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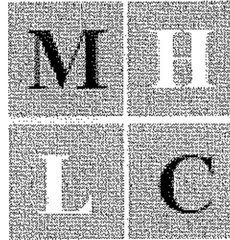

INQUIRY INTO POWERS OF ATTORNEY

Submission by the Mental Health Legal Centre Inc. to the Parliament of Victoria Law Reform Committee

September 2009, as amended December 2009

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The Mental Health Legal Centre

The Mental Health Legal Centre ("MHLC") is a statewide community legal service that, for 24 years, has provided a free and confidential legal service to anyone who has experienced mental illness in Victoria where their legal problem relates to their mental illness. MHLC was established in response to the introduction of the *Mental Health Act* 1986 (Victoria) ("MHAct") to ensure that people with mental illness had access to legal representation to assist with their navigating the new Act.

MHLC is a non-profit organisation run by an independent Committee of Management. MHLC receives the majority of its funding from the Victorian Department of Human Services and Victoria Legal Aid. In addition, project funding for a range of projects has been secured from philanthropic and other organisations. MHLC provides telephone advice and referral, and direct advocacy. In some cases this may relate to education and general inquiries concerning mental health and the law for consumers in Victoria. MHLC also undertakes research, law reform and policy work in relation to mental health and the law, based on community consultations. Policy is both reactive, in response to government law reform initiatives; and, proactive, in response to consumer initiative or requests. Of significance, in the last 12 months MHLC has:

- from the perspective of consumers, published a review of the Mental Health Review Board entitled 'Lacking Insight',' [1];
- auspiced advance directives research in two phases: documenting the views and experiences of consumers; and, documenting the views and experiences of clinicians in the public and private sectors, and with a view to trial the documents;
- researched the experience of the courts from the perspective of people with mental illness. Research highlighted issues from arrest to imprisonment, and is soon to be published; and,
- commenced a legal service for prisoners with cognitive impairment, located within the assessment units of selected prisons.

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1 Topp ThomasInvarson[2008] available on MHLC website

All MHLC activities aim to promote the rights and experiences of people who experience mental illness.

1 Executive Summary

1.1 The Mental Health Legal Centre ("MHLC") welcomes the opportunity to make this submission on a policy area that intimately affects the rights and interests of people with mental illness. Enduring Powers of Attorney ("EPAs") exist as a key mechanism by which Victorians with a mental illness can continue to exercise some control over their affairs through the appointment of an attorney to act in their interests. At the same time, the MHLC recognizes that EPAs can be abused; and, that donors can be left playing significantly lesser roles in their key life decisions.

2 List of Recommendations

- Introduction of powers of attorney (enduring and otherwise) and advance directives to ensure all people have equality before the law under the *Charter*[2] and the CRPD and can exercise their right to choose or refuse treatment and articulate their wishes
- Streamlined uniform legislation
- Introduction of consistent terms, accessible documents
- Education and promotion on the use of the documents
- Expansion of the suite of documents that allow people to document their wishes – to include advance directives and broader powers under enduring powers, medical
- Introduction of broad capacity based legislation
- Consistent enforcement and accountability mechanism to ensure effective respect and recognition of all documents, together with an independent review or appeal processes

3 The Law Reform Committee's Terms of Reference

3.1 The Law Reform Committee has been asked, under its terms of reference, to:

a. consider the differing formality requirements and terminology, and coverage of the power of attorney documents, governed by the *Instruments Act 1958* and the *Guardianship and Administration Act 1986*;

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[2] Victorian Charter of Rights and Responsibilities 2007

b. establish whether the donor of a power of attorney has capacity to create a legally enforceable document and differing execution requirements and the different tests that apply;
c. clarify the powers granted by the donor when making a power of attorney;
d. examine ways of minimising abuse in relation to the execution of and exercise of powers under powers of attorney documents;
e. consider the issue of legal capacity in the context of when an enduring power of attorney is executed and activated; and
f. advise on the need for adopting potential safeguards such as the registration of documents (voluntary or mandatory).

3.2 MHLC notes that powers of attorney executed under the *Medical Treatment Act 1988* are outside the scope of this inquiry. This submission however calls for legislation which provides for supported and substituted decision-making generally – including all powers of attorney and advance directives - to be placed in the one 'capacity-based' Act. MHLC also seeks definitional uniformity across all the legislation despite the Committee's narrower focus. Accordingly, this submission does occasionally incorporate comments on the *Medical Treatment Act 1988 (Vic)* and the *Mental Health Act 1986 (Vic)*.

4 Streamlining Attorney Documents

4.1 Presently, there are four different types of powers of attorneys, governed by three different legislative instruments, each with different forms.

4.2 There are currently no Victorian provisions that either allow or enable multiple Enduring Powers of Attorney ("EPAs") to be consolidated in one catch-all EPA document.

4.3 It is submitted that power of attorney documents should be streamlined to enable persons to enact multiple EPAs by signing one generic enduring power of attorney to cover guardianship and financial matters. It is submitted that this single document should have multiple parts, to enable the donor to consider 'tailor making' parts of the document ie to appoint one attorney for a particular decision and stipulate those powers. The donor may choose a different attorney for different responsibilities.

4.4 It is further submitted that the creation of a catch-all EPA document will resolve the current confusion relating to the multiplicity of attorney forms, and will facilitate the individual's ability to enact EPA documents.

5 Uniform Terms

5.1 Under the current legislative regime, there are two types of EPAs: an enduring power of attorney (financial) under the *Instruments Act 1958;* and, an 'Enduring power of attorney (medical treatment)' under the *Medical Treatment Act 1988*. In addition, the EPA under the *Guardianship and Administration Act 1986* is referred to as the 'Enduring power of guardianship'. These differing terminologies give rise to much confusion and uncertainty as to the scope and effect of each type of EPA, together with their relationship to each other.

5.2 For example, the scope of the powers of an enduring guardian and an agent appointed under the *Medical Treatment Act* may overlap or at least cause confusion when it comes to healthcare and medical decision-making.

5.3 It is submitted that the Victorian government should introduce a general Power of Attorney Act, which legislation applies to all Powers of Attorney- enduring and otherwise. This will ensure a consistent approach to all EPAs and clear articulation of the powers bestowed when the person has capacity and those that become active when the person loses capacity.

5.4 It is further submitted that the general power of attorney should be renamed to reflect its limited application.

6 Capacity

6.1 It is submitted that the common law presumption, that all people are presumed to have capacity unless it is proven otherwise, should apply in all cases of establishing capacity and should be explicitly articulated in any capacity-based legislation such as the GAA, Medical Treatment Act and Instruments Act. Further, that capacity is presumed unless evidence exists to the contrary.

6.2 The fact that capacity is a functional test and time-specific should be clearly articulated in legislation. It is submitted that capacity based legislation must articulate, that merely

because a decision is or may be perceived by others to be an "unwise" decision is not indicative of impaired capacity or incapacity on the part of the decision-maker.[3]

6.3 It is submitted that in determining capacity to make a decision it is the process by which the person makes the decision must be considered. This is consistent with the common law principle that a person with capacity has the right to make a decision which the law will enforce – even when the decision appears unwise or irrational, or involves a refusal of life-prolonging treatment leading to death[4].

6.4 Current legislation, lacks definition of precisely what the test of capacity (or incapacity) is beyond the common law and statutory (*Instruments Act 1958*) notion that the donor must 'understand the nature and effect' of their decision,. However we are concerned that introduction of a definition can be problematic in that it introduces 'reasonableness' which can be limited when a person has a disability by an overlay of 'best interest'. It is submitted that the introduction of such tests needs to be approached with caution. For example best interest can be in tension with best financial interest.

6.5 It is submitted that a capacity test needs to be consistent and include the following key aspects, generally understood at common law:

a. Ability to understand the information relevant to making the decision
b. Ability to retain the information relevant to making the decision
c. Ability to weigh up the relevant information
d. Ability to communicate a decision

6.6 It is submitted that neither doctors nor lawyers need to be further educated as to the nature of the concept of capacity. Indeed, the practitioners in each profession constantly assess the individual patient/client who seeks their assistance.

6.7 In the event that an individual lawyer did not feel competent to assess their client's capacity or lack thereof, s/he can always seek the opinion of the client's medical practitioner.

6.8 It is submitted that any attempts to introduce a requirement that each individual donor is formally assessed as to their capacity prior to executing a power of attorney will only lead

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[3] Re T (Adult: refusal of treatment) [1992] 4 All England Law Reports, 649; Re MB [1997] EWCA Civ 3093 ; Re B v NHS Hospital Trust [2002] EWHC 429.

[4] See also *Burke v The General Medical Council Rev 1* [2004] EWHC 1879 and the decision of the European Court of Human Rights in *Burke v UK* (unreported) ECHR, No 19807/06, 11 July 2006)

to a reduction in the number of people who choose to use this otherwise most useful document as to their wishes.

7 Respecting the Donor's Wishes

7.1 It is submitted that EPAs can be an effective manner of enabling people to retain a degree of control over their affairs. The donor specifically chooses their attorney(s), being trusted people in their lives, who will carry out the donor's wishes in the event of their incapacity.

7.2 As a corollary, it is submitted that the wishes of the donor must be the paramount consideration guiding the donee. However the current requirement that the donee act in the donor's "best interests" may be used as an excuse to adopt a paternalistic approach. Aspiring to a supported decision-making model would require that obligations upon the donee are strengthened to ensure the wishes of the doner are respected unless clear evidence can be produced as to why this should not be the case. (for example, medical evidence of incapacity at the time of the execution of the EPA).

7.3 If no clear evidence is produced there is a considerable risk that the donor's rights to privacy, property and liberty, specifically protected under ss 13,20 and 21 Charter of Human Rights and Responsibilities 2006, will be unlawfully or arbitrarily interfered with. To the extent that the state has positive obligations to promote these rights, appropriate measures should be enacted in legislation to monitor compliance, coupled with effective sanctions for a donee who fails to abide by them.

8 Abuse of EPAs

8.1 There is a danger of an abuse of power by the donee. This situation most frequently arises where elderly people have appointed family members as their attorneys. In these situations, the financial interests of elderly persons may be treated by the done(s) as their early inheritance, thereby ignoring the best interests of the donor.

8.2 In these situations there is a risk that donors will be treated in a cruel, inhuman or degrading manner. Such behaviour contravenes s.10 Charter of Human Rights and Responsibilities 2006 and it is therefore submitted that measures should be adopted to prevent the abuse of EPAs.

8.3 Notwithstanding that the abuse of power is a matter of significant concern, it is submitted that measures adopted to reduce abuse of EPAs should not compromise the overall benefits that can be achieved from the useful documents.

9 Advance Directives

9.1 It is submitted that the present suite of instruments should be expanded to incorporate documents to allow for decision making on a wider range of life style and health care issue to include increased powers of medical treatment and advance directives

9.2 What are advance directives?

Advance directives are documents that articulate a persons treatment (and other preferences) in areas of both general and mental health. With people with mental health concerns it is a document driven by a person with a mental illness which articulates their preferences for care and treatment and practical lifestyle arrangements in the event of a mental health crisis.

Typically, an advance directive contains information outlining the person's unique circumstances, including personal preferences for psychiatric medications and treatment and information about practical aspects of the person's life, such as care of children, pets, accommodation and employment.

An advance directive may encompass "instructional" directives (which direct what is to be done in a mental health crisis situation) or "proxy" directives (which appoint a person or persons to act in a manner similar to a health care proxy or power-of-attorney). The advance directive may also be a combination of the two (a "hybrid" directive).

Although not legally enforceable in Victoria, advance directives can make a significant impact on the well-being of a person with a mental illness.

9.3 Advance directives are relevant to this review for two main reasons. First, because advance directives are founded on the same human rights principles as those which underpin enduring powers of attorney and guardianship provisions. Second, because a uniform capacity-based legal framework implemented according to the principle of non-discrimination should logically, in our submission, include provisions to implement advance directives.

9.4 Advance directives with appropriate legal recognition can be an effective tool in moving towards a supported decision-making regime, as required by the UN Convention on the Rights of Persons with Disabilities.5 Advance directives are consistent with the principles underlying the promotion of EPAs – the inherent right to autonomy and self-determination and the opportunity to exercise one's capacity to the fullest extent possible. As with EPAs, advance directives promote dignity and respect for a person's ability to make and articulate decisions about themselves and what happens to them.

9.5 The concept of dignity and liberty in the case of a person with a diagnosed mental illness deserve special consideration here given the potential for the person to be subjected to coercive interventions under the *Mental Health Act 1988 (Vic)*. The profound disempowerment that results from involuntary treatment – even the mere threat of involuntary treatment – only reinforces the need to implement advance directives to maximise the person's participation in decision-making.

9.6 Winnick relevantly notes that:

> Allowing people with mental illness the opportunity to exercise self determination in matters of treatment can therefore be therapeutically beneficial, helping to achieve the goal of restoring them to as high a degree of functional capacity as may be possible so that they may resume life the community.[6]

9.7 Hence the fundamental importance of acknowledging the validity of the person's expertise in making decisions about what works and doesn't work in a crisis, based on the lived experience of mental illness.

9.8 As discussed above, advance directives, are intended to address many aspects of a person's life and are not limited to decisions about medical or psychiatric treatment. Given the multifaceted nature of the documents and their similarity to EPOAs it is most appropriate that all these documents should sit together. Advance directives should be respected not as

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[6] Winnick, Bruce J. (2008) "A therapeutic jurisprudence approach to dealing with coercion in the mental health system" Psychiatry, Psychology and Law, 15(1), 25-39, at 33.

a clinical tool, limited to psychiatric treatment, but as legal tool to promote capacity in a variety of different areas.

9.9 A human rights framework consistent with the principle of non-discrimination demands that any person who wishes to make decisions in advance about healthcare should be able to do so regardless of their diagnosis or disability. In other words people with mental illness should enjoy both equal opportunity to exercise this right and equal respect and legal force of decisions, including to refuse treatment, if they have capacity, or had capacity at the time of signing an advance directive.

9.10 Although it is beyond the scope of the review to consider the *Mental Health Act* in detail, some key points should be made about its impact on effective implementation and respect for advance directives.

9.11 Whether the person meets criteria for involuntary psychiatric treatment under the MHA and whether they have capacity to make an advance directive are questions that should be determined separately. This is consistent with overseas research which demonstrates that incapacity to make an advance directive cannot be assumed even when a person is a psychiatric inpatient.[7] It is also consistent with a functional approach to capacity and acknowledges the episodic nature of mental illness and that capacity can fluctuate over time.

9.12 The substitute decision-making model in the *Mental Health Act* is problematic in that it provides that the Authorised Psychiatrist is both the proponent of treatment and person who provides de fact consent on the person's behalf. This effectively denies a person with a mental illness the right to appoint a substitute decision-maker of their own choosing, or one appointed independently by the VCAT. Another example of discrimination and breach of the right to equality before the law under the Charter[8] and the CRPD[9].

9.13 Whatever measures are adopted to centralise storage and/or alert to the existence of an EPAs should also provide for advance directives. It is important that a balance be struck between facilitating timely notification of and access to the relevant document, as well as

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[7] See for example Ruth Cairns et al (2005) 'Prevalence and predictors of mental incapacity in psychiatric in-patients' *British Journal of Psychiatry* 187, 379-385. Elbogen et al (2007) 'Competence to complete psychiatric advance directives:Effects of facilitated decision making' *Law and Human* Behavior, 31, 275-289. See also Dawson, J., and Kampf, Annegret (2006) 'Incapacity principles in mental health laws in Europe' *Psychology, Public Policy and Law*. 12(3), 310-331at 312.

[8] Section 8.

[9] Article 5.

maintaining the privacy of the person whose document it is. This is particularly relevant for advance directives which may contain a wealth of information but which may only be relevant in part to discrete individuals and organisations.

9.14 Similar to the respect of the donor's wishes in the exercise of an enduring power of attorney, advance directives should be respected and complied with to the fullest extent possible and only departed from or overridden in limited circumstances where there is evidence to justify the clinician's decision.

9.15 The common law and human rights principle of non-discrimination would dictate that an advance refusal of treatment, provided executed when the person retained their capacity to make the decision, would be enforceable regardless of the diagnosis or reason for the subsequent loss or impairment of capacity. Genevra Richardson notes the inherent discriminatory contradiction between fiercely guarding the autonomy of people with general healthcare advance refusals, yet the reluctance to embrace the same rights for people with mental illness to refuse psychiatric treatment.[10]

9.16 A consistent enforcement and accountability mechanism is crucial to ensure effective respect and recognition of advance directives, together with an independent review or appeal process for individuals concerned.

9.17 A stringent process for documenting the reasons for not following the advance directive, and providing the person with a written copy of these reasons and their right of review and appeal is also required.

10 Public Education

10.1 It is submitted that there is a need for further education of the community in relation to the use and availability of EPAs.

10.2 It is hoped that such further education will lead to a lessening of the abuse of EPAs.

10.3 It is submitted that public education must promote social inclusion and inspire the community to assist people with disabilities in the event that they may be suffering abuse.

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[10] Genevra Richardson, (2007) 'Balancing autonomy and risk: A failure of nerve in England and Wales?' *International Journal of Law and Psychiatry* 30, 71-80 at 72. See also Tim Wand and Maria Chiarella, (2006) 'A conversation: Challenging the relevance and wisdom of separate mental health legislation' *International Journal of Mental Health Nursing* 15, 119 at 125.

11 Registration

11.1 It is submitted that a system of compulsory registration of EPAs would lead to a significant decrease in the number of EPAs written, as donors may not wish to have their private affairs subject to public scrutiny.

11.2 It is also submitted that any system of random auditing, including only of those affairs where it is believed that the attorney may be acting fraudulently, may result in few EPAs being written in the first place.