HEALTH CONSUMERS' COUNCIL

Review of Guardianship and Administration Act, 1990

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Who we are

Health Consumers Council WA (HCCWA) is the independent Peak Body for health consumers in Western Australia, championing the rights and interests of health consumers in a complex and often challenging healthcare landscape. Our purpose is to achieve equitable, person-centred, quality healthcare and improved health outcomes and experiences for everyone in Western Australia. We do this through individual advocacy, consumer engagement activities and systemic advocacy across all areas of health and healthcare.

Staff at HCCWA often engage with people who are the subject of guardianship orders in our work. While many parts of the review are areas where we are not able to make comment, we have identified a number of areas where we would like to submit our feedback.

Consumer concerns about guardianship

Consumers tell us that they are concerned about losing their autonomy when they are appointed a guardian. They feel that their guardian is someone who doesn't really know them or really care about them, and that person is charged with making important decisions about their lives. This leads into concerns about people being worried that will be forced to leave their homes and being placed in a nursing home or other facility. There are also concerns around medications and treatments being recommended by a clinician and immediately accepted by the guardian without the guardian really understanding the desires of the consumer. We've heard from people who feel they have been forced onto antipsychotic medications when they do not feel they are necessary. We have also heard of family members and friends raising concerns about the treatment of a consumer but these concerns being ignored because of the role of the guardian.

Guardianship order reviews

We are concerned about the potential for abuse of the guardianship system and would advocate for guardianship orders to be reviewed regularly to ensure that the correct guardian has been assigned to the consumer, and that the guardianship arrangement is still appropriate for the needs of the consumer.

Representation and support for the consumer at SAT

Consumers have told us about being admitted to hospital and being surprised to learn that an application had been made to the SAT to appoint a legal guardian for them. They have told us about times when they did not feel they were adequately supported in their efforts to prove that they had decisional capacity, and that this is particularly challenging in a hospital environment, which is already an unfamiliar environment where the consumer is vulnerable.

HCCWA do not represent consumers at SAT hearings, but we do help people get a second opinion, as is their right under the Australian Charter of Healthcare Rights. We also give them advice that before the SAT order is made they still have control over their own rights in the healthcare system.

Representation at the SAT of patients who are the subject of a SAT hearing is an ongoing problem. There is not currently an agency available to support those consumers who are the subject of a SAT hearing who are not mental health patients. Some agencies provide advice and support, but not representation, and with the short notice involved, Legal Aid is unlikely to be available to most consumers. Hiring a private lawyer is often the only option available to these patients, but even that can be complicated by the fact that while the consumer is permitted to see the application and supporting evidence for guardianship, they are not permitted to take a copy of it or take photographs of it which might allow them to be shared with a lawyer. These restrictions mean that the SAT hearing process ends up being weighed in favour of the applicant.

HCC Recommendation: All guardianship *appeals* to the SAT should require that the consumer have legal representation or an advocate, and that should be funded by the state government, rather than the consumer.

Consumers who have a guardian and are unhappy with their healthcare

When a consumer already has a legal guardian and is unhappy with their health care and seeking advocacy, we take the view that simply having a guardian does not preclude a consumer from having an advocate. When this occurs though, many health services are not interested in hearing from one of our advocates, as they believe they should only be liaising with the guardian.

When patients who already have a legal guardian are admitted to hospital or treated by a clinician, there needs to be more explicit evidence that the clinician is aware of those patient's rights and that these rights have been met. In the same way that the Mental Health Act has forms that need to be completed which prompt a clinician to explain rights to a patient, patients who have a SAT order should also have a checklist where their rights are explained, which also serves to remind the clinician of the legislative requirements in place.

Supported Decision Making

We argue that Supported Decision Making should be legislated. Without supported decision making there are few options available for parents and families who have a family member with a disability but who do not want to remove their rights. We all need support to make decisions, and we actively encourage people to seek support for medical decisions, to talk to friends and family, to ask questions and get second opinions. But people with cognitive and intellectual disability, appear unable to be permitted to do this without it being a "capacity' issue.

Cultural Safety

Our experiences have identified a complete lack of Cultural safety in the guardianship process. Non-Aboriginal Guardians make decisions for Aboriginal people every day, around their lives and their access to Culture, family and Country. Aboriginal people tell us that they are taken out of their community and hidden away with service providers who then "own" them. There is no Cultural oversight. It is crucial that this is addressed in the review.

Wills and Preferences or Best Interests standard

We prefer the Wills and Preferences Standard over the Best Interests standard, and this is also the model that our individual advocates use in their work. The Best Interests standard is paternalistic and outdated and has the capacity to completely strip someone's rights. If a person's wills and preferences cannot be determined, then the Best Interest Standard is an appropriate alternative, but only once it is clear that the wills and preferences cannot be determined.

If there is a significant risk of harm to the consumer then the guardian may be able to depart from a person's wills and preferences, but in order for this to occur there should be an application process to follow to ensure that the departure from the Wills and Preferences standard is appropriate.

Advanced Health Directives

Consumers should be encouraged to get legal advice when they are compiling an advanced health directive, but there should not be a legislated requirement that they do so, as this may prove to be a barrier for some people.

We believe that the Act should oblige a health practitioner to determine if an Advanced Health Directive is in place. This could be facilitated by all Advanced Health Directives being registered in a central location to allow them to be found and identified with ease. On the other hand, the act should not require that a health practitioner advise all patients of the possibility of compiling an Advanced Health Directive as there would be some circumstances where this may not be appropriate. Practitioners should be encouraged to raise this topic with consumers at an appropriate time.

We also argue that mandatory training for health practitioners should be provided to ensure that practitioners understand Advanced Health Directives and how they should be managed in a healthcare setting.

If a patient has an Advanced Care Directive and they wish to amend it, they should be able to do so without cancelling it altogether, although we do note the need to ensure that a person amending their Advanced Care Directive needs to have decisional capacity at the time of that amendment.

Section 110ZIA of the Act currently enables a health professional to override a patient's own wishes in an Advanced Health Directive and the decisions of all substitute decision makers if they are providing urgent treatment to save a patient's life. This was initially added to address concerns that people might use an Advanced Health Directive as a means of trying to commit suicide. We would argue that this section is paternalistic and should be considered for removal.

Goals of patient care

We are aware that there is a move towards encouraging patients to discuss and document their "goals of care" on admission to hospital. In some cases, these discussions may be sensitive and require reflection and deliberation. Where a patient does not have an AHD, it should be incumbent upon the health service to encourage the considered development of an AHD, with appropriate legal and clinical input.

Restrictive Practices

As is noted in the review documents, restrictive practices are often used for the convenience of staff or families, rather than for the wellbeing of the patient. There needs to be one legal framework for the use of restrictive practices.

We have seen situations where a guardian has put a person on a mental health ward as a social admission. It is our opinion that in these circumstances, if a patient does not meet the requirements of the Mental Health Act, then they should be permitted to leave unless there is a Restrictive Practices function on the SAT order. These social admissions are usually on locked wards so the consumer is a recipient of a restrictive practice (being in a locked ward) even without meeting the requirements of the Mental Health Act and without a restricted practices function on their SAT order. This is a clear denial of human rights and should not be occurring.

We often find that hospital staff are poorly informed about patient rights in the circumstances where the patient has a guardian and follow the instructions of the guardian without checking whether the instruction complies with legal frameworks. Having a single legal framework for restricted practices should help with this, as should better education of health practitioners.

Guardians should only be able to approve restrictive practices if SAT has given them the power to do so. Additionally, restrictive practice functions on a SAT finding should be reviewed at least every three months to ensure that SAT is still of the belief that restrictive practices are appropriate.

The need for restrictive practices should not be the only basis for SAT to consider the need for a guardianship order. It can be one of the factors being considered, but not the sole reason. This is because the need for restrictive practices might be short term, such as in a temporary psychosis or a temporary delirium in an elderly patient with a Urinary Tract Infection.