders. In New South Wales, interim orders appointing an administrator can be made for six months with the potential to extend the order. Temporary appointments of guardians may also be made. Recent recommendations of the NSWLRC, however, propose that this be revised to enable
the tribunal to make emergency orders for 30 days with the potential to extend them for a further 30 days. They can be extended in exceptional circumstances for an unlimited duration. The QLRC did not recommend any revision to this approach.

On the other hand, emergency orders in South Australia and Victoria may last for a maximum of only 21 days.

15.3.10 The Issues Paper asked for feedback about if and how the Act might better respond to urgent situations.

**Does there need to be any changes to the powers and processes for the Board to make orders in urgent situations?**

15.3.11 Social Work Services RHH’s submission explained the practical difficulties that can arise due to the current timeframes prescribed in the Act:

**Issue:** The timeframe for emergency orders (28 days x 2 = 56 days) and timeframe for full application to hearing (45 days) rarely allows sufficient time to gather evidence and determine the need for a full application. Often this only gives the applicant 11 days from the date of first applying for an emergency order (which could be between 7-9 working days) to get to know the person requiring a substitute decision maker, their views, whether they need a full application, who the applicant proposes as the Guardian/Administrator. GAB will only acknowledge receipt of an application with a health report. It is often difficult for a Doctor to provide a HCPR by day 11 to support a full application with clear information about diagnosis, disability and decision making. Making a hasty application within 11 days often subjects proposed represented people and their families/carers to increased stress and anxiety.

**Example:** Mrs Smith has an emergency Guardianship order granted on 1st February due to delirium and suspected dementia. On the 2nd of February she is transferred to the Roy Fagan Centre for assessment, diagnosis and restorative care, under a new treating team. It takes some time for the new treating team to get to know her, for the delirium to resolve and dementia to be diagnosed. By the 12th of February, the applicant is required to make an educated guess whether a long term application/order will be required, often making an application without robust information. In this case delirium is still present and it is not known whether Mrs Smith will regain capacity. The Social Worker must list who they propose as Guardian and therefore good practice entails detailed conversations with families/carers/interested parties to ensure the application is fair and considered. Good applications are time consuming and are often stressful for interested parties and families and the represented person.

**Recommendation:** There needs to be a provision for emergency orders to be extended (beyond 56 days), or reduce the length of time to full hearing (e.g. to 4 weeks), allowing for more time to properly assess the situation.

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1455 NSWLRC, above n 24, Recommendation 9.9(1).
1456 Guardianship and Administration Act 2000 (Qld) s 129(5). Initially, their Act provided a 28 day period, consistent with Tasmania. In 2003, reform provided a combined maximum period of six months in which an interim order may be made and renewed. In 2007, the Act was changed again to provide a three month maximum period, with the tribunal having power to renew an order in exceptional circumstances: QLRC, above n 25, [20.38]–[20.43].
1457 Guardianship and Administration Act 2000 (Qld) s 129(6).
1458 QLRC, above n 25, [20.132], [20.139].
1459 Guardianship and Administration Act 1993 (SA) s 66(1); Guardianship and Administration Bill 2018 (Vic) cl 36(3).
1460 TLRI, above n 69, Question 8.7.
more time for thorough assessment of medical condition, confirmation of disability and proven need for a substitute decision maker. This would prevent unnecessary applications, reduce unnecessary distress to the patient/family, and save time for the applicant and the Board. A timeframe of 28 days to make application would prevent such guesswork, reduce the number of unnecessary applications and would make sense that the need for an ongoing order is reviewed at the time the first emergency order is due to expire.

Suggestion: First emergency order to continue for 28 days, full application due on day 28, then 4 weeks to hearing.

15.3.12 The Board also suggested that consideration could be given to revising the current timeframes:

Consideration could be given to making a single emergency order for up to 60 days. This is because the vast majority of emergency orders made by the Board are for an initial 28 days and the Public Guardian or Public Trustee frequently has to apply for the order to be renewed for a further 28 days. This is in line with the ‘short term orders’ which are made in other jurisdictions such as Queensland. If it is deemed that a hearing is not required and notice not given, then the reality is that these short term orders should only be made in urgent circumstances, so as to not deny the represented person and interested parties natural justice.

15.3.13 The OPG endorsed reform enabling the Board to make interim orders. It commented that:

The OPG believes consideration of the arrangements available in other jurisdictions for the use of short term interim orders, held without hearings, has merit. If implemented, we believe an interim order made without a hearing should be for a maximum period of three months, and should only be made if it is not practical to make a regular/ongoing order after holding a hearing. Such orders should be reviewable by the Board on application by the represented person or other person with a proper interest in the matter.

15.3.14 Members of the Elder Law Committee also supported reform enabling the Board to make interim orders where there is an immediate threat of harm. It suggested that the Queensland Act\(^\text{1461}\) provides a useful example upon which to base reform.

15.3.15 Another submission suggested that one improvement that could be made to the Board’s processes in determining emergency applications would be to require the Board to speak directly with the applicant and to investigate the circumstances surrounding the application.

15.3.16 The Public Trustee submitted that it held no view about any changes that should be made to how the Act deals with urgent circumstances.

**The Institute’s view**

15.3.17 Reforms dealing with the way in which the Board may respond to cases of emergency involve the need to balance a person’s right to natural justice with their right to be free from abuse, neglect or exploitation. Some submissions raised issues about the length of emergency orders,
Part 15: Functions, Powers and Duties of the Board

particularly when combined with the requirement to give 10 days’ notice of a hearing to make a longer-term appointment of a representative. Options include to:

- extend the period in which emergency orders may last, noting that the Board suggested an extension to perhaps 60 days and the OPG suggesting a maximum of three months; or
- reduce the 10 days’ notice period required to give the proposed represented person notice of an application prior to hearing. This issue was the subject of a separate question in the Issues Paper and is considered in the following paragraph.

15.3.18 On balance, the Institute does not recommend extension to the length in which emergency orders may last. Victoria and South Australia provide shorter timeframes, with the NSWLRC having recently recommended a similar approach to that already included within the Act. Providing a relatively short period in which an emergency order may last safeguards a person’s rights in circumstances where hearing and notice requirements are waived, adversely impacting the person’s right to natural justice. There has also not been any conclusive finding that the person does not have decision-making ability or that there is a need for a representative. Evidence may be limited and untested. This approach promotes interventions for those requiring decision-making support operating for as short a time as possible, consistent with adopting a least restrictive approach. The Institute considers these factors outweigh the desirability of reducing potential inconvenience in having to sometimes make an application for an order appointing a representative in what might be less than ideal circumstances.

15.3.19 It is also not proposed that there be any increase to the threshold to appoint a representative for a non-represented person in urgent circumstances. This is due to the need to ensure that the Board has adequate powers to respond appropriately and effectively in urgent circumstances. Retaining the requirement for emergency orders to only be permitted for a maximum of 28 days safeguards a represented person’s interests where the threshold to appoint a temporary representative is not as high as the test to make an order appointing a representative.

15.3.20 Consistent with submissions received, it is recommended that the phrase ‘reason of urgency’ be replaced in s 65 with a more useful description to clarify when an emergency order may be made. This approach is consistent with approaches in Queensland and Victoria.

**Recommendation 15.3**

That, to make any order or give any direction under s 65 of the Act, instead of referring to ‘reason of urgency’, the Board be required to be satisfied on reasonable grounds that there is an immediate risk of harm to the person’s health, welfare, or property if an order or direction were not made, including because of a risk of abuse, exploitation, neglect or self-neglect.

**Notice of hearing**

15.3.21 All relevant people must be given no less than 10 days’ notice of a hearing. The Act provides that a determination is not invalidated because of a failure to give notice to anyone other

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1462 The applicant, proposed represented person or represented person, the Public Guardian, their guardian (if any), their administrator (if any), if it relates to medical or dental treatment then the registered practitioner proposed to carry out the treatment, and any other person that the Board is satisfied has a proper interest in the matter: Guardianship and Administration Act 1995 (Tas) s 69(1).
than the person in respect of whom a hearing is held. In South Australia, the tribunal must give ‘reasonable notice’ of a hearing. In Queensland, 14 days’ notice is required, although the tribunal has discretion to reduce this period.

15.3.22 The Issues Paper commented that, on one hand, greater flexibility to hold hearings without giving 10 days’ notice may improve the Board’s functioning. On the other hand, natural justice requires people to have adequate notice of a hearing. The Institute therefore sought feedback about whether the notice provisions in the Act require reform.

**What period of notice of a hearing should the Board need to give interested parties?**

15.3.23 There were 10 responses to this question. Four stated that the current notice requirements are appropriate and that no change was required.

15.3.24 Both the OPG and members of the Elder Law Committee supported revision to enable the Board to give ‘reasonable notice’. The OPG submitted:

> This would allow the flexibility for hearings to be scheduled at very short notice in certain circumstances, particularly if there was no disadvantage to any party to the proceedings (e.g., where there is no contention about the matter and/or where there is only one or two parties for whom short notice is adequate).

Members of the Elder Law Committee similarly commented that this:

> [provides] flexibility for the Board to regulate its own procedure whilst affording natural justice to parties which may be affected by any decision it makes.

15.3.25 The Board’s submission endorsed a standard notice period, but with the Board having flexibility to shorten that period if it deemed appropriate:

> The Board acknowledges the importance of ensuring interested parties are afforded natural justice and have sufficient notice of hearings.

> In practice, the period of notice can cause some difficulties for the Board Registry particularly if the personal circumstances of a person dictates the application to be heard quickly but don’t necessitate an emergency order. It would be useful if the Board could shorten the period of notice of a hearing if the Board considers it appropriate to do so. Such an amendment, similar to section 69(3)(b) of the Act could possibly even remove the need for the emergency order provisions in the Act.

15.3.26 Section 69(3)(b) of the Act provides:

> (3) The Board is not obliged to give notice of a hearing: …

> (b) if the matter relates to the provision of medical or dental treatment and the Board considers it proper to dispense with notice of the hearing by reason of urgency.

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1463 Ibid. Requirements for notice are provided in s 69(2) of the Act, with notice to be able to be given by post or any other method the Board considers appropriate: s 70.
1464 Ibid s 71(b).
1465 *Advance Care Directives Act 2013* (SA) s 54(1).
1466 *Guardianship and Administration Act 2000* (Qld) s 118(1).
1467 Ibid s 118(4)(b).
1468 TLRI, above n 69, Question 8.1.
15.3.27 Three submissions stated that the notice period should be extended, with two supporting at least a two week notice period and one suggesting a 30 day period. In summary, four respondents expressed support for the current notice period, three proposed that the notice period be extended and three supported flexibility to enable the notice period to be shortened.

15.3.28 The Institute does not recommend revision to the notice requirements based on the important role that it plays in affording a proposed represented person natural justice. If reform were made, the preferred option would be to give the Board discretion to shorten the length of the notice period, consistent with the existing s 69(3)(b). This alternative is preferred because it still provides a default minimum notice period applying in most instances, gives the Board flexibility to respond in urgent circumstances and aligns with existing provisions in the Act. The alternative of requiring ‘reasonable notice’ gives greater scope for the Board to shorten the notice period. It should only be in the most extreme cases where it is necessary that the Board should be permitted to shorten the notice period.

15.3.29 The Institute suggests that, if change is made, enabling notice requirements to be dispensed with because of reasons of urgency, it should still be necessary to endeavour to give ‘reasonable notice’ where possible. This is on the basis that it promotes natural justice and the rights of a person subject to an application to the Board.

**Recommendation 15.4**

1. That there is no change to the notice of hearing provisions of the Act.
2. That, if there is change to the notice of hearing provisions, the Board have discretion to shorten the notice period if it considers it proper to dispense with notice of the hearing by reason of urgency but that, if it does, it be required to provide reasonable notice.

**Representatives who may be appointed in an emergency**

15.3.30 When making emergency orders, the Board can only appoint the Public Guardian or the Public Trustee. It cannot appoint private representatives, for example, family or friends. The Issues Paper queried whether private representatives should be able to be appointed under emergency orders.

**Should the Board be able to appoint private guardians or administrators in urgent situations?**

15.3.31 Seven submissions addressed this issue, with four supporting the ability to appoint private representatives under an emergency order. PCT commented:

PCT strongly believes that when making emergency orders in the case of a person with a life limiting illness the Board should follow the Person Responsible hierarchy and appoint the appropriate Person Responsible as the Guardian. This could follow the New South Wales system regarding short term orders if appropriate.

15.3.32 Both the OPG and Members of the Elder Law Committee also suggested that this could be addressed by enabling the Board to make short-term or interim orders. The OPG submitted that:

the OPG’s view is that interim orders, under which a private guardian or administrator may be appointed for a limited period of time, has merit … particularly where the

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1469 TLRI, above n 69, Question 8.7(ii).
proposed representative has been acting informally in the same or a similar capacity but suddenly requires formal authority for a particular action. However we believe such appointments should only proceed if the Board has sufficient evidence of the proposed representative’s suitability for the role.

15.3.33 The Board and Social Work Services RHH did not support this reform. Both commented that the making of emergency orders in the absence of a hearing does not give the Board adequate opportunity to assess the suitability of a private representative, or canvas the views of others. Social Work Services RHH also commented that:

The Public Guardian and Public Trustee are aware of the legislative framework for their practice and of the powers they have. Public Trustee are also able to take swift action to protect the finances of vulnerable people.

15.3.34 The inability to appoint a private representative under an emergency guardianship order presently results in the Public Guardian automatically becoming the represented person’s ‘person responsible’ able to consent to medical treatment (where the represented person is unable to provide their own consent). This matter was discussed in Part 14,\textsuperscript{1470} with it being recommended that this be revised so that a guardian is only the person responsible if they have been granted express powers to consent to health care and treatment.\textsuperscript{1471} This would resolve the issue described above, without requiring reform to enable the Board to appoint a private representative under an emergency guardianship order.

15.3.35 This issue requires a balancing of the following considerations: firstly, the need to adopt a represented person’s views, wishes and preferences and, secondly, the need to provide adequate safeguards to protect a represented person. Presently the Board is precluded from appointing a private representative in an emergency even if it reflects the proposed represented person’s wishes. On the other hand, as discussed in Part 12,\textsuperscript{1472} one of the existing safeguards for representative decision-making is that the Board must assess a proposed representative’s suitability according to prescribed criteria. As the Board and Social Work Services RHH submitted, in urgent circumstances and without giving notice and/or holding a hearing, the Board may not have opportunity to assess the proposed representative against that criteria.

15.3.36 Given the need for appropriate and effective safeguards for those requiring decision-making support, the Institute does not propose reform to enable the appointment of private representatives under emergency orders. It is noted that the Institute has not recommended extension to the maximum duration of emergency orders, meaning that the Public Guardian or Public Trustee would only be appointed for a maximum of 28 days (with the possibility of extending for a further maximum 28 days). If reform were made to enable the Board to make interim or short-term orders despite this approach not having been endorsed, then it may be appropriate to revisit the question of whether private representatives should be permitted under an interim or short-term order.

\textsuperscript{1470} See discussion at [14.5.21].
\textsuperscript{1471} Recommendation 14.3.
\textsuperscript{1472} See [12.8.32].
15.4 The Board hearing

15.4.1 The following paragraphs address how the Act governs the way in which Board hearings are conducted, noting that the scope of this reference is to address the need for legislative reform, rather than reform to the Board’s internal policies, procedures or membership.

Parties to a hearing

15.4.2 The Act does not clarify who the parties to a hearing are. The Board has issued a Practice Direction to give guidance to its members about who the parties to a proceeding are.\textsuperscript{1473} It observes that:

Whether or not a person will be defined as a party will determine important questions about the level of participation that person can expect in a hearing. ‘Parties,’ unlike ‘witnesses,’ will have a greater entitlement to notice, access to all documentation and evidence and representation at the hearing \ldots\textsuperscript{1474} A ‘party’ is more likely than a witness to make, and be granted, preliminary applications for adjournments, exchange of documentation or representation \ldots\textsuperscript{1475} Generally, Board hearings are conducted informally and in an inquisitorial style. In some circumstances, it may be necessary to conduct proceedings in a more formal or traditional style. In those cases, it will be important to distinguish between who is a ‘party’ and who is a ‘witness’.\textsuperscript{1476}

15.4.3 A number of Acts in other jurisdictions confirm who the parties to guardianship proceedings are.\textsuperscript{1477} The Institute therefore asked for feedback about whether the Act should clarify who the parties to proceedings are.

Should the Act clarify who the parties to a hearing are?\textsuperscript{1478}

15.4.4 Eleven respondents addressed this question with seven endorsing reform to clarify who the parties to Board proceedings are. In supporting this reform, the Board stated:

Whether a person is a party is an important consideration as it will determine important questions about the level of participation that person can expect in a hearing, entitlement to notice, access to hearing papers and representation at the hearing. Clarity as to who the parties are to a hearing would appear appropriate. If the Act clarifies who the parties to a hearing are, it would also be useful for the Board to have the discretion to join anyone else not specified in the Act, it thinks should be a party.

15.4.5 Two of the three responses that did not support this reform commented that they were not aware of issues with existing arrangements.


\textsuperscript{1474} Ibid 2.

\textsuperscript{1475} Ibid 3.

\textsuperscript{1476} Ibid 4.

\textsuperscript{1477} Guardianship and Administration Act 2000 (Qld) s 119; Guardianship Act 1987 (NSW) s 3F; Guardianship and Administration Act 1986 (Vic) s 60B; Civil and Administrative Tribunal Act 1998 (Vic) s 59.

\textsuperscript{1478} TLRI, above n 69, Question 8.2.
15.4.6 Given that the Board suggests a need for clarity and that it was endorsed by most respondents who addressed this question, the Institute proposes that the Act contain a section clarifying who the parties to a hearing are. The Board’s Practice Direction lists individuals that it considers are parties to an application, interpreting the existing sections of the Act that outline who is entitled to notice of a hearing and to be represented at a hearing.\textsuperscript{1479} The Institute proposes that the Act adopt the approach outlined in the Practice Direction.

**Recommendation 15.5**

1. That the Act contain a section outlining who the parties to a hearing are.
2. That the section adopt Table 1 of the Board’s Practice Direction ‘Who is a “party” to an application before the Board?’ which provides that the parties to an application are:
   - in relation to applications involving guardianship (including reviews and advice and direction), the proposed represented person, the applicant(s), the proposed guardian, and the Public Guardian;
   - in relation to applications involving administration (including reviews and advice and direction), the proposed represented person, the applicant(s), the proposed administrator, the Public Guardian, and the Public Trustee;
   - in relation to applications for consent to health care and treatment (including advice and direction), the person who is the subject of the application, the applicant(s), the health practitioner who will carry out the health care or treatment, any person responsible for the person who is the subject of the application and the Public Guardian; and
   - in relation to applications to review an instrument (and advice and directions to enduring guardians), the donor or purported donor of the instrument, any guardian or purported guardian, the applicant(s), and the Public Guardian.
3. That, if Recommendation 7.8 is adopted, then, in relation to applications for support orders, the Act provide that the parties to an application are the proposed supported person, the applicant(s), the proposed supporter, and the Public Guardian.
4. That the Board have discretion to join anyone as a party not otherwise specified, if it considers they should be a party.

**Evidence**

15.4.7 The Board is not bound by rules of evidence, but must act in accordance with procedural fairness.\textsuperscript{1480} Evidence may be given orally or in writing and on oath or by statutory declaration.\textsuperscript{1481} Evidence given may not be used in any civil or criminal proceedings other than for an offence under the Act or at a hearing of the Board.\textsuperscript{1482} This section was discussed in Part 12.\textsuperscript{1483}

\textsuperscript{1479} Practice Direction, above n 1473, Table 1.
\textsuperscript{1480} Guardianship and Administration Act 1995 (Tas) ss 11, 7(2).
\textsuperscript{1481} Ibid s 11(5).
\textsuperscript{1482} Ibid s 11(7).
\textsuperscript{1483} See [12.9.10].
15.4.8 A person who refuses to be sworn or to answer any relevant question when required to do so is guilty of an offence, with a fine or imprisonment, or both, able to be imposed.\textsuperscript{1484}

15.4.9 The Issues Paper called for submissions about whether there is a need for any change to the way in which evidence is given at hearings.

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Does there need to be any changes to the way in which evidence is given at a hearing? \textsuperscript{21485} \\
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15.4.10 There were 11 submissions addressing this question. The Board, OPG and members of the Elder Law Committee considered that there was no need to revise the existing provisions. The Institute understands the Public Trustee’s submission as expressing a similar view:

\begin{quote}
Although Public Trustee does not support the implementation of strict rules of evidence in hearings it does take the view that some restrictions should be implemented by the Board on a case-by-case basis to ensure relevance and efficiency in process.
\end{quote}

15.4.11 Six submissions suggested reform. One respondent submitted that all evidence should be provided to all parties prior to a hearing or, if not provided beforehand, that the Board be required provide parties with all the evidence following a hearing. The rationale was that there should not be ‘secret evidence’ that is undisclosed to some parties. Two other submissions raised issues about the need for transparency in order to provide accountability.

15.4.12 Conversely, Social Work Services RHH submitted that there should be an ability to keep evidence private in certain circumstances:

\begin{quote}
there needs to be provision for protection of people providing highly sensitive information to the Board, especially where sharing that information could be harmful.

Example: A victim of abuse needs to be able to safely provide information safe from harm from the proposed represented person. Victims of abuse (e.g. a spouse or child of the PRP) often hold very important information to determine whether the PRP is engaging in risky decisions, may be able to demonstrate how impaired insight impacts the PRP’s decision making and add to the Board’s understanding of whether the least restrictive option has been trialled or could be trialled. This often informs a Board’s determination on whether a substitute decision maker is required. Therefore assisting people to provide information with some protection is important.
\end{quote}

Recommendation 12.23 addresses this issue, proposing that a person be able to apply to the Board for an order that any document lodged with the Board not be disclosed to a specified person or class of people.

15.4.13 One respondent commented:

\begin{quote}
powers such as being excused from compliance with rules of evidence and being permitted ‘to inform itself in relation to any matter and in such manner as it thinks fit’ - which, even in an undemocratic, non-Western country, would seem draconian …
\end{quote}

Another respondent expressed a similar view. The OPG, however, commented in response to a separate question of the Issues Paper that it ‘is strongly supportive of an informal inquisitorial approach to the conduct of hearings.’

\textsuperscript{1484} Guardianship and Administration Act 1995 (Tas) s 87.

\textsuperscript{1485} TLRI, above n 69, Question 8.5.
15.4.14 One respondent raised concern with their observation that evidence can go untested. Another endorsed reform to enable evidence being received and tested by email without the need for a hearing.

15.4.15 The Institute acknowledges concerns raised by respondents that, in their view, the Board has significant power to decide what evidence it receives, how it receives it and how evidence is tested or challenged. Concerns that people may have in relation to individual cases may be assisted by Recommendation 12.1, which proposes that a person be able to apply to the Board for an internal review of a first-instance decision. There would remain the ability to appeal a decision to the Supreme Court. It is not proposed that there be reform to the way in which the Act deals with the giving of evidence at a hearing given the desirability of ensuring that Board hearings and processes are accessible and user-friendly, particularly for people in respect of whom a hearing is held.

**Legal representation for people the subject of Board applications**

15.4.16 The Act provides that those attending a Board hearing may be represented in some circumstances. The applicant, the Public Guardian and the person in respect of whom a hearing is being held may be legally represented as of right.\(^{1486}\) Any other person who is given notice of a hearing may be legally represented, with leave of the Board.\(^ {1487}\)

15.4.17 The Board can appoint a person to represent the person in respect of whom a hearing is being held.\(^ {1488}\) The Board’s submission commented that its discretion to retain legal representation for a person is typically only exercised where it considers they do not have the ability to retain representation themselves.

15.4.18 Under the *Mental Health Act*, the MHT must make arrangements for a patient to be represented if they consider that the person is, or may be, personally incapable of making those arrangements and that they are not, or may not be, receiving useful assistance elsewhere.\(^ {1489}\)

15.4.19 The Issues Paper summarised the views of the Law Council of Australia which argues that people who are the subject of guardianship proceedings should have legal representation at a first hearing.\(^ {1490}\) The Council supports legal representation being free of charge, in addition to having funding available for people to obtain medical reports where there is dispute about a person’s abilities. It was noted that, in South Australia, people in respect of whom a hearing is being held for the appeal or review of a decision are entitled to be represented if they wish to be, with the associated fees paid by the government.\(^ {1491}\) The Issues Paper noted that if legal representation was compulsory for some or all Board hearings, this could detract from the benefit of having hearings conducted informally. It would also require adequate funding and resourcing.

\(^{1486}\) *Guardianship and Administration Act 1995 (Tas)* s 73(1).

\(^{1487}\) Ibid s 73(2).

\(^{1488}\) Ibid s 73(3).

\(^{1489}\) *Mental Health Act 2013 (Tas)* sch 4, pt 2, cl 7(4).

\(^{1490}\) See [8.2.10]–[8.2.17].

\(^{1491}\) *Guardianship and Administration Act 1993 (SA)* s 65(1).

\(^{1492}\) Or a legal practitioner provided pursuant to a scheme established by the Minister.

\(^{1493}\) *Guardianship and Administration Act 1993 (SA)* s 65(3).
15.4.20 The Institute sought to ascertain what level of support exists for compulsory legal representation for people the subject of applications to the Board.

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15.4.21 There were 14 responses to this question, with most expressing support for an increased use of independent representation at hearings but that it not be mandatory. Mandatory representation was not supported due to the need to promote a person’s will and preference and thus the importance of enabling a person to choose not to have legal representation. Members of the Elder Law Committee endorsed the South Australian model (explained above) which provides people with the opportunity to obtain free legal representation. They observed that this would be particularly useful where a proposed represented person’s ability to enter into a retainer with a lawyer was in doubt. Another submission also endorsed legal representation being made available if desired.

15.4.22 Several submissions indicated that there might be circumstances where representation ought to be compulsory. Two submissions stated that the Act should outline circumstances in which legal representation is required. Both the OPG and Social Work Services RHH gave similar examples of when representation should be provided. These were:

- where the proposed represented person does not have an independent informal advocate (for example, a family member) and they are unable to attend the hearing themselves; and
- where the proposed representation person is unable, or does not wish, to attend the hearing.

The OPG described the purpose as being to ensure that in these circumstances the person’s ‘wishes and concerns are able to be raised and considered.’ It submitted that representation could be provided either via advocacy or legal representation.

15.4.23 Two submissions endorsed the Mental Health Act model of requiring representation for a person in respect of whom a hearing is being held where the MHT considers that they are not (or may not be) receiving useful assistance elsewhere, and they are incapable of making those arrangements themselves.

15.4.24 One submission supported introduction of mandatory legal representation for a proposed represented person at a hearing. They commented, however, that the role of a legal representative should be to act as an advocate rather than transforming proceedings into a formal legal and adversarial environment. The Board observed that, if the Act were revised to provide for mandatory legal representation, then this would likely have resourcing implications for the Legal Aid Commission Tasmania and Community Legal Centres Tasmania and that, on that basis, there is a need for broader community consultation around this potential reform.

15.4.25 The Institute observes the importance of appropriate and effective safeguards for those impacted by the Act. Safeguards were considered in some detail in Parts 12 and 14. Provision of

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1494 TLRI, above n 69, Question 8.3.
1495 Social Work Services RHH.
1496 OPG.
representation for those appearing before the Board can function as a safeguard, as it is aimed at protecting and promoting a person’s rights and interests. It also serves as a means for a person’s views, wishes and preferences to be communicated, which is fundamental under a revised model providing greater emphasis upon the need to act consistently with a person’s will and preference. For these reasons, it is proposed that legislative provisions dealing with representation for those the subject of Board proceedings be strengthened.

15.4.26 Noting support for the Mental Health Act model, it is proposed that this form the basis of reform to the Act. This would require the Board to arrange representation for a person who it considers is not, or may not, be receiving useful assistance elsewhere, and who it considers is, or may be, unable to arrange representation themselves. A variation to the Mental Health Act is proposed to provide that the Board is not required to obtain representation for an individual where it is satisfied that it is inconsistent with their views, wishes and preference. The focus of the Convention is upon ensuring that people have supports available to them. It does not require that those supports be mandated or provided where it is inconsistent with a person’s wishes.

15.4.27 Both EOT and Speak Out advocates endorsed reform to provide a direct requirement for the Board to arrange (rather than direct) representation where it has determined that representation is necessary. This might include, for example, making initial contact by way of referral and arranging a first conference. The Institute agrees that this is appropriate and is part of ensuring that a person has access to appropriate support. This is captured in the Mental Health Act example.

**Recommendation 15.6**

1. That the Act contain an equivalent provision to cl 7(4) of sch 4, pt 2 of the Mental Health Act 2013 (Tas), requiring the Board to make arrangements for the representation of a person in respect of whom a hearing is being held if it considers that the person is, or may not be, receiving useful assistance elsewhere and that they are, or may be, personally incapable of making those arrangements.

2. That the Board be required to make arrangements for the views and interests of a person in respect of whom a hearing is being held to be independently represented where the person in respect of whom the hearing is being held does not wish to, or is unable to, attend the hearing.

3. That the Board not be required to make arrangements for separate representation of a person in respect of whom a hearing is being held where it is satisfied that it is inconsistent with the person’s views, wishes and preferences.

**Other ways to involve a person in the Board process**

15.4.28 The Issues Paper asked for suggestions about other ways that the Act could be improved to ensure that a person in respect of whom a hearing is being held is included and encouraged to participate in the process.

What is the best way to ensure that a person who is subject of an application is included in the process?\(^{1497}\)

\(^{1497}\) TLRI, above n 69, Question 8.4.
15.4.29 There were 14 responses to this question. Suggestions and comments included a person in respect of whom a hearing is being held:

- having access to information;
- having contact with Registry staff prior to a hearing;
- being encouraged to attend a hearing; and
- providing opportunity for the person to speak at a hearing.

15.4.30 Social Work Services RHH suggested that the Act require advocates and representatives (if any) to ensure that a person is included in the process.

15.4.31 It was also suggested that adjustments can be made to the hearing environment to encourage and support a person being included and able to participate in the process, including:

- hearings being conducted informally, in an inquisitorial style, adopting a therapeutic jurisprudential approach. A good investigative process prior to a hearing was also endorsed;
- the importance of providing appropriate and accessible venues;
- the use of telephone or video conferencing facilities and communication assistance; and
- the use of advocates.\(^{1498}\)

15.4.32 The Board commented that ‘[h]earings need to be user friendly, non-threatening and non-adversarial, which means that the training of staff and Board members is critical.’ It noted that it already employs a number of strategies (including those listed above) to facilitate a person’s inclusion in the Board process. It commented that the AGAC is in the process of developing best practice guidelines in response to recommendations of the ALRC to ensure that a person in respect of whom a hearing is being held has opportunity to participate in the hearing process. The Institute has not made recommendations proposing reform to the Board’s existing processes and instead proposes that consideration is given to implementing the AGAC’s recommendations once made. Many suggestions raised by respondents to this review outlined how policy and physical, technological and educational strategies can assist to make Board hearings accessible. These matters do not require legislative reform and thus fall outside of the Terms of Reference for this review.

**Use of intermediaries**

15.4.33 The Institute has recently made recommendations in relation to the development of an intermediaries scheme within the criminal justice system in its Final Report, *Facilitating Equal Access to Justice: An Intermediary/Communication Assistant Scheme for Tasmania*.\(^{1499}\) The report recommends use of intermediaries as a means of providing individuals with access to support to maximise their participation within the legal system on an equal basis with others.

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\(^{1498}\) One submission stated that they considered that it was an ‘absolute imperative’ that where a person does not have an attorney acting on their behalf, that the person have an independent advocate to advocate on their behalf, including having a role to receive and explain information from residential care facilities or the Board.

15.4.34 The report commented that it was outside of the scope of the reference for that project to consider the potential use of intermediaries within the civil system, including in tribunal proceedings such as the Board.\textsuperscript{1500} It also falls outside of the scope of this reference. There would, however, seem to be synergies between the need to ensure that support is available for those within the criminal justice system and those in the guardianship jurisdiction. Both the OPG and EOT’s submissions highlighted the opportunity that could exist for the use of intermediaries within this jurisdiction. The Interim Children’s Commissioner also supported further consideration of the use of intermediaries in Board proceedings involving consent to medical treatment for children. The Institute recommends that the potential use of an intermediaries scheme within the Board be investigated.

\begin{center}
\textbf{Recommendation 15.7}
\end{center}

That a review be conducted in relation to the merits of utilising intermediaries in the guardianship jurisdiction.

\section*{15.5 Powers of the Board}

\subsection*{15.5.1}
The Act gives a range of powers to the Board. Some of these have been discussed in previous Parts. Additional powers are discussed in this section.

\subsection*{15.5.2}
The Board’s powers to appoint administrators and guardians were considered in Part 8. Its powers to supervise administrators and guardians, and review, revoke and amend their appointment were explained in Part 12.\textsuperscript{1501} Powers to request copies of a person’s Will were also considered in Part 12.\textsuperscript{1502}

\textit{Powers in relation to unlawful detention}

\subsection*{15.5.3}
The Board has power to make orders when it receives information that a person with a disability is being detained against their will. If the Board receives information that a person with a disability:

\begin{itemize}
  \item is being unlawfully detained against their will; or
  \item is likely to suffer damage to their physical, emotional or mental health or well-being unless immediate action is taken,
\end{itemize}

the Board can order the Public Guardian or another person to visit the person with a police officer to prepare a report for the Board.\textsuperscript{1503} Police may use reasonably necessary force to enter the premises for that purpose.\textsuperscript{1504} Any person who delays or obstructs a person acting under these provisions is liable on summary conviction and a fine may be imposed.\textsuperscript{1505}

\subsection*{15.5.4}
If, after considering the resulting report, the Board is satisfied that the person is being unlawfully detained against their will, or is likely to suffer damage to their physical, mental, or

\begin{footnotes}
\footnotetext{1500}{Ibid [1.5.2].}
\footnotetext{1501}{See [12.5], [12.6].}
\footnotetext{1502}{See [12.9.22].}
\footnotetext{1503}{Guardianship and Administration Act 1995 (Tas) s 29.}
\footnotetext{1504}{Ibid s 29(3).}
\footnotetext{1505}{Ibid s 29(4).}
\end{footnotes}
emotional health or well-being unless immediate action is taken, the Board may order the person’s removal to a safe place until an application for a guardian is heard.\textsuperscript{1506} Police also have power to enter premises and remove a person with a disability if they consider that they are, or have been, ill-treated, neglected or unlawfully detained against their will, or that they are likely to suffer serious damage to their physical, emotional or mental health or well-being unless immediate action is taken. Police must be accompanied by a person that the Public Guardian nominates and may use reasonable necessary force.\textsuperscript{1507} The nominated person must take the person to a safe place as soon as possible, ensure an application for guardianship is made and provide the Board with a written report.\textsuperscript{1508}

15.5.5 EOT made the following comments about this section:

we are concerned about the linkage in sections 29 and 30 of the Act to application for guardianship order because of the potential to automatically link abuse of persons with disability (including older persons) to questions about their capacity. We consider that the circumstances in which this authority may be used is broadened …

Guardianship orders should not be turned into a catch-all protective mechanism or a strategy of first resort in situations where the Board receives information that a person is subject to abuse or unlawful detainment. There are several reasons why this is the case:\textsuperscript{1509}

• Guardianship orders are a reactive response and emphasis on its use to address situations where individuals are vulnerable deflects emphasis from preventative strategies
• It leads to a focus on situations where individuals are suffering abuse at the hands of others
• It deflects assessing where more simple service system measure may improve the person’s quality of life
• It generally risks turning adult protection into something that is seen as someone else’s responsibility

Importantly also the use of guardianship orders to appoint a substitute decision-maker as a first response or only possible response is inconsistent with the CRPD.

Nor do we consider it appropriate to restrict the powers of the Board or Public Guardian to examining the situation of people with disability. Not all people with disability need protection and not all adults who need protection have a disability. Our preference is to use a broader term such at at-risk adults. This would encompass persons who because of disability, age or illness may be unable to care for themselves or protect themselves against significant harm or exploitation.\textsuperscript{1510}

15.5.6 This submission raises the point that not all at-risk adults have disability and that not all people with disability are at risk. Recommendation 12.28 recommends that there be a separate review into the merits of establishing adult safeguarding legislation in Tasmania. EOT’s submission demonstrates the utility in reviewing this matter to ensure that the Board and/or the Public Guardian

\textsuperscript{1506} Ibid s 29(2).
\textsuperscript{1507} Ibid s 30(2).
\textsuperscript{1508} Ibid s 30(3).
\textsuperscript{1509} John Chesterman, Responding to violence, abuse, exploitation and neglect: Improving our protection of at-risk adults (Report for the Winston Churchill Memorial Trust of Australia, 2013) 78.
\textsuperscript{1510} Office of the Public Advocate (Victoria), Submission to the Australian Law Reform Commission in Response to the Elder Abuse Issue Paper (August 2016).
or another authority are able to adequately respond to concerns about the abuse or neglect of adults, irrespective of whether the adult has a disability. It falls outside of the scope of this reference to consider this matter in any detail.

Other reform needed to the Board’s powers?

15.5.7 The Institute asked broadly whether there is any need for reform to the existing powers given to the Board under the Act.

<table>
<thead>
<tr>
<th>Should there be any changes made to the powers of the Board?</th>
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15.5.8 Several responses have been considered elsewhere in this Report:

- the OPG expressed its view that the Board have greater flexibility to determine the revocation of orders without holding a hearing. This issue was considered earlier in this Part;\(^{1512}\)
- two submissions suggested a need for reform in relation to the Board’s powers to request and read copies of a person’s Will. This was considered in Part 12;\(^{1513}\)
- one respondent proposed reform to appeal processes. This was also considered in Part 12;\(^{1514}\) and
- another raised issues about the Board’s accountability and transparency, a matter addressed earlier in this Part and in Part 12.

15.5.9 One respondent suggested that the Board should have a duty to attempt to investigate matters, including in an emergency, and that it be required to demonstrate that it had done so. As this matter relates to a potential reform to the duties of the Board, it is considered below.

15.5.10 The Board raised several matters for potential reform. Two have been addressed elsewhere:

- that the Board have power to make an emergency guardianship order despite the person being the donor of an instrument. This is the effect of Recommendation 15.2; and
- that upon revoking an instrument, the Board have power to appoint a guardian, consistent with equivalent powers the Powers of Attorney Act. This is the effect of Recommendation 12.7(2).

The following matters it raised have not been considered elsewhere and are thus addressed in this Part:

- that the Board have a general power to do ‘all things necessary and convenient’ to carry out its functions and powers, consistent with other statutes creating bodies like the Board.

The Act provides that the Public Guardian has power to ‘do all things necessary or convenient to be done in connection with the performance of his or her functions.’\(^{1515}\) The Institute endorses an equivalent power being included for the Board, as suggested;

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\(^{1511}\) TLRI, above n 69, Question 8.8.  
\(^{1512}\) See [15.2].  
\(^{1513}\) See [12.9.22].  
\(^{1514}\) See [12.4].
• that, whilst the Board has power under s 10 to appoint an Australian legal practitioner or medical practitioner or any other person with appropriate expertise to assist the Board in any proceedings, it commented that does not have funding to meet the costs of that assistance or to fund independent medical reports. It noted that this provision has been utilised in relation to obtaining expertise to assist the Board in applications for sterilisation and consent to restrictive practices. It commented that ‘[s]ignificant difficulty results in finding medical practitioners who are willing to assist the Board without payment.’

The Institute considers that this issue is not one requiring legislative reform, but a matter relating to the Board’s resourcing. The issue of resourcing is considered in Part 18; 1516 and

• that other jurisdictions have legislative provisions dealing with the appointment of an administrator for the estate of a missing person, irrespective of disability and capacity. It suggested that ‘consideration of this issue as to whether the Act or the Magistrates Court, civil division is the appropriate jurisdiction may be appropriate.’

The Institute acknowledges this suggestion, noting that it falls outside of the scope of the Terms of Reference for this project. It is suggested that the utility of legislative reform to deal with the administration of a missing person’s estate be separately reviewed.

**Recommendation 15.8**

(1) That an equivalent power to that granted to the Public Guardian in s 15(2) of the Act be conferred upon the Board, providing it with power to do all things necessary or convenient to be done in connection with the performance of its functions.

(2) That the need for legislative reform to deal with the appointment of an administrator for the estate of a missing person be reviewed.

### 15.6 Duties of the Board

15.6.1 The Board has an overriding duty to perform its functions in accordance with the guiding principles of the Act of what is in a person’s best interests, least restrictive of their freedom of decision and action and, if possible, carrying out their wishes. 1517 These principles were considered in Part 3 with recommendations made for their reform.1518

15.6.2 As the Institute’s Terms of Reference asked specifically about whether there should be reform to the duties of the Board, the Institute asked a separate question about this:

**Should the Board have any additional, or different, duties?**

15.6.3 As with the previous question, most responses have been addressed elsewhere in this Report, including:

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1515 Guardianship and Administration Act 1995 (Tas) s 15(2).
1516 See [18.2.26].
1517 Guardianship and Administration Act 1995 (Tas) s 6.
1518 See Recommendation 3.3.
1519 TLRI, above n 69, Question 8.9.
• that the Board should have a duty to consult with those close to a represented or proposed represented person, including their carers. This matter is addressed in Part 3 and throughout this Report; and

• that the Board should need to facilitate resolution of a dispute via mediation prior to a formal hearing. This was considered in Part 12.\textsuperscript{1520}

15.6.4 Other suggestions that have not been discussed elsewhere were:

• that the Board should have a duty to attempt to investigate matters, including in an emergency, and that it be required to demonstrate that it had done so (as noted above).

The Institute considers that this requirement is already implicit, including s 11(4) which provides that the Board may inform itself in relation to any matter and in any manner that it sees fit. Legislative reform is not proposed;

• that both the OPG and the Board provide community education. The OPG stated that ‘[i]t would be useful for the Act to clarify what, if any, role the Board should play in this area.’

This matter is considered in Part 16 as part of discussion of the functions and duties of the Public Guardian;\textsuperscript{1521} and

• that both the Board and the Public Guardian have a duty to promote good practice in relation to supported decision-making in the community.

Recommendation 3.3 proposes that one of the revised guiding principles of the Act be that ‘people who require support in decision-making must be provided with access to the most effective support necessary for them to make, communicate and participate in decisions that affect their lives.’ The Board would be required to exercise its functions and powers in accordance with this overarching guiding principle. Recommendation 6.4 proposes that the Act confirm that a person has decision-making ability if they can make decisions with practicable and appropriate support. Similarly, Recommendation 6.4 proposes that an adult not be treated as unable to make a decision about a matter unless all practicable steps have been taken to provide the adult with support and access to necessary information to make and communicate a decision. It is suggested that these proposals address the desirability of the Board and Public Guardian promoting good practice in relation to supported decision-making in the community.

15.6.5 The Board did not address this question and the Public Trustee responded that there was no need to revise the Board’s duties contained within the Act.

15.6.6 As a concluding question, the Institute asked broadly whether stakeholders considered there was any need to reform other provisions of the Act dealing with the functions, powers and duties of the Board not otherwise addressed in earlier responses.

\begin{paracol}[1522]  
\textbf{How else can the Act be improved in relation to the functions, powers and duties of the Board?}\textsuperscript{1522}  
\end{paracol}
15.6.7 The OPG raised several matters:

- that the Board have flexibility to make an on-going guardianship order upon hearing an application for medical consent, if it was satisfied that a guardian making health care decisions rather than the Board consenting to specific treatment would be in the person’s best interests. This matter was addressed in Part 13;\(^{1523}\)

- for the Board to be able to make a guardianship order on reviewing an instrument, noting that the Board may make an administration order on an application to review an enduring power of attorney. Recommendation 12.7 addresses this issue;

- considering granting the Board uniform powers to conduct ‘own motion’ reviews of any type. It is understood that this is addressed via Recommendation 12.5 relating to the Board’s power to review instruments of its own motion. The Board already has power to review administration and guardianship orders of its own motion; and

- giving the Board the ability to decline registration of an enduring instrument if there is clear evidence that the donor did not have the mental capacity to make it. This is the effect of Recommendation 4.11(1).

15.6.8 Other submissions pointed to the need for reform to processes and practices rather than the need for legislative reform. For example, it was commented that the avenue of seeking advice from the Board needs to be well promoted, regularly communicated, and an accessible process. PCT submitted:

PCT receives approximately 30 calls per year relating to the GAB and Public Guardian. These calls have never been about following legislative requirements, but rather people not understanding the reason for decisions, or service providers not understanding that families and friends can still be involved in palliative and end of life care, even if they are not the Guardian.

15.6.9 Other submissions raised matters that are addressed elsewhere in this Report, including:

- the need for the Board to be accountable including that the Ombudsman’s power be improved and that the Board not be immune from claims against it. One respondent commented ‘other state [organisations] — such as the Anti-Discrimination Commission, Anti-Discrimination Tribunal, the Ombudsman Tasmania and the Prosecution Service — will not investigate the misconduct of bodies such as the GAB and the Legal Aid Commission’; and

- that evidence before the Board should be able to be subject to a subpoena and able to be used in another court.

15.6.10 Some suggested improvements to the Board’s processes, including reducing the amount of paperwork, making it easier for a represented person to complain about their representative and ensuring that hearings are accessible. Revision to the Board’s internal processes and practices falls outside of the scope of this review unless requiring legislative reform, although issues of accessibility were discussed previously in this Part.\(^{1524}\)

\(^{1523}\) See Recommendation 13.8(4).

\(^{1524}\) See [15.4.28].
15.6.11 Carers Tasmania suggested that there be methods of checking on the safety or wellbeing of representatives as well as represented persons as part of review processes, noting that carers are also vulnerable to abuse. This was the only submission that raised this issue and it is not directly raised by the Terms of Reference so has thus not been considered further. Recommendation 3.3 does, however, propose that one of the guiding principles of the Act be an acknowledgement of the important role that families and carers and other informal supporters play.

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1525 Carers Tasmania referred the Institute to a Carers Queensland report which reportedly found that one third of carers had been emotionally abused, and 15 per cent physically abused.
Part 16

Functions, Powers and Duties of the Public Guardian

16.1 Introduction

16.1.1 The Public Guardian is one of the two bodies established by the Act, the other being the Board. The Public Guardian's role can be broadly divided into two functions. The first is to act as a representative for individuals. The second is to act as an advocate for the rights of people with disability, irrespective of whether they have a representative appointed for them.

16.1.2 The role of the Public Guardian is itself a safeguard aimed at protecting and promoting the rights and interests of people with disability at an individual and broader systemic level. Whilst Parts 12 and 14 made specific recommendations proposing improvements to safeguards in relation to representative decision-making and consent to health care and treatment, this Part also aims to strengthen the role of the Public Guardian as a means of safeguarding those impacted by the jurisdiction.

16.1.3 The Terms of Reference asked the Institute to consider the functions, powers and duties of the Public Guardian. This Part reviews these matters and makes recommendations for reform.

16.2 Role of the Public Guardian

16.2.1 The Act provides that the functions of the Public Guardian are to:

- foster the provision of services and facilities for persons with a disability;
- support the establishment of organisations which support persons with a disability;
- encourage the development of programs that support persons with a disability (including advocacy programs, educational programs, and programs to encourage persons to act as guardians and administrators);
- to promote, speak for and protect the rights and interests of persons with a disability;\textsuperscript{1526}
- to deal, on behalf of persons with a disability, with persons or bodies providing services;
- to represent persons with a disability before the Board;
- to investigate, report, and make recommendations to the Minister on any matter relating to the operation of the Act;

\textsuperscript{1526} Queensland describes this more directly as 'promoting the protection of the adults from neglect, exploitation or abuse': Guardianship and Administration Act 2000 (Qld) s 209(1)(b).
to act as a guardian or administrator when appointed by the Board;
• to disseminate information about the functions of the Public Guardian, the Board and the operation of the Act;
• to give advice on the powers that may be exercised under the Act relating to persons with a disability, as to the operation of the Act generally and on appropriate alternatives to taking action under the Act; and
• any other function assigned to it.

16.2.2 The OPG’s submission commented that these descriptions could be improved to better articulate the Public Guardian’s role. For example, it stated that:

the advocacy functions of the OPG need to be made explicit and to be focused on the aims of advocacy, i.e., promoting and protecting the rights and interests of people with impaired capacity for decision-making or reduced capacity for self-representation. In relation to the systemic (as opposed to individual) advocacy, the focus should be on influencing and promoting reforms to legislation, policy and service/program provision that protect people with a disability from harm and encourage autonomy and participation in all aspects of community life.

16.2.3 More broadly, there appears to be some duplication, or at least lack of clarity, in the list of functions allocated to the Public Guardian, particularly in relation to the establishment of services, programs and facilities (refer to the first three dot points above). It would assist both the OPG and the community to provide greater clarity. Noting that the OPG supports reform to improve clarity surrounding the role of the Public Guardian, it is recommended that this be reviewed.

Recommendation 16.1
That the descriptions of the functions of the Public Guardian in s 15(1) of the Act be reviewed for clarity and to eliminate duplication.

16.2.4 The OPG’s submission stated that:

the OPG’s view is that the roles and functions of the Public Guardian need strengthening in four main areas: (1) its investigation functions; (2) its role in community education; (3) its role in supporting other decision-makers; and (4) its systemic advocacy role.

A stronger role in each of these domains is essential to ensure that guardianship and administration appointments generally, as well as the appointment of the Public Guardian specifically, are truly a last resort. Whilst resourcing has been the key barrier to the OPG fully performing the ‘non-guardianship’ functions currently conferred on the Public Guardian, we believe it is critical that the legislation make explicit the role expected by Parliament and by the community.

1527 In 2016–2017, the OPG fielded more than 200 telephone and email enquiries from the public: OPG, above n 578, 22.
1528 Guardianship and Administration Act 1995 (Tas) s 15(1).
16.2.5 The following sections consider some of the existing functions of the Public Guardian and evaluate options for reform.

**Community education**

16.2.6 Two of the existing functions of the Public Guardian are to disseminate information about the functions of the Public Guardian, the Board and the operation of the Act and to give advice on the powers that may be exercised under the Act, the operation of the Act generally and on appropriate alternatives to taking action under the Act.\(^{1529}\) The OPG’s submission commented that both the OPG and the Board provide community education. The OPG stated that ‘[i]t would be useful for the Act to clarify what, if any, role the Board should play in this area.’ In relation to its community education function, the OPG submitted that:

Our view is that these functions should remain with the OPG and that the legislation should make it clear that the OPG has the primary or lead role. This would avoid duplication with the role the Board might take, in providing education sessions and developing written and other information/education materials.

16.2.7 Noting the need to ensure that resources are used effectively, it is agreed that there should be clearly defined roles for the Public Guardian and the Board in this area. The Act does not provide a specific role for the Board to disseminate community information. At a practical level, it is useful for the Board to have readily accessible information about the Act and its own processes for those who come into contact with the Board, or who contact the Board seeking out this information. The Institute has not made recommendations for legislative reform on the basis that there may not be a need for such change, but with the issue instead addressed through the Board and OPG coordinating activities.

**Other roles?**

16.2.8 This Report has already made recommendations to extend the role and powers of the Public Guardian. Parts 4 and 12 outlined reforms to provide the Public Guardian power to mediate matters.\(^{1530}\) The OPG’s submission also proposed the following extensions of the Public Guardian’s role, depending on other reforms to the Act:

**Supporting other decision-makers**

Our view is that the OPG should take the lead role in supporting and guiding enduring guardians and attorneys, Board-appointed private guardians and administrators, persons responsible and any future decision making supporters or co-decision makers. We believe this role/function should be explicitly identified in the legislation … our view is that the Public Guardian’s role should be one of support, education and guidance rather than formal monitoring and oversight. In the event that new roles arise under revised legislation for supporters and co-decision makers, our view is the OPG is the logical agency to take the lead in the provision of training and education, and potentially in coordinating new services …

\(^{1529}\) Ibid ss 15(1)(i)–(j).

\(^{1530}\) Recommendations 5.7, 12.4.
Other

In addition, the OPG should be considered as the agency to take on the role of coordination and/or management of any new related services, such as an official visitor scheme and an intermediary scheme, in the event that such programs are introduced to Tasmania.

16.2.9 The first proposal is that the Act explicitly confirm the role of the Public Guardian to support representatives. This is implicit in the current drafting of the Act, which provides that one of the Public Guardian’s functions is to give advice on the powers that may be exercised under the Act, the operation of the Act generally and on appropriate alternatives to taking action under the Act.\textsuperscript{1531} Explicitly confirming that one of the roles of the Public Guardian is to support representatives and supporters has the following advantages:

- it may assist in increasing community awareness of the role that the Public Guardian can play in supporting supporters and representatives;
- supporting supporters and representatives promotes them acting in accordance with the Act and performing the role competently; and
- it is one means of providing a person with broader decision-making support.

For these reasons, the Institute endorses this proposal.

**Recommendation 16.2**

That one of the functions of the Public Guardian be to support and educate representatives, supporters and informal supporters, including by giving advice on the functions and powers that may be exercised under the Act, the operation of the Act generally and on appropriate alternatives to taking action under the Act.

16.2.10 The second of the OPG’s suggestions is that it take a lead role in coordinating and managing any newly related services, such as an official visitor scheme or intermediary scheme. These matters are addressed elsewhere in this Report.\textsuperscript{1532}

**Investigative function**

16.2.11 The Act states that the Public Guardian may investigate complaints and allegations against representatives.\textsuperscript{1533} It must investigate matters that the Board refers to it for investigation.\textsuperscript{1534} The Board advises that its staff no longer investigate matters that are the subject of an application and instead refers matters to the Public Guardian where it considers that further information is required.\textsuperscript{1535}

\textsuperscript{1531} Guardianship and Administration Act 1995 (Tas) s 15(1)(j).

\textsuperscript{1532} See Part 17 in relation to an official visitor scheme, Part 15 in relation to the potential use of intermediaries.

\textsuperscript{1533} Guardianship and Administration Act 1995 (Tas) s 17. The OPG did not receive any requests from the public in 2016–2017: OPG, above n 578, 23.

\textsuperscript{1534} Guardianship and Administration Act 1995 (Tas) s 17.

\textsuperscript{1535} See Guardianship and Administration Board, above n 235, 4-5.
16.2.12 The OPG submitted that:

Currently section 17 gives the Public Guardian quite narrow powers to investigate (1) complaints and allegations concerning the actions of a guardian, administrator or a person acting under an enduring power of attorney and (2) any other matter before the Board, on the request of the Board. In many other jurisdictions, the investigative functions extend to people with a disability who are not represented persons and may be made at the Public Guardian/Advocate’s own initiative.

16.2.13 It is proposed that the Public Guardian be able to investigate matters of its own motion. This provides the Public Guardian with an equivalent ability to the Board to determine when investigations should occur. It removes the need for the Board’s involvement, thus reducing its workload. This may improve the jurisdictions’ responsiveness and lead to improved outcomes, better safeguarding the rights of people requiring decision-making support. It provides consistency with powers granted to the Public Guardian in Queensland and aligns with the VLRC’s recommendations.1536

16.2.14 It is also suggested that the Public Guardian be able to investigate matters involving non-represented people. The OPG submitted that:

The OPG is of the strong view that its investigation function should be broadened to include investigating circumstances where a person with a disability (other than currently represented persons) is suspected to be subject to or at risk of abuse, exploitation or neglect.

16.2.15 EOT also submitted:

we are of the view that the ability to undertake the functions [to proactively protect the rights of people with disability] should be adequately resourced as part of a broader strategy to prevent and address the abuse of vulnerable adults including people with disability and other adults who by reason of age or illness may be unable to protect themselves against significant harm or exploitation.

This safeguarding function should be legislated to enable protective actions to be taken even in situations where a person does not satisfy the need for substituted or supported decision making.

16.2.16 This is already implicit, as the Board may, and does, refer investigations to the Public Guardian involving non-represented people. It is proposed that this be extended to enable the Public Guardian to also investigate matters involving non-represented people of its own motion. The ability to investigate matters relating to non-represented people is a function typically conferred upon Public Guardians in other jurisdictions.1537 It functions as a safeguard, particularly when most members of the community requiring decision-making support are supported informally and do not have a representative appointed.

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1536 See for example *Public Guardian Act 2014* (Qld) s 19. The VLRC recommended that Public Guardians have power to investigate matters of its own motion: VLRC, above n 24, Recommendation 329.

1537 *Guardianship and Administration Act 1993* (WA) s 97(1)(c); *Guardianship and Administration Act 1986* (Vic) s 16(1)(b); *Guardianship and Administration Act 1990* (WA) s 97(1)(c); *Public Guardian Act 2014* (Qld) s 19(b).
16.2.17 The OPG also suggested that the Public Guardian have power to investigate other
decision-makers in addition to representatives:

The current powers to investigate complaints or concerns about the acts or wrong-
doings of guardians, administrators and attorneys should remain and be extended to
other substitute decision-makers including persons responsible and any (formal)
supporter or co-decision maker.

16.2.18 This suggestion is endorsed on the basis that it aligns with the existing functions of the
Public Guardian in supervising representatives. It serves as a safeguard for those who do not have
a formal representative appointed, but have a need for decision-making support in the context of
health care and treatment decisions.

Recommendation 16.3

That the Public Guardian have the following additional functions and powers:

• to investigate complaints and allegations against supporters and representatives including
  persons responsible;
• to investigate matters of its own motion; and
• to investigate circumstances where a person with a disability is suspected to be subject to or
  at risk of harm, abuse, exploitation or neglect.

Investigations in relation to elder abuse

16.2.19 Four submissions referred to and supported the Public Guardian having power to
investigate allegations of elder abuse. This could provide a mechanism to better detect, investigate
and respond to allegations of elder abuse. The potential role would seem to align with existing
investigative functions and powers granted to the Public Guardian within the Act.

16.2.20 Victims of elder abuse may include people with disability, but are not exclusively
individuals with disability. Elder abuse extends to a range of other individuals within the
community who, for a range of reasons, are at risk of abuse, neglect or exploitation. To the extent
that a person with disability may be subject to elder abuse, Recommendation 16.3 would enable
the Public Guardian to investigate, by direction of the Board or at its own instigation, allegations
of elder abuse against a non-represented person. The issue to resolve is whether the Public
Guardian should play a role in investigating elder abuse perpetrated against people without
disability. People without disability should have equal protections from the risk of elder abuse as
those with disability. One option to seek to detect and respond to elder abuse might be to grant
the Public Guardian specific powers to investigate elder abuse irrespective of whether the alleged
victim is a person with disability.\textsuperscript{1538} One advantage to that approach is that it results in all
members of the community being treated equally and having equal protections against abuse.

\textsuperscript{1538} This is consistent with recommendations of the Legislative Council General Purpose Standing Committee
No. 2, \textit{Enquiry into Elder Abuse in New South Wales}, Recommendation 11. This was recently referred to by the
Coroner as an option for potential reform in the \textit{Findings and Recommendations of Coroner Olivia McTaggart
following the holding of an inquest under the Coroners Act 1995 into the death of Janet Lois Mackoqdli 2018 TASCID
274, 189.}
Granting the Public Guardian powers to investigate elder abuse in this broad manner would, however, extend the existing scope of its traditional role relating only to people with disability.

16.2.21 The Coroner recently recommended that:

the Tasmanian government give consideration to the establishment of an independent body with specific responsibility for elder abuse by, inter alia, investigating complaints, researching and responding to the ill-treatment of older people, developing community education programs and by overseeing cases where there is a risk of elder abuse.\(^{1539}\)

And further that:

alternatively, that the Tasmanian government give consideration to enhancing the powers of, and appropriately resourcing, the Office of the Public Guardian so that the above functions can be effectively performed.\(^{1540}\)

16.2.22 Elder abuse is an increasing problem requiring both a legislative and policy response.\(^{1541}\) Responding effectively to elder abuse is a matter that requires separate consideration. It is outside of the scope of this review to consider comprehensive responses to the issue of elder abuse in Tasmania. Recommendation 12.28 of this Report does, however, propose that the merits of introducing adult safeguarding legislation in Tasmania be further investigated. This comprises one possible strategy to better address issues of elder abuse in the community. In relation to this issue, the OPG’s submission commented that:

The OPG is mindful of the findings and recommendations of the recent ALRC report into elder abuse which included recommendations for the states to enact adult safeguarding laws and establish adult safeguarding agencies. Whilst the report did not finally propose that Public Guardians/Advocates should necessarily be given a broader adult safeguarding function, much consideration was given to the roles already undertaken in most jurisdictions and the logic in strengthening and possibly extending their investigation functions to vulnerable adults who do not necessarily have impaired decision-making capacity. The OPG’s proposed broadening and strengthening of the Public Guardian’s investigation function would ready the office for likely future policy development in this area.

Should the Board or Public Guardian investigate matters before the Board?

16.2.23 Two submissions raised whether it should be the Board or the OPG that investigates a matter prior to a Board hearing. One respondent submitted that this should be a role for the Public Guardian. Members of the Elder Law Committee’s submission commented:

The PG [Public Guardian] might be appropriately placed to be the policing body/punitive guardian of the legislation … Alternatively the Board’s funding should be increased to enable the return of a dedicated investigator role (the Board functioned well in the years that a dedicated investigator was employed).

\(^{1539}\) Janet Lois MacKozdi 2018 TASCD 274, [200].

\(^{1540}\) Ibid [201].

\(^{1541}\) For further discussion, see Lacey, above n 1037.
16.2.24 This would appear a matter of policy and thus falls outside the scope of the Institute’s Terms of Reference. The Institute notes, however, the importance of avoiding any perception of conflicting interests and that the Public Guardian has the advantage of being an independent body separate to the Board that hears and determines a matter.

**Systemic advocacy role**

16.2.25 The Australian Human Rights Commission has recently endorsed the role of systemic advocacy as one component of safeguarding the rights and interests of people with disability within institutional settings.\(^\text{1542}\) It comments that effective systemic advocacy requires organisations to be ‘well trained and resourced’ to undertake this function.\(^\text{1543}\)

16.2.26 The Public Guardian reports that the OPG has limited resources to take a proactive role in fostering the provision of services and facilities for people with disability.\(^\text{1544}\) It does not currently have additional advocacy programs other than its direct work in its role as a guardian for individuals. It makes referrals to community-based advocacy services as required.\(^\text{1545}\)

16.2.27 The Institute asked for feedback about whether the Public Guardian should continue to have a role in systemic advocacy for people with disability, or whether there is any merit to that function being delegated to a separate body as occurs in some other jurisdictions. The Issues Paper noted that in Queensland, the systemic advocacy function is delegated to a separate authority, called the Public Advocate who:

- acts as a watchdog for all vulnerable citizens whether or not subject to a guardianship order;\(^\text{1546}\)
- conducts a public advocacy role in promoting and protecting the rights of people with disability, and protects against neglect, abuse and exploitation;\(^\text{1547}\) and
- encourages the development of programs and the provision of services and facilities.\(^\text{1548}\)

The Public Guardian then performs the roles of acting as a representative and conducting investigations at an individual level.

16.2.28 The Institute is cognisant that delegating systemic advocacy to a separate body does not necessarily mean that the work would be performed any differently or better as success largely depends upon adequate resourcing. In a small jurisdiction such as Tasmania, it may not be sustainable to separate the functions amongst different organisations. The Institute therefore

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\(^\text{1542}\) Australian Human Rights Commission, above n 60, 40.

\(^\text{1543}\) Ibid.

\(^\text{1544}\) OPG 2016, above n 1299. See also OPG, above n 578, 7.

\(^\text{1545}\) OPG 2016, above n 1299, 20.

\(^\text{1546}\) Terry Carney, ‘Australian Guardianship Tribunals: An adequate response to CRPD disability rights recognition and protection of the vulnerable over the life course?’ (2017) 10 *Journal of Ethics in Mental Health* 1, 3.

\(^\text{1547}\) See, for example, *Guardianship and Administration Act 2000* (Qld) s 209.

\(^\text{1548}\) See, for example, ibid; *Guardianship and Administration Act 1993* (SA) s 21.
asked for feedback about whether establishing a separate role of a Public Advocate might better serve the needs and interests of people with disability in Tasmania.

Is there merit to further investigating the establishment of a separate Office of the Public Advocate?\(^{1549}\)

16.2.29 Fourteen submissions addressed this question. Many noted the importance of systemic advocacy. The Board, for example, commented:

The Board wishes to highlight the need for systemic advocacy. Systemic advocacy seeks to influence or secure positive long-term changes that remove barriers and address discriminatory practices to ensure the collective rights and interests of people with decision making incapacity are upheld and can address systemic abuse and neglect. Systemic advocacy also pursues positive changes to legislation, policy and service practices and facilitates referral to and information exchange with relevant government and community sector organisations. These are important functions, particularly if there are significant changes to the Act being considered.

16.2.30 Several respondents pointed to a perceived gap in the current provision of systemic advocacy in Tasmania. Six responses expressed support for the establishment of a Public Advocate being further considered, with five indicating some level of reservation or rejection of the option. Other submissions did not indicate a view either way, highlighting the potential advantages and disadvantages to each model.

16.2.31 The OPG did not agree that there be a separate Office of the Public Advocate. It submitted that:

The OPG is strongly opposed to the establishment of a separate office to undertake the public advocacy functions currently conferred on the Public Guardian. There is no merit in creating yet another small office in such a small jurisdiction; there is, however, risk that splitting the functions would further stretch resources.

The only other jurisdictions that have separate offices of the Public Guardian and Public Advocate are the ACT and QLD. In the ACT, there is a single office of The Public Trustee and Guardian, and a separate Public Advocate, who is also the Children and Young People Commissioner. Anecdotally, we understand there is some overlap in the roles resulting in unnecessary duplication of (scarce) resources. In Queensland, the Public Guardian has responsibility for protecting the rights and interests of children and young people in the child protection system, as well as adults with a disability. Again, we have heard anecdotally that there is some overlap/duplication in the roles of the Public Guardian and public Advocate.

The OPG advocates consideration of models that might combine statutory offices in other protective jurisdictions such as the Children’s Commissioner or Official Visitor schemes where there is a synergy of roles, which would provide some economies of scale and sharing of administrative resources.

The OPG is open to a change in title from Public Guardian to Public Advocate. For those states and territories other than the ACT and Queensland, half have Public Guardians and half have Public Advocates. The functions of all include both acting as

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\(^{1549}\) TLRI, above n 69, Question 9.1.
guardian of last resort and systemic advocacy. Two potential advantages of calling Tasmania’s officer the Public Advocate rather than Public Guardian might be decreased confusion between the roles and offices of the Public Guardian and the Guardianship and Administration Board, and a greater consciousness of and focus on the systemic advocacy functions, which to date have been poorly neglected.

16.2.32 The Public Trustee did not express a view, commenting ‘that a business case be undertaken to identify the pros and cons and financial viability of such a proposal.’ PCT also submitted that it considers there is merit to further investigating this model, but that it believes it would not be economically viable. It submitted that ‘it may be more appropriate to examine further programs and funding for existing organisations like Advocacy Tasmania and relevant Community Legal Centres.’ Members of the Elder Law Committee also submitted that if the Public Guardian is not able to adequately fulfil its advocacy function, an increase in financial resources and powers ought first be considered.

16.2.33 Two submissions commented that, in their observations, the system is already too complicated and that a further body for people to interact with would only add to complexity and confusion.

16.2.34 Speak Out advocates highlighted the following matters that it considered relevant:

- that the roles of a guardian and advocate are different, with possibly different desirable skill-sets;
- that making the roles separate might assist to provide clarity of function and reduce competing pressures impacting upon the performance of a systemic advocacy role; and
- the need to avoid the system becoming disparate.

They commented that, if the roles were to be separated, the respective bodies would need to keep each other informed. They noted that it may be desirable to maintain a watching brief in relation to the role of the Senior Practitioner and Disability Commissioner under the NDIS, querying the role that a Public Advocate would play following these national reforms, whilst acknowledging that not all people with disability will fall under the NDIS.

16.2.35 The Board expressed support for the institution of a Public Advocate being further considered, commenting:

Essentially, the Public Guardian prioritises some of her functions as specified in the Act over others, when in fact the legislation gives equal priority to all of these functions. While this is partly a resourcing issue, the result is a lack of systemic advocacy. Even with greater resourcing being provided to the Public Guardian, this prioritisation could continue, and therefore gives some weight to the appointment of a separate authority.

16.2.36 TasCOSS endorsed establishment of a Public Advocate separate to the OPG. It proposed that the Public Advocate’s role be to ‘engage in individual advocacy, community empowerment and systemic oversight and advocacy.’ It suggested that some of its functions could include to:
• establish a legislated supported decision-making regime including performing an oversight and monitoring role;
• execute a decision-support program; and
• produce and disseminate capacity building resources, including coaching decision-makers and supporters.

It expressed a preliminary view that these roles should not be assigned to the Public Guardian, commenting that ‘that this would not be desirable due to the conflicting demands of these very different roles.’

16.2.37 Advocacy Tasmania endorsed establishment of a separate Office of the Public Advocate, stating that it observes that ‘[t]hese offices fulfil an essential role in other jurisdictions.’

16.2.38 In summary, responses to this question indicated that systemic advocacy for people with disability remains important as it was when the Act was initially enacted. Whilst EOT plays an important role in protecting and promoting the equal rights of Tasmanians, it is the specific remit of the Public Guardian to advocate exclusively for people with disability. EOT states that there is a need for both the Board and the OPG to take a proactive role in protecting the rights of people with disability.

16.2.39 The Board’s submission comments that the potential for the Public Guardian to prioritise its workload in acting as a representative over its other functions should be avoided. It is acknowledged that the role of representative can be both time-intensive and time-critical, particularly when the Public Guardian is appointed under an emergency order. It can take time to develop a relationship with a represented person. The need to ensure the establishment of strong relationships becomes increasingly important under proposed reforms calling for decision-making based on a person’s view, wishes and preferences. This review also recommends enhanced powers for the Public Guardian under a revised Act to better safeguard the rights and interests of people who may become subject to the Act. The potential increase in functions should be considered when determining future resourcing allocations to the OPG.

16.2.40 It may be that the establishment of a separate Office of Public Advocate is the best way to ensure that there is a separation of functions and accountability for the performance of the dual roles currently allocated to the Public Guardian. Alternatively, if the issue is one of resourcing, then this problem should be addressed without establishment of a Public Advocate being necessary. The underlying cause, and therefore solution, needs to be further analysed. The Institute endorses the Public Trustee’s comments that it is appropriate that the assessment of whether there is a need for a Public Advocate requires development of a business case. As the OPG notes, Tasmania is a small jurisdiction and it is important that resources are used wisely and that there not be dilution of resources. It is proposed that these matters be further considered.

**Recommendation 16.4**

That strategies be developed to improve the delivery of systemic advocacy for people with disability.
Amalgamation of the roles of the Public Guardian and Public Trustee

16.2.41 The previous section considered the desirability of reform to establish a separate Office of the Public Advocate. The Issues Paper also noted, in the ACT, roles traditionally assigned to a Public Advocate/Public Guardian and Public Trustee have been combined through the establishment of a ‘Public Trustee and Guardian.’1550 Its role is to act as guardian and administrator for individuals.1551 The Institute asked whether there was merit to further investigating this model in Tasmania, noting that one of the Institute’s Terms of Reference is to consider ways to make the Act more sustainable and responsive.

Is there merit to further investigating the combining of the role and functions of the Public Guardian and the Public Trustee?1552

16.2.42 There were eight responses to this question, with only one expressing support for this model. As with the previous question, the Public Trustee submitted that it held no deliberated view and that a business case ought to be developed to consider the merits and financial viability of this option.

16.2.43 The OPG did not support the amalgamation of the functions of the Public Trustee and Public Guardian, commenting:

An amalgamation of the functions of The Public Trustee and the Public Guardian in Tasmania was explored three to four years ago and not, ultimately, pursued. Whilst there is some similarity in the functions of each, there are significant cultural and philosophical differences in the approaches taken and vastly different skills and expertise required of account managers compared to those of guardians.

The Public Trustee in Tasmania is a Government Business Enterprise (GBE) operating on a commercial basis, with clear expectations that it will pay dividends to Government. The functions of the Public Guardian do not sit easily in such a model of operation. Arguably the activities of the Public Guardian, if it were to be merged with The Public Trustee, could be provided as a Community Service Obligation (CSO) under part 9 of the Government Business Enterprise Act 1995. The OPG considers there would be real risk the full range of functions of the Public Guardian would not be adequately funded under such an arrangement.

There are occasionally conflicts of interest between the roles of guardian and administrator which could be difficult to resolve if The Public Trustee and Public Guardian were merged as one authority. In addition, from time to time The Public Trustee is unable to act as the administrator for a represented person due to a conflict of interest it has with another role it performs, for example, when a represented person contests a will for which The Public Trustee is executor. In such cases the Public Guardian may be appointed as the administrator thereby avoiding The Public Trustee’s conflict of interests.

1550 See Public Trustee and Guardian Act 1985 (ACT).
1551 Ibid ss 13(1)(g)–(h).
1552 TLRI, above n 69, Question 9.2.
The Public Guardian needs to be free to advocate on behalf of represented persons under administration at both individual and systemic levels. This would be difficult if the Public Guardian and Public Trustee roles were merged.

16.2.44 Members of the Elder Law Committee made similar observations about the Public Trustee as a GBE and the potential for conflicts of interest to arise:

The Public Trustee (‘PT’) is a GBE and is focused on profit. Merging the PG and PT gives rise to conflict of interest concerns (because the PT are in an interested position to get the administration).

16.2.45 One respondent endorsed this option as effectively providing a ‘one stop shop’ for members of the community. It was commented that:

I want to know that if I’ve walked through a door that looks like it is the right door, then it IS the right door, and I’m not about to be told to look for a different door.

16.2.46 In addressing another question, another respondent stated: ‘There should be collaboration between the Public Guardian, Public Trustee and any Advocate when decisions have to be made that reflect a person’s stated wishes.’

16.2.47 Issues relating to the potential amalgamation of the Public Trustee and Public Guardian involve similar considerations to those raised in Part 4 in relation to whether the roles of an administrator and guardian ought to be merged. For several reasons, including the differing functions and desirable skill-sets and the potential for conflicts of interest, it was recommended that the legislative framework retain separate roles of administrators for financial matters and guardians for personal matters. For these same reasons, and noting the lack of public support for this model, the Institute has not made recommendations to merge the roles of the Public Trustee and Public Guardian. The Institute does, however, endorse further consideration being given to the development of strategies which may have the potential to create efficiencies within the jurisdiction. Consideration should also be given to options to respond to feedback (such as that extracted above) indicating community perception that the existing framework is confusing and expressing a desire for the system to be more user-friendly and consumer driven.

16.3 Powers of the Public Guardian

16.3.1 The Public Guardian has power to do all things necessary or convenient to be done in connection with the performance of her functions. This next Part considers specific powers granted to the Public Guardian in the Act. The Coroner has recently commented that the Act ‘does not appear to provide comprehensive and targeted powers to the Office of the Public Guardian.’

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1553 See [4.2].
1554 Guardianship and Administration Act 1995 (Tas) s 15(2).
1555 Janet Lois Mackozdi 2018 TASCD 274, [195].
Investigative powers

16.3.2 As discussed previously in this Part, the Public Guardian must investigate matters that the Board refers to it for investigation, and may investigate other complaints and allegations against representatives. The Act does not confer express powers upon the Public Guardian to execute its investigative function. The Issues Paper commented that it could be appropriate to provide a direct power for the Public Guardian to compel the provision of information. It noted that the Public Guardian could, for example, be given equivalent powers to those provided to the Board to require government departments, state authorities, services providers and representatives to provide reports and information relevant to an investigation.

16.3.3 The Institute observes that the Public Guardian’s investigative role is not that dissimilar to the roles of the Senior Practitioner under the Disability Services Act and Official Visitors under the Mental Health Act. It is therefore useful to review how those Acts deal with the provision of information and the need for third parties to assist those bodies when investigating complaints or concerns. The Mental Health Act provides that anyone with responsibilities under the Act is required to assist Official Visitors investigating matters by giving people reasonable help to make complaints. It provides:

(3) if a person discharging responsibilities under this Act knows that a patient has expressed a wish to see or complain to an Official Visitor, the person must, to the maximum extent of the person’s lawful and physical capacity to do so –

(a) grant Official Visitors access to those parts of premises in which the patient is being accommodated or being assessed or treated; and

(b) facilitate private and direct communication between Official Visitors and the patient (consistently with the patient’s wishes); and

(c) grant Official Visitors access to records relating to the patient’s assessment, treatment and care, including clinical records (unless the patient has asked that Official Visitors not be granted that access); and

(d) grant Official Visitors access to other relevant records or registers required to be kept under this Act; and

(e) answer questions about the assessment, treatment and care of the patient to the best of the person’s knowledge and in a full and frank manner (unless the patient has asked that Official Visitors not be provided with that information); and

(f) give Official Visitors such other reasonable assistance as they may require.

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1556 Guardianship and Administration Act 1995 (Tas) s 17.
1557 Ibid. The OPG did not receive any requests from the public in 2016–2017: OPG, above n 578, 23.
1558 Under s 15(2) of the Guardianship and Administration Act 1995 (Tas), the Public Guardian has power to do all things necessary or convenient to be done in connection with the performance of his or her functions.
1559 See ibid s 11(11).
1560 Official Visitors are members of the community whose role it is to visit facilities and check on the rights and welfare of patients. They receive and investigate complaints and review the appropriateness of facilities.
1561 Mental Health Act 2013 (Tas) s 163(3).
16.3.4 The *Disability Services Act* provides:

(1) The Senior Practitioner may require a disability services provider, any employee of the provider, and a funded private person, to provide the Senior Practitioner with any reasonable assistance that the Senior Practitioner may require to perform a function or exercise a power of the Senior Practitioner in the disability services provider’s premises or the private funded premises of the funded private person.

(2) A disability services provider, any employee of the provider and a funded private person—

(a) must not fail to provide reasonable assistance when required to do so under subsection (1); and

(b) must give full and true answers to the best of the provider’s, employee’s or funded private person’s knowledge, respectively, to any question asked by the Senior Practitioner in the performance or exercise of a function or power of the Senior Practitioner under this Act.\(^{1562}\)

16.3.5 It is also useful to review how the powers of the Public Guardian are addressed in other jurisdictions. In Queensland, for example, the *Public Guardian Act 2014* provides as follows:

**22 Right to information**

(1) The public guardian has a right to all information necessary to investigate a complaint or allegation, or to carry out an audit, in connection with an adult.

(2) The public guardian may, by written notice given to a person who has custody or control of the information, require the person—

(a) to give the information to the public guardian; and

(b) if the person is an attorney or administrator and the information is contained in a document—to give the document to the public guardian; and

(c) if the person is not an attorney or administrator and the information is contained in a document—to allow the public guardian to inspect the document and take a copy of it.

(3) The person must comply with the notice, unless the person has a reasonable excuse.

Maximum penalty—100 penalty units.

(4) It is a reasonable excuse for a person not to comply with the notice because complying with the notice might tend to incriminate the person.

(5) Subject to subsection (4), this section overrides—

(a) any restriction, in an Act or the common law, about the disclosure or confidentiality of information; and

(b) any claim of confidentiality or privilege, including a claim based on legal professional privilege.\(^{1563}\)

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\(^{1562}\) *Disability Services Act 2011* (Tas) s 33.

\(^{1563}\) *Public Guardian Act 2014* (Qld) s 22.
16.3.6 The Institute asked whether, and how, the powers of the Public Guardian might be reformed.

**Should there be any changes made to the powers of the Public Guardian?**

16.3.7 Some of the responses to this question have been addressed previously in this Part as they related primarily to the role and functions of the Public Guardian rather than its powers.

**Investigative powers**

16.3.8 In relation to the Public Guardian’s investigative powers, the OPG submitted:

The OPG is also of the strong view that its powers of investigation should be strengthened and made enforceable by specific powers to compel people or organisations to provide information. To be effective, such powers should include the ability to serve notices requiring a person or organisation to provide specific documents and other relevant material; to answer questions, both in writing or in person; to attend conferences; and to visit the person in any premises if access by the owner is denied, either with a warrant or on an order of the Board as currently available under section 29 of the Act (noting that this section has rarely, if ever, been used) …

The advantages of an expanded scope in investigation functions and enhanced powers to enforce the provision of information include:

- It will go some way to filling the current gap in responding to abuse …
- Proactive referrals to other agencies such as the police, the Ombudsman, the Aged Care Complaints Commissioner, and medical or other therapeutic counselling/support services.
- Opportunity for dispute resolution and other interventions that might avoid the need for applications to be made to the Board for the appointment of guardians and administrators, or the review of enduring appointments.
- Advocacy for improved service provision, again with the potential to avert guardianship and administration applications/appointments.
- Means of monitoring and providing education, support and guidance to substitute decision-makers (private guardians and administrators; people operating or purporting to operating under an enduring power of attorney; persons responsible) and, potentially, to formal supporters or co-decision makers if such arrangements are included in the legislation.

16.3.9 Members of the Elder Law Committee commented that ‘[g]iven the comments in the Issue’s Paper, the possible need for greater powers of investigation should be closely examined.’

16.3.10 Speak Out submitted that the Public Guardian needs stronger powers to ensure that people are safe. Speak Out advocates commented that the powers of the Senior Practitioner under the Disability Services Act could be adapted for the Public Guardian. They also commented that the Public Guardian should have power to access bank accounts and other information, in order to

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1564 TLRI, above n 69, Question 9.4.
investigate allegations of abuse. Another respondent commented that ‘[t]he Public Guardian appears to have little power to revoke an appointment or properly investigate issues due to time constraints and lack of funding.’

16.3.11 MIGA submitted that there should be some limits to the extent to which medical or health practitioners should be required to provide information:

If the Public Guardian is provided with investigative powers to compel information from medical and other health practitioners, there should be: …

• Scope for reasonable excuse for declining or otherwise failing to provide information in response to the exercise of any investigatory powers, including around issues of self-incrimination and practicality

This matter was discussed in Part 12.1565

16.3.12 Whilst the Act provides a ‘catch all’ provision, providing the Public Guardian with power to do all things necessary to perform its role, it is agreed that the Act should confer specific powers upon the Public Guardian to enable her to execute the Public Guardian’s investigative function as a critical component of the role.

16.3.13 As discussed in Part 12, the Convention requires that ‘all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse … Such safeguards shall ensure that measures relating to the exercise of legal capacity … are subject to regular review by a competent, independent and impartial authority or judicial body.’1566 The ALRC’s Safeguards Guidelines provide that interventions for people who require decision-making support must be subject to regular, independent and impartial monitoring and review.1567 The Public Guardian’s oversight and investigative role is one of the existing overarching safeguards of the Act. The Public Guardian's ability to investigate complaints or concerns is particularly important for people who are socially isolated and may not have others from within their existing support network able to supervise the suitability of decision-making supports and the conduct of representatives.

16.3.14 The Institute has not made suggestions about the precise powers that ought to be given to the Public Guardian to perform investigations. These details should be guided by suggestions of the OPG about how they see the Act best facilitating the investigative process, in addition to further consultation with key stakeholders likely to be impacted by the reforms. Powers given to the Senior Practitioner and Official Visitor under the Disability Services Act and Mental Health Act may be useful to guide legislative reform. Further consideration could also be given to adopting or adapting the powers granted to the Public Guardian in Queensland (extracted previously in this Part). The Institute makes several suggestions about the powers that could be conferred, without this list being intended as an exhaustive list. These include:

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1565 See Recommendation 12.22(e).
1567 ALRC, above n 3, Recommendation 3-4.
• confirming the Public Guardian’s rights to information, with s 22 of the Public Guardian Act 2014 (Queensland) providing a useful example of a provision of this type;

• giving the Public Guardian powers to require provision of reports, information, or documents relevant to an investigation. This could be achieved through providing equivalent powers to the Board (as provided in s 11(11) of the Act) to require any government department or state authority, or a service provider, representative or person responsible to provide a report or information on any matter relating to a matter being investigated. Recommendation 12.22 proposes that this provision be extended to include provision of a ‘document’, and that the section also include health practitioners, and for ‘service provider’ to be defined by way of a non-exhaustive list;

• confirming that anyone with responsibilities under the Act is required to assist the Public Guardian conducting investigations, with s 163(3) of the Mental Health Act providing a useful example upon which to consider legislative reform;

• requiring people to answer questions or attend conferences; and

• granting the Public Guardian powers to access premises either with a warrant or on an order of the Board, as currently available under s 29 of the Act.

**Recommendation 16.5**

That the Public Guardian have adequate powers to conduct investigations. These provisions should:

• provide the Public Guardian with equivalent powers to the powers of the Board to require the provision of reports, documents and information;

• require individuals and bodies to assist the Public Guardian with its investigations, including answering questions and attending conferences;

• give the Public Guardian power to access premises either with a warrant or on an order of the Board; and

• permit a person to decline to provide information or answer a question in exceptional circumstances, for example, where it might tend to incriminate the person.

16.3.15 The OPG’s submission also referred to specific powers of the Public Guardian in Queensland, enabling it to suspend the operation of enduring powers of attorney:

Queensland’s Public Guardian has broad investigation powers, and has specific powers to suspend (and reinstate) the operation of a power of attorney for up to three months. During the period of any suspension the public trustee assumes the role of attorney. The OPG is of the view that these provisions have merit and should be considered for Tasmania’s Public Guardian.

16.3.16 This reform has not been further considered on the basis that further consultation is desirable to ascertain what support exists for this potential reform. The ability for the Public Guardian to suspend the operation of an enduring instrument would extend the scope of its existing powers which, in relation to enduring instruments, only extends to applying to the Board seeking that it revoke a document. This proposal would also have implications for the Powers of Attorney Act.
Part 16: Functions, Powers and Duties of the Public Guardian

Protections for disclosing information to the Public Guardian

16.3.17 The Issues Paper noted that, to encourage the provision of information to the Public Guardian, it may be beneficial to extend the current provisions which protect people who provide information or give reports to the Board to also cover information provided to the Public Guardian.\textsuperscript{1568} MIGA’s submission commented:

If the Public Guardian is provided with investigative powers to compel information from medical and other health practitioners, there should be:

- Protections from civil, criminal, disciplinary or other liability under an administrative process, and against any discrimination or adverse action in the context of employment or other workplace arrangements, in relation to the exercise of the public representative’s proposed investigation powers …

16.3.18 The ALRC noted that this is an important part of removing impediments to people reporting abuse.\textsuperscript{1569} The Institute proposes that the Act provide individuals who report suspected abuse with the same protection regardless of whether that report is made to the Board or the Public Guardian.

**Recommendation 16.6**

That the application of s 85 of the Act be extended to cover provision of information to the Public Guardian.

Other functions and powers\textsuperscript{2}

16.3.19 Other suggestions made to reform the Public Guardian’s powers are as follows:

16.3.20 Members of the Elder Law Committee commented that reform could include:

- Partnering with charitable/not-for-profit organisations to provide guardians?
- Consideration might also be given to decentralising it from a government body out into communities. This would require amending the legislative framework for delivery, accountability and monitoring of services.

16.3.21 Currently when a professional administrator or attorney is required, there is the option of appointing either the Public Trustee or Tasmanian Perpetual Trustees Limited. There is no equivalent alternative professional guardian institution, with the Public Guardian being the only alternative unless another private professional was willing, able and suitable to act in the role. This limits the options available and gives some merit to members of the Elder Law Committee’s suggestion. As they note, this would require amendment to the legislative framework and it is outside of the Institute’s Terms of Reference to consider the matter further.

16.3.22 A second respondent commented that the Public Guardian must have adequate powers to execute a donor’s wishes under an instrument:

\textsuperscript{1568} See Guardianship and Administration Act 1995 (Tas) s 85.

\textsuperscript{1569} ALRC, above n 66, [9.54], Part 14.
The Public Guardian needs to have the full power to execute the expressed wishes of a competent person when they register their EG [enduring guardian] document, in the absence of family member or other person to act as a person’s Guardian …

This matter was discussed in Parts 4, 5 and 11 with a range of reforms proposed to enhance obligations for representatives to uphold a represented person’s views, wishes and preferences.

16.4 Duties of the Public Guardian

16.4.1 The Public Guardian has an overriding duty to perform her functions in accordance with the guiding principles of the Act. These principles were discussed in Part 3.1570

16.4.2 As the Terms of Reference called for investigation into the utility of any reform to the existing duties of the Public Guardian, the Institute asked a specific question about this.

Should the Public Guardian have any additional, or different, duties?1571

16.4.3 Responses to this question have been included elsewhere in this Report as relevant. EOT, for example, commented: ‘From a legislative perspective, the Board and Public Guardian should be required to promote good practice [supported decision-making] throughout the community.’ This was discussed in Part 15.1572 It was noted that several recommendations made in this Report would strengthen the need for the Board and Public Guardian to promote good practice supported decision-making throughout the community.

16.4.4 In answering the Institute’s question in the Issues Paper about how the Act might be improved in relation to the Public Guardian (see below), PCT commented:

While PCT believes that the Public Guardian could have additional duties, in line with those outlined in the Issues Paper, this should be weighed up with the capacity of the Public Guardian to perform these duties. Unless further funding can be provided to the Public Guardian, adding additional duties may lead to current duties not being able to be performed effectively.

These views are acknowledged and have been considered when making recommendations throughout this Part. The issue of resourcing is considered more fully in Part 18.1573

16.5 Other reforms?

16.5.1 The Institute concluded by asking more broadly how the Act might otherwise be improved in relation to the functions, powers and duties of the Public Guardian.

How else can the Act be improved in relation to the functions, powers and duties of the Public Guardian?1574

1570 See Recommendation 3.3.
1571 TLRI, above n 69, Question 9.5.
1572 See [15.6.4].
1573 See [18.2.26].
16.5.2 Most answers have either been addressed previously in this Part, or elsewhere in this Report. For example, two submissions endorsed a role for the Public Guardian to mediate disputes.

16.5.3 Two respondents raised matters relating to the internal policies and processes of the Public Guardian:

- that they had observed that the staff of the OPG did not regularly meet with a represented person; and
- that it is difficult to raise issues internally where issues relate to the Public Guardian herself.

These submissions are included for completeness although, as they relate to matters of policy and process, they fall outside of the scope of the Institute’s Terms of Reference.

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1574 TLRI, above n 69, Question 9.3.
Part 17

Interrelationship with other Legislation

17.1 Introduction

17.1.1 The Terms of Reference asked the Institute to review the interrelationship between the Act and other relevant legislation, including the Mental Health Act, Disability Services Act, Powers of Attorney Act, Alcohol and Drug Dependency Act, Public Trustee Act and the Trustee Act.

17.1.2 Some of these Acts also deal with the making of substitute decisions for people deemed unable to make their own decisions. These include:

- the Powers of Attorney Act, which enables a person to appoint an attorney to make financial decisions for them if they lose capacity to make their own decisions;
- the Disability Services Act, which provides for decisions in relation to the use of restrictive interventions by disability services providers and funded private persons;
- the Mental Health Act, which governs the assessment and treatment of people with mental illness; and
- the Alcohol and Drug Dependency Act, which deals with the treatment and control of persons suffering from alcohol or drug dependency.

17.1.3 It is outside the scope of this review to analyse these Acts or consider options for their reform. The purpose of this Part is to instead summarise the operation of related legislation, and how these Acts should interact following legislative reforms proposed.

17.2 Mental Health Act

17.2.1 The Mental Health Act deals with the assessment and treatment of people with mental illness.\textsuperscript{1575} The Act is intended as the primary source of authority for the involuntary assessment and treatment of persons with mental illness in Tasmania.\textsuperscript{1576}

17.2.2 The MHT has jurisdiction in relation to the operation of the Mental Health Act. The MHT functions independently of the Board. The effect is that individuals may be the subject of

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\textsuperscript{1575} ‘Mental illness’ is defined as temporary, repeated or continuous ‘serious impairment of thought (which may include delusions)’ or ‘a serious impairment of mood, volition, perception or cognition’: Mental Health Act 2013 (Tas) s 4.

\textsuperscript{1576} Ibid s 13.
applications before the MHT and the Board. This results in the person having to attend separate hearings and being subject to separate orders.\textsuperscript{1577}

17.2.3 Amendments to the \textit{Mental Health Act} in 2013 were intended to resolve issues relating to the interaction between the \textit{Mental Health Act} and the Act. The Second Reading speech notes:

While the current \textit{Mental Health Act} 1996 provides authority for the detention of persons with a mental illness, the authority for treatment for persons lacking decision-making capacity is contained within the \textit{Guardianship and Administration Act} 1995.

The review process highlighted deficiencies in the current legislative framework, suggesting that working between the two Acts is unnecessarily complex …

This Bill seeks to remedy the difficulties associated with the current framework, which sees decisions about the treatment of a person with a mental illness who lacks capacity made pursuant to the \textit{Guardianship and Administration Act}; while decisions about the setting in which treatment should be given are made pursuant to the \textit{Mental Health Act}.\textsuperscript{1578}

17.2.4 The Institute requested advice about whether respondents consider there remain any issues relating to the interaction between the Act and \textit{Mental Health Act} and whether any consequential reforms to the Act is needed. The first question asked was:

\begin{itemize}
  \item (i) Are there any gaps between the Act and the \textit{Mental Health Act 2013} that need to be resolved?\textsuperscript{1579}
\end{itemize}

17.2.5 Six respondents\textsuperscript{1580} addressed this question, although the Public Trustee expressed that it held no view. The MHT stated that it holds the view that there are no gaps between the Acts. The Board did not make a submission in response to this question.

17.2.6 The OPMHS submitted that the Act should facilitate a person undergoing assessment, similar to the way that the \textit{Mental Health Act} provides. This was considered in Part 6.\textsuperscript{1581}

17.2.7 Members of the Elder Law Committee stated that an existing gap is the lack of Official Visitor Scheme under the Act which is included under the \textit{Mental Health Act}. This issue was considered in Part 13, with it being proposed that an Official Visitors Scheme operate under the Act.\textsuperscript{1582}

17.2.8 The Institute also enquired about any overlaps between the Act and the \textit{Mental Health Act} that need to be resolved:

\begin{itemize}
\end{itemize}

\textsuperscript{1577} For further discussion of these issues, see Smith and Rigby, above n 433, 14.
\textsuperscript{1578} Tasmania, \textit{Parliamentary Debates}, House of Assembly, 27 September 2012, 1, 3 (Michelle O’Byrne Minister for Health, Second Reading Speech Mental Health Bill 2012).
\textsuperscript{1579} TLRI, above n 69, Question 14.1(i).
\textsuperscript{1580} Public Trustee, OPG, members Elder Law Committee, OPMHS, MHT.
\textsuperscript{1581} See [6.11.3].
\textsuperscript{1582} Recommendation 14.7(5).
(ii) Is there any overlap between the Act and the *Mental Health Act 2013* that needs to be resolved?  

17.2.9 Two submissions stated that there needs to be clear distinction maintained between the roles of each respective Act. Recommendation 9.4 proposes that the Act make clear that the proposed term ‘health care and treatment’ be defined to specifically exclude assessments and treatments for mental illness covered under the *Mental Health Act*, consistent with the MHT’s submission.

17.2.10 Members of the Elder Law Committee expressed support for a more holistic approach between the *Mental Health Act* and Act, which may be progressed if Tasmania introduces a single Civil and Administrative Appeal Tribunal. On this point, however, the MHT submitted that:

The Mental Health Tribunal is of the view that a single Tribunal would have various streams given that each jurisdiction considers different types of decisions requiring different expertise. Therefore under a single Tribunal a person may still come before various protective jurisdiction streams and not be treated holistically.

17.2.11 The OPG also endorsed reform to avoid individuals being subject to orders under both the Act and the *Mental Health Act*:

The OPG is keen to avoid, wherever possible, a person being subject to both a treatment order under the MH Act and a guardianship order … Currently, someone subject to a treatment order under the MH Act can also be subject to a guardianship order with powers for the guardian to decide where the person is to live – our view is that if the person’s accommodation is central to their treatment, the requirement to live in particular accommodation should form part of the treatment order. This is arguably available under subsection 41(5) of the *Mental Health Act* however it seems it is not often used for this purpose.

17.2.12 The OPMHS made similar statements:

For example, a Guardian may be making accommodation and medical decisions for a Represented Person due to their dementia, and parallel to this the MHT may have authorised a Treatment Order for treatment of Schizophrenia. In the initial phases of this, the person may have three hearings in the first two months, and could be trying to understand two separate processes which are new to them (while impaired). This requires significant intrusion upon the person through hearings and other processes, the existence of more than one order is more restrictive. For many impaired people we see, the process of hearings is enormously stressful, and can be difficult to understand.

A less restrictive approach would be for allowances to be made for the use of the GAA in some cases (e.g. where people lack capacity due to illnesses not covered by...

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1583 TLRI, above n 69, Question 14.1(ii).
1584 OPG.
1585 The Issues Paper referenced the Department of Justice’s Discussion Paper, *A Single Tribunal for Tasmania*, above n 778, which refers to one of the potential advantages of amalgamation of tribunals being the way in which a person’s interaction with different jurisdictions can be dealt with more holistically. See for example at 110. For further discussion of the potential benefits of amalgamation of the Mental Health Tribunal and Guardianship and Administration Board within a single Civil and Administrative Tribunal, see Smith and Rigby, above n 433, 177–178.
Part 17: Interrelationship with other Legislation

the MHA) to also consent to treatment of mental illness. For example, once a Guardian for medical consent is appointed, they could have the authority to provide consent for medical decisions including psychiatric treatment.

Separately to this, when a Person is admitted with the consent of a Guardian, but happens to be on a MHA order, then their MHA order needs to be amended to reflect their whereabouts. This introduces redundant processes to satisfy the Board that admission is necessary. This may need remedy of either the MHA or its implementation.

We hold the view that there should be a single legislative framework for the care/treatment of people with any form of disability who lack the capacity to consent to such care/treatment and thus require a proxy decision maker. To have a legislative framework (MHA) that distinguishes ‘mental illness’ from other conditions is fundamentally discriminatory and perpetuates societal discrimination against those with mental illness. There is growing understanding of the biological basis of serious mental illnesses such as schizophrenia, making a legislative distinction between conditions such as schizophrenia and dementia even less relevant. The needs of people with serious mental illness in terms of financial/accommodation/social decisions frequently overlap with mental health treatment decisions, the former currently covered by GAB legislation, the latter by the MHA. This is cumbersome and more intrusive for the patient.1586

17.2.13 These submissions raise matters relating to the Mental Health Act rather than the Act, and thus fall outside the scope of this review. The Institute observes that the State Government is presenting conducting a review of the Mental Health Act and that these issues are best addressed through that project.

17.3 Disability Services Act

17.3.1 The Disability Services Act governs disability services providers and funded private persons in Tasmania. The Disability Services Act has recently been the subject of statutory review.1587 A more comprehensive review of the Act will be undertaken in 2019 once the roll-out of the NDIS is complete.1588

17.3.2 As also observed in relation to the Mental Health Act, some individuals may be subject to both the Act and the Disability Services Act. The Issues Paper asked whether there are any issues in relation to the interaction between the Disability Services Act and the Act.

Are there any issues relating to the interaction between the Disability Services Act and the Act that need to be resolved? How could these be resolved?1589

1586 Similar views are expressed in Smith and Rigby, above n 433.
1589 TLRI, above n 69, Question 14.3.
17.3.3 Four submissions addressed this question although the Public Trustee’s submission stated that it held no view. Both the Board and members of the Elder Law Committee raised matters relating to the regulation of restrictive practices. This is considered below.

17.3.4 The OPG commented:

We are unaware of any significant current issues. Consistency in definitions for terms such as ‘disability’, ‘restrictive practices’, ‘chemical restraint’ and ‘therapeutic’ should be pursued.

17.3.5 As noted, the Disability Services Act will be the subject of review following full implementation of the NDIS in Tasmania in July 2019. The Institute recommends that the recommendations made in this Report be considered as part of that review to provide consistency where possible and appropriate.

Recommendation 17.1

That the recommendations made in this Report be considered as part of the review of the Disability Services Act 2011 (Tas) to take place following full implementation of the NDIS in Tasmania in July 2019.

17.4 Regulation of restrictive practices

17.4.1 Restrictive practices involve the use of interventions and practices that have the effect of restricting the rights or freedom of movement of a person with disability.\textsuperscript{1590} NDS’s submission commented that ‘restrictive practices by their nature reduce a person’s control and choice and impede a person’s access to valued roles in community life.’ The UN Human Rights Council has urged States to review laws, policies, and practices:

\begin{quote}
with a view to eliminating all forms of discrimination, stigma, prejudice, violence, abuse, social exclusion and segregation within that context, and to promote the right of persons with mental health conditions or psychosocial disabilities to full inclusion and effective participation in society, on an equal basis with others.\textsuperscript{1591}
\end{quote}

17.4.2 The Convention Committee has stated that it:

\begin{quote}
is concerned that persons with disabilities, particularly those with intellectual impairment or psychosocial disability, are subjected to unregulated behaviour modification or restrictive practices such as chemical, mechanical and physical restraints and seclusion, in various environments, including schools, mental health facilities and hospitals.\textsuperscript{1592}
\end{quote}

It notes that the use of restraint is inconsistent with Article 15 of the Convention which confirms the prohibition on torture and other inhumane and degrading treatment or punishment against

\begin{flushleft}
\textsuperscript{1590} ALRC, above n 66, [8.4].
\textsuperscript{1591} UN Human Rights Council, United Nations General Assembly, Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development, UN Doc A/HRC/36/L.25 26 (September 2017) 4.
\textsuperscript{1592} Convention Committee, above n 23, [35]–[36].
\end{flushleft}
people with disability.\textsuperscript{1593} It thus recommends elimination of the use of restraint, consistent with this principle.\textsuperscript{1594} The Australian Human Rights Committee comments that ‘where restrictive practices are used, strict authorisation procedures should be in place, and their use continually monitored.’\textsuperscript{1595} It endorses the Queensland legislation as being ‘highly regulated with significant external oversight mechanisms.’\textsuperscript{1596}

17.4.3 The National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector (the ‘National Framework’) states that reducing and eliminating the use of restrictive practices is consistent with the Convention.\textsuperscript{1597} The National Framework commits each of the states and territories to reduce the use of restrictive practices. Advocacy Tasmania’s submission to this review commented:

\begin{quote}
It is vital that the extensive work which has been undertaken to eliminate restrictive practices, wherever they occur, continues. The National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector and the push for the complete elimination of these practices needs to inform the drafting of the Act.
\end{quote}

17.4.4 EOT also noted that:

the Australian Government ratified the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) on December 21 2017 …

OPCAT provides safeguards for people who are detained in a variety of settings and establishes mechanisms for inspection and monitoring of these facilities including prisons, youth justice facilities, mental health facilities and immigration detention centres.

17.4.5 Both the \textit{Mental Health Act} and \textit{Disability Services Act} regulate the use of restrictive interventions/practices, as explained below.

\textbf{Mental Health Act}

17.4.6 The \textit{Mental Health Act} regulates the use of chemical, mechanical and physical restraint.\textsuperscript{1598} These are defined as follows:

\textit{chemical restraint} means medication given primarily to control a person’s behaviour, not to treat a mental illness or physical condition;

\textit{mechanical restraint} means a device that controls a person’s freedom of movement;

\textsuperscript{1593} Ibid.
\textsuperscript{1594} Ibid [36].
\textsuperscript{1595} Australian Human Rights Commission, above n 60, 58.
\textsuperscript{1596} Ibid. Queensland’s approach is also endorsed by the Queensland Office of the Public Advocate: Queensland Office of the Public Advocate, \textit{Legal Frameworks for the use of restrictive practices in aged care: An analysis of Australian and international jurisdictions} (June 2017) 15.
\textsuperscript{1598} \textit{Mental Health Act 2013} (Tas) s 57.
physical restraint means bodily force that controls a person’s freedom of movement.\textsuperscript{1599}

17.4.7 Involuntary patients may only be placed under restraint in limited circumstances.\textsuperscript{1600} Chemical or mechanical restraint must be authorised by the Chief Civil Psychiatrist, as must physical restraint of a child.\textsuperscript{1601} Physical restraint of an adult must be authorised by the Chief Civil Psychiatrist, a medical practitioner or an approved nurse.\textsuperscript{1602} Those authorised to approve the use of restraint must be satisfied that it is necessary:

- to facilitate the patient’s treatment; or
- to ensure the patient’s health or safety; or
- to ensure the safety of other persons; or
- to effect the patient’s transfer to another facility, whether in this state or elsewhere.\textsuperscript{1603}

17.4.8 The Act then provides a range of safeguards in relation to the use of authorised restraint.\textsuperscript{1604} The Chief Civil Psychiatrist has power to intervene in relation to the use of restraint, including of their own motion, and may give notice that the use of restraint is to be discontinued.\textsuperscript{1605} The MHT also has power to review the use of restraint, including of its own motion.\textsuperscript{1606}

**Disability Services Act**

17.4.9 The Disability Services Act regulates the use of restrictive interventions for people with disability receiving services from disability service providers and funded private persons.\textsuperscript{1607} The Disability Services Act deals with both physical and medical restrictions, defined as follows:

- environmental restriction, in relation to a person with disability, means a restrictive intervention in relation to the person that consists of the modification of an object, or the environment of the person, so as to enable the behavioural control of the person but does not include a personal restriction;

- personal restriction, in relation to a person with disability, means a restrictive intervention in relation to the person that consists wholly or partially of –

  (a) physical contact with the person so as to enable the behavioural control of the person; or

  (b) the taking of an action that restricts the liberty of movement of the person.\textsuperscript{1608}

\textsuperscript{1599} Ibid s 3.
\textsuperscript{1600} Ibid s 57.
\textsuperscript{1601} Ibid s 57(1)(b).
\textsuperscript{1602} Ibid.
\textsuperscript{1603} Ibid ss 57(1)(b), 57(6).
\textsuperscript{1604} See for example ibid s 57(2).
\textsuperscript{1605} Ibid s 147.
\textsuperscript{1606} Ibid s 187.
\textsuperscript{1607} See Disability Services Act 2011 (Tas) pt 6.
Restrictive intervention is defined as follows:

*restrictive intervention* means any action that is taken to restrict the rights or freedom of movement of a person with disability for the primary purpose of the behavioural control of the person but does not include such an action that is—

(a) taken for therapeutic purposes; or
(b) taken to enable the safe transportation of the person; or
(c) authorised under any enactment relating to the provision of mental health services or to guardianship ... ¹⁶⁰⁹

17.4.10 For the purposes of the *Disability Services Act*, the term ‘restrictive practice’ is defined to exclude any action authorised under any Acts relating to guardianship.¹⁶¹⁰

17.4.11 Under the *Disability Services Act*, restrictive interventions must have prior substitute consent from either the Secretary of the Department (in the case of environmental restrictions¹⁶¹¹), or the Board (in the case of personal restrictions¹⁶¹²).

17.4.12 The report following the recent review of the *Disability Services Act* notes that the Board submitted to that review that the *Disability Services Act* should also contain a definition of physical restraint, detention and seclusion.¹⁶¹³ The report suggests that consideration be given to adopting the Board’s suggestion that the *Disability Services Act* list one of the functions of the Senior Practitioner as being to give advice to guardians.¹⁶¹⁴

**NDIS**

17.4.13 Following full implementation of the NDIS in Tasmania, the NDIS Quality and Safeguarding Framework will commence.¹⁶¹⁵ The Framework intends to provide a nationally consistent approach to the use of restrictive practices.¹⁶¹⁶ The NDIS Quality and Safeguarding Framework provides that restrictive practices include:

- **Seclusion:** the sole confinement of a person with disability in a room or physical space at any hour of the day or night where voluntary exit is prevented, impeded or not facilitated.

¹⁶⁰⁸ Ibid s 34.
¹⁶⁰⁹ Ibid s 3.
¹⁶¹⁰ Ibid s 4(1).
¹⁶¹¹ Environmental restrictions are modifications to a person’s environment to enable behavioural control: *Disability Services Act 2013* (Tas) s 34.
¹⁶¹⁴ Ibid.
¹⁶¹⁵ Department of Social Services, Government of Australia, above n 1384.
¹⁶¹⁶ Ibid.
• **Chemical restraint**: the use of medication or chemical substance for the primary purpose of influencing a person’s behaviour or movement. It does not include the use of medication prescribed by a medical practitioner for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness or physical condition.

• **Mechanical restraint**: the use of a device[^1617] to prevent, restrict or subdue a person’s movement for the primary purpose of influencing their behaviour. It does not include the use of devices for therapeutic or non-behavioural purposes. For example, it may include the use of a device to assist a person with functional activities as part of occupational therapy, or to allow for safe transportation.

• **Physical restraint**: the sustained or prolonged[^1618] use or action of physical force to prevent, restrict or subdue movement of a person’s body, or part of their body, for the primary purpose of influencing a person’s behaviour. Physical restraint is distinct from the use of a hands-on technique in a reflexive way to guide or redirect a person away from potential harm/injury, consistent with what could reasonably be considered the exercise of care towards a person.

• **Psycho-social restraints**: usually involves the use of ‘power-control’ strategies.

• **Environmental restraints**: restrict a person’s free access to all parts of their environment.

• **Consequence driven practices**: usually involve withdrawing activities or items.[^1619]

### 17.4.14
Under the Framework, the role of the NDIS Senior Practitioner will be to provide clinical leadership in relation to reducing and eliminating the use of restrictive practices in the NDIS, make directions and recommendations, and proactively examine practices and complete follow-ups in relation to incidents or concerns.[^1620] States will remain responsible for authorising the use of restrictive practices within its jurisdiction.[^1621]

### 17.4.15
In relation to the authorisation process for the use of restrictive practices, the Framework provides:

Commonwealth legislation will set out the key principles around the use of restrictive practices, including that the intervention is the least restrictive response available, is used only as a last resort, and that the risk posed by the proposed intervention is in proportion to the risk of harm posed by the behaviour of concern. Relevant state and territory legislation will specify the conditions that must be met for the use of a restrictive practice to be approved in a positive behaviour support plan. This means that at a minimum, a decision to include a restrictive practice in a positive behaviour support plan must be consistent with state and territory legislation around the approval process. States and territories may enact (or amend) separate laws that

[^1617]: A device may include any mechanical material, appliance or equipment.

[^1618]: ‘For example, a physical force or action lasting longer than approximately 30 seconds, that is not a reflexive manual restraint’: Department of Social Services, Government of Australia, above n 1384, fn 43 citing McVilly (2008).

[^1619]: Ibid, 67.

[^1620]: Ibid 71.

[^1621]: Ibid 72.
provide mechanisms for seeking approval to include restrictive practices in a behaviour support plan.\textsuperscript{1622}

17.4.16 The report into the recent statutory review of the \textit{Disability Services Act} states that:

Under the NQSF [NDIS Quality and Safeguarding Framework] there will be nationally-agreed standards for restrictive interventions. The states and territories retain a central role in the authorisation and administration of, and education about, restrictive interventions, and Tasmania will consider the specific functions needed in a future review of the Act.\textsuperscript{1623}

It goes on to state that ‘[d]efinitions, and alignment with other Tasmanian legislation [in relation to restrictive practices], to be considered in the future review.’\textsuperscript{1624}

17.4.17 NDS’s submission made the following comments about changes it anticipates following full implementation of the NDIS:

Under ADHC policy and best practice, it is important that the decision-maker who authorises the use of restrictive practices is independent from the clinician who is drafting the behaviour support plan (BSP) or who seeks to use restrictive practices. While independence has always been a challenge it will potentially become more pronounced under the NDIS. Operationally under the NDIS funding model, it will be difficult to understand how organisations will pay for each other’s time to sit on panels compared with the currently more flexible ADHC block-funding system.

NDS is concerned about the increased potential for the unregulated use of restrictive practices. We believe that serious restrictive interventions require independent legal authorisation. Clarity is needed on where the responsibility for seeking authorisation sits and the level of authorisation required.

17.4.18 As commented elsewhere in this Report, many individuals requiring decision-making support will not fall under the NDIS.

\textit{The Act}

17.4.19 The Act does not contain special provisions governing the use of restrictive interventions.\textsuperscript{1625} The result is a different level of regulation and oversight depending on the context in which the restrictive intervention is being administered. The Board’s submission commented on this circumstance, stating:

No other legislation covers the regulation of the use of restrictive practices in non-disability settings, such as aged care facilities, hospitals, education, boarding facilities and private dwellings. This means that not all adults with a disability and decision making impairment are protected from the improper use of restrictive practices. Arguably, these

\textsuperscript{1622} Ibid.
\textsuperscript{1624} Ibid 29.
\textsuperscript{1625} The Regulations include within the class of ‘special treatments’ any treatment involving the use of an aversive stimulus, whether that stimulus is mechanical, chemical, physical or otherwise: \textit{Guardianship and Administration Regulations 2017} (Tas) reg 11.
adults outside the scope of the Disability Services Act 2011 and the Mental Health Act 2013 are at greater risk of abuse of being arbitrarily deprived of their liberty or subject to inappropriate or unlawful use of restrictive practices.

17.4.20 The ALRC has noted that ‘given the variety of settings in which restrictive practices are used, there is a need for a national or nationally consistent approach to regulation beyond the disability services sector and the NDIS.’\textsuperscript{1626} To provide consistency with the use of restrictive practices outside the scope of the Mental Health Act and Disability Services Act, one option for reform would be to make provision within the Act to confirm who can provide substitute consent to the use of restrictive interventions. The Issues Paper commented that, if the Act contained provisions dealing with the use of restrictive interventions, then a decision would need to be made about which types of interventions a person responsible can consent to, and any that require the consent of the Board. One option raised was to extend the definition of ‘special treatment’ to require the Board to consent to the use certain restrictive interventions.

17.4.21 The Institute first asked whether the Act should contain special provisions regulating the use of restrictive practices outside of the context of the Disability Services Act and Mental Health Act.

| (i) Should the Act contain provisions regulating the use of restrictive practices that do not fall under the Disability Services Act 2011 or Mental Health Act 2013?\textsuperscript{1627} |

17.4.22 Nine respondents made submissions in response to this question. All indicated a need for legislative reform in relation to the use of restrictive practices in Tasmania. Many observed the impact that the use of a restrictive practice has upon the rights of an individual and that there is a need to ensure that a person’s interests are safeguarded. Four respondents\textsuperscript{1628} submitted that there needs to be ‘comprehensive consideration of how restrictive practices should be monitored and regulated in Tasmania’,\textsuperscript{1629} and that there should be consistency amongst different settings.\textsuperscript{1630} The MHT submitted that this is necessary to ensure that ‘the interests of all people with a disability are protected from abuse, neglect, undue influence or harm whilst receiving necessary and appropriate treatment.’ NDS recommended that this could be achieved by way of ‘an inquiry about the potential to enact legislation that explicitly deals with restrictive practice.’

17.4.23 EOT submitted that:

Concern has been expressed about the misuse of restrictive measures, including physical, mechanical and chemical restraint by many stakeholder groups and we consider that the regulation of use should be extended beyond the measures included in the Disability Services Act 2011 and the Mental Health Act 2013 …

\textsuperscript{1626} ALRC, above n 66, [8.18].
\textsuperscript{1627} TLRI, above n 69, Question 14.4(i).
\textsuperscript{1628} The Board, OPG, MHT, NDS.
\textsuperscript{1629} The Board.
\textsuperscript{1630} The OPG referred specifically to disability and aged care sectors. NDS stated ‘[l]egislation must occur across settings including mainstream interfaces such as health and education, there is potential for it to apply to private individuals as well’.
we consider that the Guardianship and Administration Act should include provisions setting out responsibility for the approval of restrictive practices, including monitoring and review arrangements.

17.4.24 The Board, OPG and EOT noted developments occurring nationally to progress the regulation of restrictive practices, including under the NDIS. The Board referred to the NSW Civil and Administrative Tribunal’s submission to the equivalent review recently undertaken in New South Wales, which noted that:

The legislative response at a federal level, if any, to the ALRC’s Inquiry on ‘Protecting the Rights of Older Australians from Abuse’ (announced on 24 February 2016) may also have an impact on the regulation of the use of restrictive practices in aged care facilities in NSW. We note in this regard the proposal (at 11-7) of the ALRC Discussion Paper on the chapter concerning the use and regulation of restrictive practices that the Aged Care Act 1997 (Cth) should regulate the use of restrictive practices in residential aged care.

That submission went on to state that:

Any proposed legislative reform of the Guardianship Act in relation to restrictive practices should therefore have careful regard to these broader reforms to ensure consistency. It would seem to be a very unsatisfactory position for people with cognitive disability to have applied to them a different legislative regime depending on whether they live in a group home funded by the NDIS and subject to the NDIS Quality and Safeguarding Framework and (as yet unseen) legislation governing the use of restrictive practices, whilst residents of aged care facilities that are governed by the Aged Care Act are potentially subject to a different legislative regime in relation to the use of restrictive practices.

17.4.25 The OPG’s submission also highlighted work being progressed in relation to the regulation of restrictive practices nationally:

There is significant work currently being undertaken nationally: the ALRC’s Equality, Capacity and Disability Report referred to the ‘patchwork’ of laws and frameworks across the country and in different sectors and urged harmonised regulation to cover the use of restrictive practices in a range of settings including supported accommodation, aged care facilities, mental health facilities, hospitals, prisons, and schools; the NDIS’s quality and safeguarding framework will soon issue national rules for the oversight of restrictive practices for its participants, with the states having given in principle agreement to implement compatible legislation and policy; and the ALRC report into elder abuse recommended national law reform to ensure regulation of restrictive practices in aged care facilities, particularly to address overuse of chemical restraint or sedation.

1631 The Hon Bruce Lander QC, above n 1365. ‘The consumers who resided at the Oakden Older Persons Mental Health Service (Oakden Facility) were some of the most frail and vulnerable persons in our community. They did not have a voice. They were obliged to live in a facility which could only be described as a disgrace, and in which they received very poor care. The process and procedures were such that they were forgotten and ignored. The State did not provide them with the level of care that they deserved.’
17.4.26 EOT also noted:

The ALRC, for example, recommends that binding regulation be developed governing restrictive practices across a broad range of settings including supported accommodation and group homes, residential aged care facilities, mental health facilities, hospitals, prisons and schools.\(^{1632}\)

The Australian Government and the Council of Australian Governments should develop a national approach to the regulation of restrictive practices in sectors other than disability services, such as aged care and health care.

This is a matter that has also been raised in the context of addressing violence, abuse and neglect against people with disability\(^{1633}\) and in relation to preventing elder abuse.\(^{1634}\)

17.4.27 In summary, respondents expressed support for there being a comprehensive review of the legislative framework governing the use of restrictive practices in all contexts within the state. It is apparent that there are presently gaps and inconsistencies in approach, resulting in people subject to restrictive practices having differing levels of protection depending on the context in which the practice occurs. The Institute endorses legislative reform to achieve consistency as an essential component of protecting individual’s rights.

17.4.28 Noting the appropriateness of there being consistency amongst the regulation of restrictive practices in different settings within the state, and the benefits of a nationally consistent approach, the Institute is not able to advance proposals for comprehensive legislative reform as part of this review. The need for, and approach to legislative reform in relation to the use of restrictive practices requires further consideration and broader consultation. Reforms should be guided by developments at a national level. This should be progressed in a coordinated manner, with the potential for this to align with the further review of the \textit{Disability Services Act} scheduled to occur in 2019 following full roll-out of the NDIS in Tasmania.

\begin{table}[h]
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\begin{tabular}{|l|}
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\textbf{Recommendation 17.2} \\
That there be comprehensive consideration of how the use of restrictive practices should be monitored and regulated in Tasmania. \\
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\end{table}

17.4.29 The Institute also asked, if the Act contained provisions regulating the use of restrictive practices, who should be able to provide substitute consent.

(ii) If so, are there any restrictive practices that only the Board should be able to consent to rather than a person responsible?\(^{1635}\)

17.4.30 Most responses expressed the view that any substitute consent regime for the use of restrictive practices must have appropriate safeguards. Consistent with the ALRC’s Safeguards Guidelines, Advocacy Tasmania submitted that those safeguards should ensure that any use of

\(^{1632}\) ALRC, above n 3, Recommendation 8-2, 256.
\(^{1633}\) Senate Community Affairs References Committee, above n 67; ALRC, above n 3, 91 ff.
\(^{1634}\) ALRC, above n 66, 142.
\(^{1635}\) TLRI, above n 69, Question 14.4(ii).
restrictive practices are proportional and tailored, apply for the shortest time possible and are subject to regular external review. NDS expressed a similar view, stating that restrictive practices:

should always be used as a last resort and it is critical for clear processes to be in place before the decision to use restrictive practices is made … Guardianship laws in TAS should include effective safeguards that protect a person needing decision-making support from abuse.

NDS went on to state that:

Restrictive practices should only be used to protect the rights or safety of the person or others. They should be time limited, subject to review and least restrictive in the circumstances. A behaviour support plan and clinical assessment must be in place. There are some restrictive practices however that should never be sanctioned, and thus should not form part of any regulatory framework. Those include strategies that tend to be punitive in nature, highly subject to misuse or abuse, and those that have little evidence to suggest that they have any long-term efficacy or impact in their use.

17.4.31 NDS submitted that there either needs to be education of private guardians about giving substitute consent to the use of restrictive practices, or a stricter approach considered. Advocacy Tasmania submitted ‘[t]hese decisions must not be being made by Guardians without regular external review and accountability.’ NDS similarly submitted that ‘[r]estrictive practices require ongoing monitoring and review not just one off consent from guardians.’ Members of the Elder Law Committee supported the need for Board consent.

17.4.32 The OPG supported the role of the Senior Practitioner in performing an oversight function:

We are particularly supportive of the role of Senior Practitioners to oversee, monitor, and importantly to provide guidance and education to minimise the use of restrictive practices and ensure they are not used improperly or inappropriately. We would like to see such a role in the aged care sector. We see the roles of Senior Practitioners and behaviour support practitioners as essential in ensuring best clinical practice – the regime for approval of or consent for restrictive practices (where they can’t be avoided) needs to clarified, but should sit under these functions.

17.4.33 NDS also commented that:

Disability services have developed considerable expertise in positive behaviour supports that reduce or eliminate the need for restrictive practices. This expertise must be called upon in situations, while also regulating the circumstances where it may occur.

17.4.34 As noted above, the details of legislative provisions to regulate the use of restrictive practices fall outside the scope of this review aside from the matter of chemical restraint which is considered in the following section. The Institute emphasises that these are important matters which require the development of immediate, comprehensive strategies and legislative reform.
Chemical restraint

17.4.35 The present review calls for consideration of the role and powers of persons responsible and guardians. Some restrictive interventions do not neatly fit within the Act’s current jurisdiction which governs a person’s ‘person or circumstances’ (proposed to be revised to ‘personal matters’), and ‘treatment’ (proposed to be revised to ‘health care and treatment’). One matter that currently falls within the scope of ‘treatment’ is the use of chemical restraint. The OPG’s submission explained:

The current law gives a person responsible very limited authority: to consent to medical treatment. Regulation 12 sets out the type of medical treatment that cannot be given without consent under section 41 of the Act, which includes ‘the administration of a restricted substance primarily to control the conduct of the person to whom it is given’. The corollary of this is that chemical restraint is medical treatment (for which consent must be provided).

17.4.36 The NDIS Quality and Safeguarding Framework provides that the term chemical restraint describes:

the use of medication or chemical substance for the primary purpose of influencing a person’s behaviour or movement. It does not include the use of medication prescribed by a medical practitioner for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness or physical condition.\(^\text{1636}\)

The Mental Health Act similarly defines chemical restraint as ‘medication given primarily to control a person’s behaviour, not to treat a mental illness or physical condition.’\(^\text{1637}\) The Disability Services Act does not regulate the use of chemical restraint, dealing only with environmental and physical restraints.\(^\text{1638}\)

17.4.37 The Board explained the current regime under the Act as follows:

Regulation 12 of the Guardianship and Administration Regulation 2017 prohibits the use of chemical restraint without consent ‘under Division 2 of Part 6’. The relevant division of the Act provides for consent by the Person Responsible …

If the chemical restraint is aversive then it is special treatment and a person responsible can’t give consent.\(^\text{1639}\)

17.4.38 The OPG submitted:

Our view is that a regime for the regulation of the administration of medication for the purpose of controlling a person’s behaviour requires very careful consideration. Our tentative view is that it should probably be included in the consent regime for other restrictive practices.

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\(^\text{1636}\) Department of Social Services, Government of Australia, above n 1384, 67.

\(^\text{1637}\) Mental Health Act 2013 (Tas) s 3.

\(^\text{1638}\) Refer to [17.4.9] above.

\(^\text{1639}\) See Guardianship and Administration Regulations 2017 (Tas) reg 11.
17.4.39 The Board submitted that:

The current regime is problematic in that there is no supervision or monitoring of chemical restraint beyond the person responsible as defined in the Act, who in most cases may not be suitably qualified to consider restrictive interventions and is dependent on the advice a medical professional. The person responsible may therefore too readily acquiesce in the authority of a medical professional …

Whether many individuals acting as person responsible are aware and suitably skilled to consider whether the chemical restraint is being done for purposes other than to ‘promote health and wellbeing’ is not clear.\(^\text{1640}\)

The Board commented that ‘[c]larity is required to ensure chemical restraint is not left, in essence, unregulated.’

17.4.40 The Board submitted that the Disability Services Act should include regulation of chemical restraint, noting that some other Australian jurisdictions include chemical restraint as a restrictive intervention. The Review Committee’s report following the recent review of the Disability Services Act states:

- GAB regards definition of ‘chemical restraint’ as ‘a significant omission from the current Act’ and is problematic under current requirements of the GA Act
- GAB submits that the Secretary should be able to approve chemical restraint under Section 38
- The Commissioner for Children submits that it is desirable to regulate chemical restraint to ‘promote the reduction and elimination of its use and to uphold the rights of children with disability’ and suggests the Mental Health Act 2013 provides an example of a legislative framework.\(^\text{1641}\)

The report concludes:

- This issue will be addressed through a nationally-agreed definition of restraint, including chemical restraint, to be included in the NQSf rules under the NDIS.\(^\text{1642}\)

17.4.41 The Institute considers that regulation of the use of chemical restraint under the Act should fit within the ALRC’s Safeguards Guidelines. The present approach does not fit within the Guidelines. Given that the use of chemical restraint is a significant intrusion upon the rights of the individual, it is proposed that this be a matter of reform.

17.4.42 The Institute considers that issues relating to substitute consent to the use of chemical restraint are similar to those discussed in Part 14 when considering the admission/detention of a patient within a secure facility.\(^\text{1643}\) Both impact upon a person’s right to freedom of liberty and movement. That Part concluded that a person’s consent to admission within a secure facility

\(^{1640}\) The Board’s submission made further comments about the current test that persons responsible must apply to give consent in these contexts. These statements are included and addressed in Part 11 as part of formulating the proposed Decision-Making Process.


\(^{1642}\) Ibid.

\(^{1643}\) Refer to [14.6].
should fall outside of the scope of a person responsible authority. This was recommended due to the importance of providing adequate safeguards for individuals, including a decision-maker's suitability being assessed, decisions being subject to independent oversight and periodic review, and providing a right of appeal. Submissions outlined in previous paragraphs indicate that there should be similar safeguards for individuals subject to chemical restraint.

17.4.43 It is proposed that the Act adopt a similar approach to the giving of consent to the use of chemical restraint. The Institute reinforces that this reform is intended as a temporary solution, pending state and national developments to improve regulation of the use of restrictive practices including the outcome of the separate, coordinated review of the regulation of restrictive practices recommended by the Institute.

**Recommendation 17.3**

(1) That substitute consent to the use of chemical restraint be included within the comprehensive review of the legislative framework governing regulation of the use of restrictive practices, proposed in Recommendation 17.2.

(2) That, pending the outcome of that review:

(i) the Act include a definition of chemical restraint as meaning ‘medication given primarily to control a person’s behaviour, not to treat a mental illness or physical condition’;

(ii) the Act enable interested parties to apply to the Board for the review of any substitute decision to consent to the use of chemical restraint pursuant to the Act; and

(iii) the Board and Public Guardian be able to conduct ‘own motion’ investigations and reviews of any substitute consent to the use of chemical restraint pursuant to the Act.

**Education**

17.4.44 The NDS commented that it considers much can be achieved via education and capacity building to better regulate the use of restrictive practices:

Some other barriers include a risk management culture rather than positive approaches to behaviour support, lack of staffing and staff supervision, lack of adequate education for staff, and client stigmatisation (a perception that care of the person requires restraint based on the person’s characteristics or diagnosis). Therefore, any discussion of regulation must recognise the importance of removing these barriers through capacity-building and education about the human rights context of restrictive practices.

17.4.45 It submitted that:

- More education on the prevention and use of restrictive practices needs to be available, particularly for families and the informal supports and sectors such as education.
- People with a disability should also be aware of, and be supported to access, sources of independent advice and advocacy.

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1644 Recommendation 14.7(3).
17.4.46 The benefits of education are noted and addressed more broadly in Part 18.  

17.5 **Powers of Attorney Act**

17.5.1 The *Powers of Attorney Act* enables a capable adult to appoint an attorney to make financial decisions for them, if they instruct them to do so, or if the donor subsequently loses capacity to make financial decisions themselves. In effect, these provisions are equivalent to those within the Act enabling the appointment of an enduring guardian to make personal decisions. The appointment of enduring guardians was discussed in Part 4.

17.5.2 Often reforms to the *Powers of Attorney Act* and the Act have been made concurrently, given similarities between the Acts. At times, however, not all reciprocal changes have been made to both Acts, creating inconsistencies. This Report has made several recommendations aimed at remedying these differences.

17.5.3 The Institute asked whether stakeholders consider there are any matters relating to the interaction between the two Acts that need to be addressed.

**Are there any issues relating to the interaction between the Powers of Attorney Act that need to be resolved?**

17.5.4 Six respondents addressed this question. The Public Trustee submitted that there are not any present issues, commenting: ‘Although there are issues arising out of the Acts there is nothing that needs to be resolved at this stage that causes the Public Trustee’s functions to be unworkable.’

17.5.5 The Board and OPG expressed a desire for consistency between the Acts wherever possible. The Board commented that it had identified inconsistencies throughout its submission where relevant.

17.5.6 Two commented on the merits of combining both Acts, with one respondent not endorsing this approach, whilst members of the Elder Law Committee commented that this could be considered as it would ‘create one place for a member of the public to obtain their documents and information from.’ It also noted that ‘[i]t must be confusing for them to have to seek two separate documents, registering in two separate places.’ Recommendation 4.2 proposes that there be a separate review into the merits of developing a single enduring document enabling the appointment of representatives for both personal and financial matters. This may ultimately lead to the need for legislative reform.

17.5.7 Members of the Elder Law Committee endorsed the use of a central registration system for both instruments and enduring powers of attorney, including there being an ‘easily searchable free online facility.’ The registration of enduring documents was considered in Part 4, with it being

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1645 See [18.2.9].

1646 TLRI, above n 69, Question 14.7.
recommended that the desirability of establishing a single repository for enduring documents be considered further.\textsuperscript{1647} In summary, all issues raised have been addressed elsewhere in this Report.

17.5.8 Respondents expressed a desire for consistency between the Acts wherever possible. This Report makes a raft of proposals to reform the Act. It is appropriate that the \textit{Powers of Attorney Act} be reviewed against these recommendations to ensure consistency. This includes:

- Recommendation 3.3, dealing with the guiding principles of the Act;
- Recommendations made in Part 4 and 12 in relation to the appointment, removal and supervision of enduring guardians;
- Recommendations made in Part 6 in relation to the assessment of a person’s decision-making abilities; and
- Recommendations in Part 7 proposing introduction of a legislated supported decision-making scheme for personal matters.

\textbf{Recommendation 17.4}

(1) That the \textit{Powers of Attorney Act 2000} (Tas) be reviewed in light of the obligations and principles articulated in the \textit{Convention on the Rights of Persons with Disabilities} and recommendations contained in this Report, noting in particular:

- Part 3 of this Report which deals with the guiding principles of the Act, including Recommendation 3.3;
- Parts 4 and 12 of this Report in relation to the appointment, removal and supervision of enduring guardians;
- Recommendations in Part 6 of this Report in relation to the test and assessment of a person’s decision-making ability; and
- Recommendations in Part 7 of this Report proposing introduction of a legislated supported decision-making scheme for personal matters.

(2) That as far as possible there be consistency between the structure and provisions of the Act and the \textit{Powers of Attorney Act 2000} (Tas).

\section*{17.6 \textit{Alcohol and Drug Dependency Act}}

17.6.1 The \textit{Alcohol and Drug Dependency Act} governs the treatment and control of persons suffering from alcohol dependency or drug dependency.

17.6.2 This Report proposes reform to the Act to remove the pre-condition of disability to invoke the Act’s jurisdiction.\textsuperscript{1648} Instead, it is proposed that the Act require assessment of a person’s decision-making ability. It is proposed that the Act provide that a person is taken to have

\textsuperscript{1647} Recommendation 4.17(3).
\textsuperscript{1648} Recommendation 6.1.
the ability to make a decision unless the person or body considering their ability is satisfied that they are unable to:

- understand information relevant to a decision;
- retain information relevant to a decision;
- use or weigh information relevant to a decision; or
- communicate the decision.\textsuperscript{1649}

17.6.3 The Issues Paper noted that, if the Act removed the need for existence of a disability, then this may have implications for the \textit{Alcohol and Drug Dependency Act}. It was noted that it may be beneficial to confirm the interrelationship between the two Acts, including confirming when decisions relating to the treatment of a person with alcohol and drug dependency fall under the provisions of the \textit{Alcohol and Drug Dependency Act} and when they fall under the Act.

17.6.4 With this context, the Institute asked:

\begin{tabular}{|l|}
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(i) Are there any gaps between the Act and the \textit{Alcohol and Drug Dependency Act 1968} that need to be resolved? \\
(ii) Is there any overlap between the Act and the \textit{Alcohol and Drug Dependency Act 1968} that needs to be resolved?\textsuperscript{1650} \\
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\end{tabular}

17.6.5 The OPG and Advocacy Tasmania responded to this question, both making similar comments. The OPG submitted:

The OPG is not aware if this Act is ever used. Whilst not an area of expertise of the OPG, the framework appears outdated and not in step with current treatment and rehabilitation practices.

17.6.6 Advocacy Tasmania stated:

Our experience is that the \textit{Alcohol and Drug Dependency Act} is rarely used in practice and is not a rights-compliant piece of legislation. If the Act needs to continue in operation, it would be better-served within more modern and rights-based legislation. However, we have concerns about the usefulness, rights implications and appropriateness of involuntary treatment in this context.

17.6.7 As noted, Recommendation 6.1 proposes that the Act not require a person to have disability for the purposes of establishing whether they have decision-making ability. This has the effect of extending the Act’s jurisdiction. If it is decided that there should remain separate regulation of the treatment and control of persons with alcohol or drug dependency, then it will be necessary to exclude those matters regulated by the \textit{Alcohol and Drug Dependency Act} from the

\textsuperscript{1649} Recommendation 6.3. \\
\textsuperscript{1650} TLRI, above n 69, Question 14.6.
Act’s operation. It is outside the scope of the Institute’s Terms of Reference to consider the need for, or desirability of retaining the *Alcohol and Drug Dependency Act* as part of this project.\(^{1651}\)

**Recommendation 17.5**

1. That consideration is given to the need to continue operation of the *Alcohol and Drug Dependency Act 1968 (Tas)*.

2. That if the *Alcohol and Drug Dependency Act 1968 (Tas)* continues in operation, the Act confirm that it does not apply to the treatment and control of persons suffering from alcohol dependency or drug dependency dealt with under the *Alcohol and Drug Dependency Act 1968 (Tas)*.

### 17.7 Other legislation

17.7.1 The *Trustee Act 1898 (Tas)* contains provisions about the powers and duties of trustees in Tasmania. Under the Act, administrators have power to invest a represented person’s estate in any manner that trustees can invest.\(^{1652}\) The *Public Trustee Act 1930 (Tas)* deals with the constitution and regulation of the Public Trustee. Whilst the Institute was not aware of issues relating to the interaction of these Acts and the Act, a question was asked about this, seeking stakeholder’s advice.

Are there any issues relating to the interrelationship between the Act and any other legislation that needs to be resolved, for example:

- the *Public Trustee Act 1930*;
- the *Trustee Act 1898*; or
- any other legislation?\(^{1653}\)

17.7.2 One submission commented that the Commonwealth Charter of Residents Rights is not given priority. This matter was considered in Part 3 when evaluating the guiding principles of the Act.

17.7.3 In relation to the operation of the *Public Trustee Act*, the Public Trustee submitted that there were no issues, and that ‘[a]lthough there are issues arising out of the Acts there is nothing that needs to be resolved at this stage that causes the Public Trustee’s functions to be unworkable.’

17.7.4 The OPG endorsed consistency between legislation where possible.

17.7.5 Noting that no particular issues were drawn to the Institute’s attention, it has not made recommendations for reform.

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\(^{1651}\) Smith and Rigby, above n 433, advocate the benefits of alcohol and drug dependencies falling within the guardianship jurisdiction: at 178.

\(^{1652}\) *Guardianship and Administration Act 1995 (Tas)* s 56(2)(b).

\(^{1653}\) TLRI, above n 69, Question 14.7.
17.8 Statutory reviews of legislation

17.8.1 Both the Mental Health Act and Disability Services Act mandate reviews of the respective Acts. Under the Mental Health Act, a review must be conducted every six years, and under the Disability Services Act, every three years.\textsuperscript{1654} The Act does not mandate a review of the Act. The Issues Paper asked whether there is merit to doing so.

\begin{itemize}
  \item[(i)] Should the Act mandate a statutory review of the Act?
  \item[(ii)] If so, what timeframe is appropriate?\textsuperscript{1655}
\end{itemize}

17.8.2 There were five responses, with three endorsing the Act providing a statutory review period. The Public Trustee submitted that it held no view, whilst members of the Elder Law Committee commented that there were advantages and disadvantages to each:

having a set time frame may ensure more timely discussion and change, but if it has to be done within a certain time frame it may become unhelpfully rushed and less conducive to a full review. Having a time frame for review is a good method to bring about a review however.

17.8.3 The OPG endorsed the establishment of a mandated review period, commenting that ‘[t]his is particularly important in the current environment of significant change associated with the NDIS and reforms in the aged care sector.’ Social Work Services RHH also commented that it was desirable ‘due to changes in medical practices and changes in the way humans interact with each other (e.g. the internet, social media).’

17.8.4 Consistent with submissions received, the Institute recommends that the Act mandate a statutory review period, in the same way that the Mental Health Act and Disability Services Act provide. This strategy is endorsed not only to ensure that the Act remains appropriate and responsive, but to progress compliance with obligations under the Convention.

17.8.5 The Convention Committee has stated that the effect of the Convention is to require the abolition of substituted decision-making frameworks and the replacement of those schemes with supported decision-making arrangements.\textsuperscript{1656} It provides that ‘development of supported decision making systems in parallel with the maintenance of substitute decision making regimes is not sufficient to comply with article 12 of the Convention.’\textsuperscript{1657}

17.8.6 It is generally accepted that State parties to the Convention will not become wholly compliant with the Convention immediately and that reform to legislation, policies and practices will take time. A mandated review period provides opportunity for any reforms to the Act to be reviewed and revised and provides opportunity for further reflection upon strategies to achieve compliance with the Convention. It also provides opportunity to review the Act in light of other developments occurring in the disability sector, notably full implementation of the NDIS and reforms to the aged care sector.

\textsuperscript{1654} Mental Health Act 2013 (Tas) s 229; Disability Services Act 2011 (Tas) s 53.
\textsuperscript{1655} TLRI, above n 69, Question 14.5.
\textsuperscript{1656} Convention Committee, above n 21, [26].
\textsuperscript{1657} Ibid [28].
There were a range of views about the timeframe for review, ranging between three to 10 years. Noting that the Institute has proposed a range of significant reforms as part of this Report, that there are wide ranging developments occurring nationally in the disability sector, and the importance of making continual improvements to legislative approaches to reflect the rights and interests of people requiring decision-making support, the Institute proposes a three year review period, consistent with the *Disability Services Act*.

**Recommendation 17.6**

1. That the Act mandate a statutory review of the Act.
2. That the statutory review period be every three years.
Part 18

Enablers and Future Developments

18.1 Introduction

18.1.1 This final Part considers options to improve the guardianship jurisdiction in addition to, and complementary to, legislative reform. This Part has been included based on feedback received during the Institute's public consultation indicating that many of the issues or limitations with the jurisdiction result from issues unrelated to the legislative framework. It is these matters that are addressed in this Part.

18.1.2 This Part also reviews likely future developments that may impact upon the operation of Tasmania’s guardianship laws. It outlines matters that may need to be addressed and future actions that may be required, noting that there are presently significant changes occurring in the disability space nationally.

18.1.3 Both of these matters address the Institute’s Terms of Reference which sought advice about ways in which Tasmania’s guardianship laws can be more sustainable and responsive.

18.2 Sustainability and responsiveness of the Act

18.2.1 The characteristics of the Tasmanian population, and those involved in guardianship applications, have changed since the Act was established. This has, and will, continue to affect the way in which guardianship law in Tasmania is applied and experienced.

18.2.2 The Tasmanian population is ageing. At June 2016, 46 per cent of Tasmanians were over the age of 45 years.\textsuperscript{1658} The Board reports that in 2016–2017, 55 per cent of applications it received related to people over the age of 65.\textsuperscript{1659} Since 2012, the most commonly identified disability has consistently been dementia.\textsuperscript{1660} The OPG reports that 49 per cent of represented people it acted as guardian for as at 30 June 2017 were over the age of 60.\textsuperscript{1661} The President of the Board has noted that ‘[a] major challenge into the future will be the impact on the increasing aging population on the need for guardianship and administration orders …’\textsuperscript{1662}

18.2.3 The Board managed its largest workload to date in 2016–2017. It saw an increase in the number of applications by 49 per cent compared with the previous financial year.\textsuperscript{1663} This is

\textsuperscript{1658} Australian Bureau of Statistics, ‘Population by Age and Sex, Regions of Australia, 2016: Tasmania’.
\textsuperscript{1659} Guardianship and Administration Board, n 235, 18.
\textsuperscript{1660} Ibid.
\textsuperscript{1661} OPG, above n 578, 12. Note that this reflected a slight decrease from 30 June 2016.
\textsuperscript{1662} Guardianship and Administration Board, Annual Report 2015–2016, 3.
\textsuperscript{1663} Guardianship and Administration Board, n 235.
primarily a result of a 107 per cent increase in applications for emergency administration orders and a 55 per cent increase in applications for administration orders. A total of 1772 applications were made to the Board.1664

18.2.4 The OPG reports a 30 per cent increase in the number of represented people on its caseload between 2016 and 2017 and a 35 per cent increase compared to 2015.1665 As at 30 June 2017, the OPG had 214 represented people on its caseload.1666 The Public Trustee reports that as at 30 June 2017, it acted as administrator for 682 represented people. This reflected a 19 per cent increase from 30 June 2016.1667 Similarly, the Legal Aid Commission of Tasmania reports that it provided 3,383 client services to people living with disability and mental health issues in Tasmania.1668 Its workload in this area increased by 33 per cent between 2015–2016 and 2016–2017.1669

18.2.5 These statistics demonstrate an increasing workload for the Board, the OPG, Public Trustee, and Legal Aid. This is a significant factor in light of the Institute’s Terms of Reference which required consideration of how the Act can be responsive and sustainable.

18.2.6 The Issues Paper sought feedback about how the Act could be more sustainable and responsive.

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<th>What improvements would make the Act more sustainable and responsive to the needs of Tasmanians?</th>
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18.2.7 Thirty verbal and written submissions were received.1671 Some indicated that there is no general need for improvement to the Act. Some individuals the Institute spoke with commented that the Act has served them well and provided great support for those caring for a person with a decision-making disability. The Public Trustee reiterated that ‘it does not hold a general view as to developments/improvements to the Act.’

18.2.8 Suggestions made to make the Act more sustainable and responsive included:

- providing adequate education about the Act and related laws, including ways that the Act can provide clarity about related legislation, for example the *Powers of Attorney Act*;1672

1664 Ibid.
1665 OPG, above n 578, 12.
1666 Ibid 12.
1670 TLRI, above n 69, Question 1.3.
1671 Including comments made in group consultation meetings convened by COTA, Carers Tasmania and Dementia Australia (Tasmania).
1672 Seven submissions raised this issue.
• providing robust complaint mechanisms to deal with allegations of abuse and that there is adequate investigation and prosecution of offences. This was addressed in Part 12;

• confirming the rights of people with disability reflected in the Convention. This is addressed throughout this Report;

• development of nationally consistent laws and mutual recognition of instruments and tribunal orders;

• adequate funding for professionals and bodies working in this area, including ensuring that the jurisdiction is adequately resourced to deal with issues outside of business hours;

• recognising the importance of carer and family supports, including ensuring that there is consultation with families, carers, and others close to a person requiring decision-making support;

• ensuring that legislation is not overly prescriptive, but rather outlines broad principles;

• eliminating situations where it is perceived that invoking the Board’s jurisdiction is used as a threat or means of coercion for non-represented people and those close to them. It is considered that this can be primarily addressed through education and by ensuring that the appointment of a representative may only occur a last resort;

• providing clarity in relation to the use of ACDs and withdrawing and withholding consent to treatment. These matters were addressed in Parts 5 and 13; and

• major changes in practice and service provision in relation to decision-making supports.

Education

18.2.9 The most common suggestion to make the Act more sustainable and responsive was the need for education. Seven submissions raised this issue.

1673 Six submissions raised this issue.
1674 Five submissions raised this issue.
1675 See for example [12.11.8].
1676 Two submissions raised this issue.
1677 Four submissions raised this issue.
1678 Three submissions raised this issue.
1679 Three submissions raised this issue.
1680 One submission raised this issue.
1681 One submission raised this issue.
1682 One submission raised this issue.
1683 See [5.5.20], [13.5], Recommendations 5.6, 13.9.
1684 One submission raised this issue.
18.2.10 It was observed that there is a lack of understanding amongst the community about the Act and how it interacts with other legislation. COTA, for example, stated that:

The Act should clearly articulate that there are four instruments, governed by four separate Acts, that contribute to giving effect to a person’s rights, will and preferences: wills, enduring powers of attorney, enduring guardianship, and advanced care directives …

COTA Tasmania believes it is essential for the Act to make provision for education in the duties of administrators and guardians and the rights of those who are the subject of enduring instruments. This education should be provided to both the person making the appointment and the appointees. This will make the Act more sustainable and effective by reducing disputes and exploitation, which will in turn reduce the workload of the state.

18.2.11 PCT made similar observations:

No matter the outcome from this review one of the biggest issues for service providers and the community is confusion over the role of the GAB, the Public Guardian, and the Person Responsible.

18.2.12 Members of Carers Tasmania commented that education needs to be provided at an early stage. This includes:

- education about the nature and effect of instruments, powers of attorney and ACDs as tools to record wishes and directions for future decision-making; and
- education at the time of making an instrument or ACD, so that both the donor and enduring guardian understand the role, duties and powers of representatives.

18.2.13 Others also stressed the importance of ensuring that any reform to the Act is accompanied by an effective community education campaign. EOT commented:

We consider that the introduction of any new legislative framework governing guardianship arrangements should be accompanied by a broad based information campaign aimed at service providers outlining their ongoing responsibility under discrimination and disability law.

18.2.14 It was commented that educational materials must be provided in a range of formats and not limited to web-based information.

18.2.15 The need for education of the rights and responsibilities under legislation was also recently recommended as a matter requiring action as part of the review of the Disability Services Act.1685 A three year elder abuse training strategy is one of the agreed action items under the 2015–18 Elder Abuse Prevention Action Plan developed by the DHHS.1686

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The Institute’s view

18.2.16 The Convention requires State parties to adopt awareness raising strategies to reinforce the rights and dignity of persons with disability.\textsuperscript{1687} The Australian Human Rights Commission has stated that accessible, quality, safeguarding and oversight mechanisms for people with disability who have experienced or are vulnerable to experiencing violence ‘provide information in a variety of formats to meet people’s different communication needs,’ and ‘disseminate information through a variety of ways, including face to face, over the phone, online, and out-reach through advocates and organisations that provide services and supports to people with disability.’\textsuperscript{1688} It endorses education as a preventative strategy to prevent the occurrence of violence, abuse and neglect.\textsuperscript{1689}

18.2.17 Education serves several functions. Primarily, it is a proactive strategy to seek to reduce the incidence of breaches of the Act and other conduct that could amount to abuse, neglect, or exploitation. It was reinforced to the Institute that most individuals seek to ‘do the right thing’ and act in accordance with the law but may breach the Act through lack of understanding. A reduction in the number of breaches of the Act would reduce the workload of the Board, the OPG, Public Trustee and police.

18.2.18 Education also has a positive effect upon the represented person and those close to them, including their representative. A shift towards greater emphasis upon support should extend to supporting supporters themselves. One of the ways this can be achieved is through education and resources for representatives and supporters.

18.2.19 Education would assist in raising awareness of people’s ability to plan for potential future incapacity by completing an enduring power of attorney, instrument and ACD. Completing these documents serves three critical functions:

- it enables a person to communicate their views, wishes and preferences for future circumstances where they may have difficulty in communicating those views, wishes and preferences. In effect, the documents serve as a communication aid for potential future decision-making. A person is able to either ‘decide in advance’, by giving directions to health practitioners or their representative, or a person can communicate values to assist representatives to ascertain the person’s will and preference. It is one means of supporting a person to make their own decisions;

- it enables a person to choose who they want to act as their representative. This ensures the person retains control of the decision-making process and is able to exercise their will and preference in their choice of representative. In default, the Board appoints a representative on a person’s behalf, based where possible on what it understands reflects the person’s wishes; and

- it would likely result in a reduced workload for the Board. It may reduce the need for applications for orders appointing guardians and administrators — necessarily reducing

\textsuperscript{1687} \textit{Convention on the Rights of Persons with Disabilities} art 8.

\textsuperscript{1688} Australian Human Rights Commission, above n 60, 41.

\textsuperscript{1689} Ibid 56.
the caseload of the OPG and Public Trustee. The Board and OPG could then focus their resources upon the supervision of representatives and supporters to safeguard the rights of individuals.

18.2.20 The Act historically applied to people with intellectual disability who may never have had the prescribed capacity to complete an enduring document. Now the Act is applying increasingly to individuals with dementia, who have the ability to put in place enduring documents. This provides a real opportunity to ensure that those who are most likely to have some interaction with the Act and the Board have adequately planned and documented their views, wishes and preferences for future decision-making.

Recommendation 18.1
That there be adequately funded robust and accessible public education about the Act and any reforms. Educational materials should be produced in a variety of formats and include both print and web-based information.

Accessibility

18.2.21 The second most frequent comment made during public consultation was that the Act, and the law generally, is too difficult to understand. Six submissions raised the importance of using simple, easily understood language. Members of the Elder Law Committee commented that improving terms used and definitions ‘may better assist people’s understandings of their roles and obligations.’

18.2.22 The OPMHS on the other hand, commented that the language of the Act is one of its current strengths:

One of the outstanding benefits of the current GAA 1995 is its relative simplicity, the avoidance of excessive, repetitive, unnecessary, complicated paperwork ... It is essential that the working of The Act remains understandable so that, as much as possible, represented persons and those close to them can sufficiently understand the legal framework, as well as to avoid misunderstanding amongst professionals providing care and services. Excessively complex requirements, or largely bureaucratic requirements, can add enormous distraction from truly relevant issues.

18.2.23 Article 9 of the Convention confirms the right of people with disability to an accessible environment.\textsuperscript{1690} Part of implementing a shift towards supporting people with decision-making is ensuring that information is presented in an accessible format, so that people can understand it. Legislation is one example of information that needs to be made as accessible as possible. It is especially important that laws that apply directly to people with impaired decision-making ability are easy to understand for the person, their carers, families and broader support networks.\textsuperscript{1691}

18.2.24 Whilst a commonly expressed view was that the Act is difficult to understand, the Institute notes the OPMHS’s observations that, when compared to the Mental Health Act, one of

\textsuperscript{1690} Convention on the Rights of Persons with Disabilities art 9.
\textsuperscript{1691} This approach is consistent with the NSWLRC’s recommendations: NSWLRC, above n 24, Recommendation 4.2.
the real advantages of the Act is its relative brevity. There is therefore the need to balance the desirability of reform with the need to ensure that this is not to the detriment of readability and accessibility. The Institute has taken this into account when considering and developing recommendations for reform, aiming to ensure that the Act does not become overly complicated or prescriptive.

18.2.25 With any reform to the Act, the Institute welcomes the development of Easy-Read information booklets and use of innovative technologies to ensure that information about the Act is accessible. The Institute commends the Board and OPG for its Easy-Read summaries of the Act available online and endorses further development and distribution of these in a range of formats.

**Recommendation 18.2**

That the Act be as accessible as possible, including:

- a logical structure;
- use of plain English;
- clearly defined terms;
- avoiding internal referencing to other sections of the Act; and
- brevity.

**Resourcing**

18.2.26 One concern expressed during the Institute’s consultations was the adequacy of resources allocated to those working within the guardianship sector in Tasmania. This issue was discussed in Part 16 in relation to the OPG’s advice that it is unable to perform the Public Guardian’s systemic advocacy role due to lack of resources.\textsuperscript{1692} Resourcing was also discussed in Part 4 in relation to the register of instruments.\textsuperscript{1693} Some community members expressed dissatisfaction with difficulties contacting professional representatives outside of business hours, restricting the ability of a represented person to be spontaneous, particularly in relation to their spending on incidentals.

18.2.27 This review’s Terms of Reference asked for consideration of whether the current guardianship and administration framework will be sustainable and responsive to the needs of Tasmanians, noting demographic changes in particular. The most significant demographic change since the Act was enacted has been Tasmania’s ageing population and the increasing prevalence of dementia. As noted above, in recent years the most frequently identified disability of people the subject of an application to the Board has consistently been dementia. The annual reports of the Board, OPG, Public Trustee and Legal Aid reveal increasing workloads across the board.

18.2.28 The Institute considers workload \emph{per se} to be an insufficient reason to justify reform to the Act. As Carney notes, we do not consider workload within the health care system to be a

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\textsuperscript{1692} See [16.2.26].

\textsuperscript{1693} See [4.7.16].
satisfactory reason to ‘cut corners’ and provide a lesser level of service to those requiring care. We expect the same service, regardless of demand and expect that service providers ensure that they are adequately resourced to meet demand. Carney states:

it might be argued that it is wrong to ‘move the goal posts’ by diluting present justice entitlements compared to those available to past generations, merely because demographic shifts have led to an increase in demand. For if it is inequitable and wrong to restrict a public service like critical health care for such reasons, why should guardianship be treated differently?

18.2.29 That said, the Institute is mindful that Tasmania is a small jurisdiction and there is a need to be agile and use resources wisely. It has been cognisant of the importance of considering resourcing when formulating recommendations about potential reforms to the Act.

18.2.30 It is the Institute’s view that there is much to be gained from adopting a proactive approach through education and planning. Education would assist to avoid breaches of the Act, which would reduce the burden upon the resources of the police and courts, as well as the Board. Support to plan and document arrangements for future, such as via the creation of an enduring power of attorney, instrument and ACD, would reduce the workload of the Board, a matter discussed above. Education is therefore likely to have a positive impact upon improving capabilities within the jurisdiction.

18.2.31 The Institute’s Terms of Reference asked for consideration of the appropriateness of current measures to address poor conduct of guardians, administrators and persons responsible. The Board and the OPG are critical to achieving this objective. Reform to the law is of little assistance if the Board and OPG are not properly resourced to carry out the safeguarding functions assigned to them under the Act.

**Recommendation 18.3**

That the State Government review and monitor the adequacy of resources allocated to groups directly involved in administering the Act, notably the Board, OPG, Public Trustee and Legal Aid Commission of Tasmania, to ensure that those bodies are able to perform their functions, duties and powers effectively.

**National developments**

*Uniform guardianship laws*

18.2.32 Another criticism raised during public consultation was the lack of nationally consistent guardianship laws. Four submissions raised this matter. NDS explained the hurdles that people with disability and those close to them experience as a result of differences in laws across the country:

There is a need to review cross-jurisdictional arrangements with cross-over decision-making structures between the commonwealth and the states clear or there will be room for confusion. People with disability and their families could experience

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1694 Carney, above n 1546, 6.
additional jurisdictional hurdles across different areas of their lives. Our members report both inconvenience and more serious disruption as a result of inconsistent approaches to the appointment of guardians, administrators, nominees or the recognition of enduring powers of attorney or guardianship. The experiences of people with disability and their families should be assessed and ways to maximise recognition of cross-jurisdictional arrangements should be put forward.

18.2.33 With an increasingly transient population and Tasmanians travelling interstate for medical treatment, there is a growing need for legislative uniformity. One barrier to the system not working as effectively as it might otherwise is a lack of consistency amongst jurisdictions, that there is no automatic recognition of documents and orders made interstate and an apparent lack of confidence within the community that arrangements put in place in one state will be recognised in another jurisdiction. Differences amongst jurisdictions also lead to ‘folklore’ and a lack of appreciation of the variations in legislative provisions when people may have lived elsewhere, or have family living elsewhere.

18.2.34 To the extent possible, the Institute has aimed to ensure that its recommendations align with guardianship laws in other jurisdictions and the recommendations of other Australian law reform commissions. But with sometimes significant variation, it can be difficult to achieve consistency because there simply is no consistency from which to work.

18.2.35 It is outside of the scope of this reference to achieve a nationally consistent approach to guardianship laws. The Institute understands that there is already work underway, particularly through the efforts of the AGAC and the Council of Attorneys-General (CAG), to progress uniform laws. The Institute looks forward to this work progressing and suggests that any reform to the Act arising as a consequence of this review be made in light of, and subject to, any future developments at a national level for uniformity.

**NDIS and related reforms**

18.2.36 There are likely to be a range of other developments that will impact the future operation of the Act. Notable examples include the full roll-out of the NDIS and consequential amendments to the *Disability Services Act*, regulation of the use of restrictive practices, and work being progressed in relation to nationally consistent laws. It is recommended that government maintain a watching brief in relation to these matters to ensure that any necessary or desirable amendments are made to the Act.

**Recommendation 18.4**

1. That the need for reform to the Act be further reviewed upon any amendments being made to the *Disability Services Act 2011 (Tas)*, *Mental Health Act 2013 (Tas)* or *Aged Care Act 1997 (Cth)* to ensure consistency wherever possible.

2. That the State Government work with the other state and territory governments, and the federal government, with a view to developing nationally consistent guardianship laws, including substitute consent to health care and treatment.

3. That if agreement is reached nationally about the enactment of uniform guardianship laws, the State Government work to enact uniform legislation.
(4) That there be clear and streamlined pathways for instruments, enduring powers of attorney and advance care directives made or registered in another jurisdiction to be recognised, registered and used in Tasmania.

**Broader reforms needed**

18.2.37 It would be misguided to believe that amendments to the Act alone would achieve greater compliance with the Convention. The Convention requires a much broader policy reform and a commitment from all levels of government. With a shift in focus towards supporting a person to make their own decisions, there must be a commitment to developing and enhancing supports available for people who require them. It requires education for professionals working with people with decision-making support needs, including staff of the Board, Public Trustee, OPG, Legal Aid, service providers and health practitioners. Broader community education is also critical to strengthen and validate the use of decision-making support.

18.2.38 The OPG commented that it is particularly keen to see supported decision-making arrangements being formulated and implemented through policy and program development. EOT made similar comments, observing that:

> a shift to a rights-based framework will require a range of strategies aimed at improving education across the community, increasing the availability of advocacy and supports and improving safeguarding mechanism in situations where those rights are threatened. Whilst the National Disability Insurance Scheme arrangements may have some impact in this regard, the vast majority of this work will fall to State governments. However it is currently outside the remit and capacity of State guardianship bodies. This requires both a legal and policy response.

18.2.39 It is outside the Terms of Reference to consider and make detailed recommendations about the changes in policy, practice and resources that may be required to successfully implement this shift. But, it is noted that:

- the Convention requires all levels of government to ensure that people who require decision-making support have support available to them to make, communicate and implement decisions;
- decision-making supports must be of a high-quality, readily available and accessible; and
- there must be equitable access to supports, taking into account linguistic and cultural diversity, gender and age diversity, those in lower socio-economic groups and those living in rural and remote areas. Supports must also be available for individuals who are socially isolated and may not have others within their social network from which to draw decision-making support.

**18.3 Implementation of reforms**

18.3.1 The Institute acknowledges that this Report proposes a significant number of reforms to the Act. To streamline implementation, the Institute proposes that legislative reforms be enacted in tranches as follows:
**Tranche 1**: Immediate amendments

**Tranche 2**: Immediate actions

**Tranche 3**: Longer-term actions

18.3.2 The Institute has also listed recommendations not requiring any action other than for noting within a separate category. These are outlined in Table 18.1 below.

18.3.3 Recommendations included in Tranche 1 are those where minor revisions are proposed to ‘tidy’ existing legislative provisions, or resolve what appear to be unintended omissions or oversights from the existing legislation. Whilst individually some of the recommendations classed in this category may appear insignificant, these reforms will individually and collectively create significant improvement to the operation of the existing legislative framework.

18.3.4 Recommendations listed under Tranche 2 should be considered for immediate action concurrent to reforms within Tranche 1. The Institute has, however, ranked these recommendations within a separate category with the intention of ensuring that the number of legislative reforms proposed does not inhibit or delay the immediate enactment of the straightforward reforms categorised in Tranche 1. Recommendations listed in Tranche 2 are those where there should not be impediment to immediate implementation, but where the reforms are more substantive in nature compared to those in Tranche 1.

18.3.5 Recommendations within Tranche 3 comprise more substantive legislative reforms, or recommendations that cannot be addressed until some future point as explained in the recommendation. The Institute reinforces that categorising recommendations within Tranche 3 does not mean that these reforms ought to be delayed beyond what is necessary or required.

**Table 18.1: Reform Implementation Strategy**

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**Recommendation 18.5**

That reforms proposed in this Report are progressed in accordance with the implementation strategy outlined in Table 18.1 of this Report.