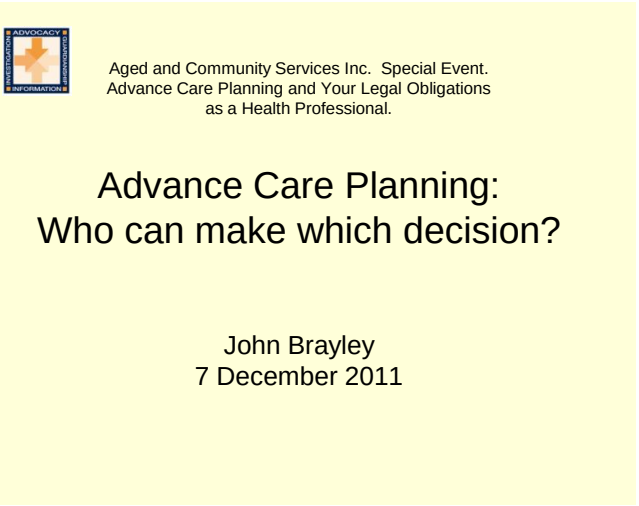


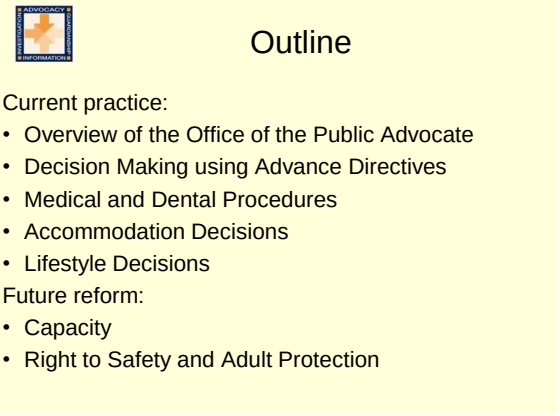
The benefits of advance directives are real. Advance directives provide for autonomy. Advance directives express a person's will even when a person can no longer communicate and understand. Advance directives let the individual appoint their substitute decision maker rather than leaving it to a tribunal. Advance directives can make sure that family and friends are not left in a state of angst and possible conflict, which then needs to be sorted out by a tribunal such as the Guardianship Board. We all should have advance directives.

Health and aged care professionals play a critical role. Early on, professionals give information about directives, their benefits, risks, and how they work. Later on, professionals are then obliged to comply with these directives when they relate to a range of decisions: not just health, but also accommodation and lifestyle.

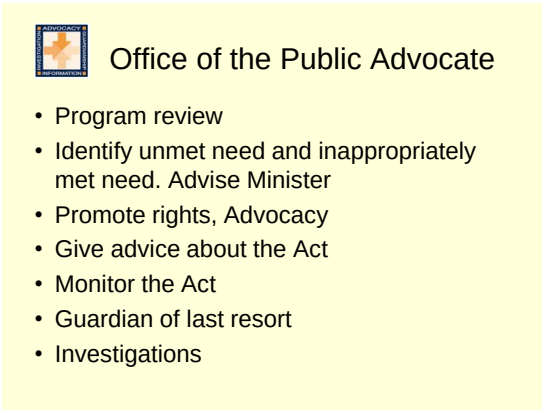
Health and aged care professionals can also pick up when there are problems in the operation of an advance directive. It might be that a medical attorney or enduring guardian does not understand their role. Education and advice might be needed, the provision of information sheets, the Manual for Private Guardians, or referral to our Office.

Rarely, but often enough, a substitute decision maker can exploit an advance directive, in particular the enduring powers of guardianship or attorney. The very instrument that can protect people's rights can also take them away, if in the hands of a person intent on exploiting the power the appointment gives, to abuse an older person or to make personal gain.

This is all made more difficult by the complicated regime of four different advance directives currently in place. This is being fixed with new legislation, but the existing system will be around for a little while yet.



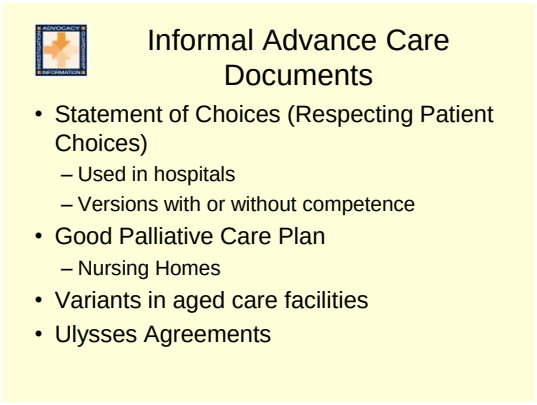
This is the outline of the presentation. The theme is who can make what decisions. It considers the role of advance directives, but also guardianship and administration powers. Central to the whole area is the concept of mental incapacity. In this presentation, I will discuss capacity, informal arrangements, and the different areas of decision making.



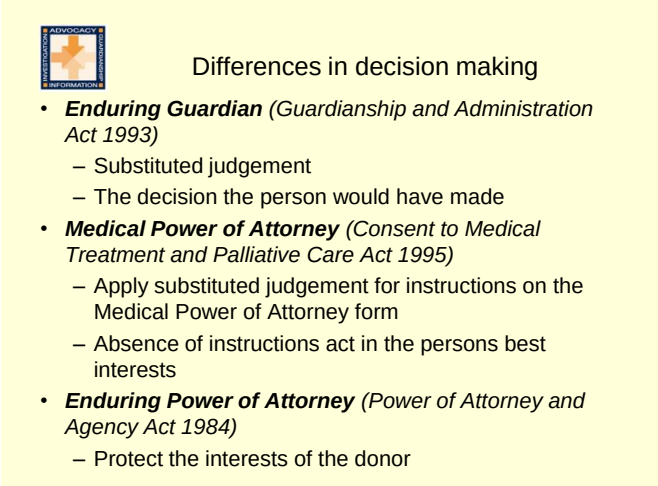
First of all, a word about our Office. The Public Advocate is an independent statutory official, accountable to the South Australian Parliament, legislated for by the *Guardianship and Administration Act 1993*. We assist people who have a mental incapacity — which is broadly interpreted as people who have dementia, a neurological disease affecting cognition, brain injury, intellectual disability, autism or mental illness. The functions are listed on the slide — they include program review, making recommendations to the Minister on unmet need, promoting rights, monitoring the Act, and the Public Advocate being appointed guardian of last resort.

As already discussed, today there are four advance directives in South Australia, covered by three pieces of legislation. The decisions covered and the types of directives are described on this slide: the Enduring Power of Attorney for financial decisions; the Enduring Power of Guardianship for lifestyle, accommodation and health decisions; the Medical Power of Attorney for health decision-making; and an Anticipatory Direction which gives instructions for care when a person is in the terminal phase of a terminala illness or in a persistent vegetative state. There is overlap and duplication between the potential use and roles of the Enduring Power of Guardianship and the Medical Power of Attorney in health care situations.

The first three — the EPG, the EPA and the Medical Power of Attorney —appoint an agent to make substitute decisions, but each of these directives also allows specific instructions to be written on the form that the person appointed must follow. The last directive – the Anticipatory Direction — is a personal directive only, without appointing a substitute decision maker. Following the South Australian advance directive review, there will be new legislation to simplify this system.



In addition, there are informal documents, the two common ones being the Statement of Choices, and the Good Palliative Care Plan. These can provide a useful tool, for writing down a plan after a person has lost capacity. However, if a person still has capacity and can use one of the statutory directives already listed, this better protects a person's wishes. In the future, if there is greater uptake of formal advance directives, which will be an aim of introducing new legislation, then informal documents should have less of a role.



The different advance directives also use different decision-making principles. So, the Enduring Guardian needs to give paramount consideration to what the wishes of the person would have been if he or she was not mentally incapacitated. In essence, this is what the person would have chosen to do themselves, to the extent that there is reasonably ascertainable evidence.

In contrast, a Medical Power of Attorney will make substitute decisions if instructions are put on the form, but otherwise must make a decision about what is in the person's best interests.

At times, the difference between substituted judgement and best interests considerations can lead to a completely different decision. This reflects the difference between what people might have chosen for themselves, and what another decision maker might determine is in their best interests.

This is also where health professionals can help guide substitute decision makers about matters they should consider. For example, did mum or dad ever talk about what they would want to happen if they ever were in a situation like this? Independent advice to substitute decision makers can be provided by the Office of the Public Advocate enquiry line. In addition, on our website there are a number of fact sheets covering guardianship and administration and related matters.

The substituted judgement standard is the most respected in this area. It is the one supported in the recently released National Framework for Advance Care Directives.

I want to pause for a moment to discuss an example of a substituted judgment decision.

The case actually involves enduring guardians making a decision about electroconvulsive therapy (ECT). The person for whom they were guardians is an older person who had severe depression, and had poor hydration and lack of proper eating. This person had stated their wish in the past never to have ECT, and had made their enduring guardians promise never to consent to this.

This case illustrates how substituted judgement works. I cannot give more details because of the provision in the *Guardianship and Administration Act 1993* to protect client privacy. However, I can discuss some non-identifying facts and principles, as there is broad public interest in such principles being disseminated.

As stated, the guardians were acting on what the person had wished, basing their decision on this paramount consideration. The Guardianship Board considered this matter three times.

On the first occasion, the Guardianship Board was asked to give its consent to ECT. However, the provisions of the *Mental Health Act 2009* s42, are clear that the Board can only consider consent if the person cannot consider the question of consent themselves, and does not have a Medical Power of Attorney, enduring guardian or appointed guardian who could consider this consent. This person had an enduring guardian, so therefore the Board could not consider the question of consent.

In the second hearing, the Guardianship Board was asked to revoke the Enduring Power of Guardianship. Section 26 of the *Guardianship and Administration Act 1993* allows the Board to do this if the enduring guardian has acted in an incompetent or negligent manner or contrary to the principles of the Act.

The Board concluded on a majority view that whilst they disagreed with the decisions of the guardians, they could not say, as a matter of law, that the conduct of the guardians was incompetent or negligent, so therefore the application was dismissed.

A third application was made shortly afterwards to a differently constituted Board. In the third hearing, the EPG was revoked and the Board consented to the ECT. The enduring guardians appealed to the District Court and their appeal was upheld. The Court set aside the orders made by the Board, because of a lack of procedural fairness in this third hearing. The enduring guardians' role was restored.

Enduring guardians can be called on to make major decisions. In this case, it was not life or death at the point that it was made, but it could have been in the future. It is reasonable to suppose that a best-interests decision would have been different to a substituted judgement decision.

In fact, the intersection of the *Mental Health Act* and the *Guardianship and Administration Act* highlights this tension. The enduring guardians were appointed under the Guardianship Act, and were therefore obliged to make substituted judgement their paramount consideration. However, the *Mental Health Act* does not have this paramount requirement, so once the enduring guardianship was revoked, the Board was not obliged to consider the person's own wishes in the same way, as the Board's consent is made under the *Mental Health Act*.

ECT can be very effective for depression, particularly for older people, and it is highly likely that a person making a best-interest decision would consent to treatment. Yet the enduring guardians stuck to the paramount principle in the *Guardianship and Administration Act.*

This type of application of substituted judgement in ECT is a new issue in South Australia since July 2010. In the old *Mental Health Act 1993*, the only type of advance directive allowed under that Act was the Medical Power of Attorney. An enduring guardian, or for that matter, a guardian appointed by the Board, could not make a consent decision concerning ECT under the old Act.

You will recall from the earlier discussion that a Medical Power of Attorney must make a best interests decision, unless there is a specific instruction in writing on the form to the contrary. Now, for the first time we see cases of the substituted judgement principle applied to ECT, which extends substituted judgement beyond what is specifically written on the form as is the case with a Medical Power of Attorney, to what in the opinion of the guardian the wishes of the person would have been, even if there are no written instructions.

This is an ECT example but of course, there are many other major decisions that an enduring guardian may need to make: it could be a decision about active treatment for a life-threatening medical illness, a decision to consent to a not-for-resuscitation plan that might lead to death, or to consent or not consent to ICU admission. By the very nature of the substituted judgement principles, a decision that a guardian makes for mum or dad, or other person, could be different to the decision that the guardian would make for themselves in the same situation or what the guardian considers is best interest.

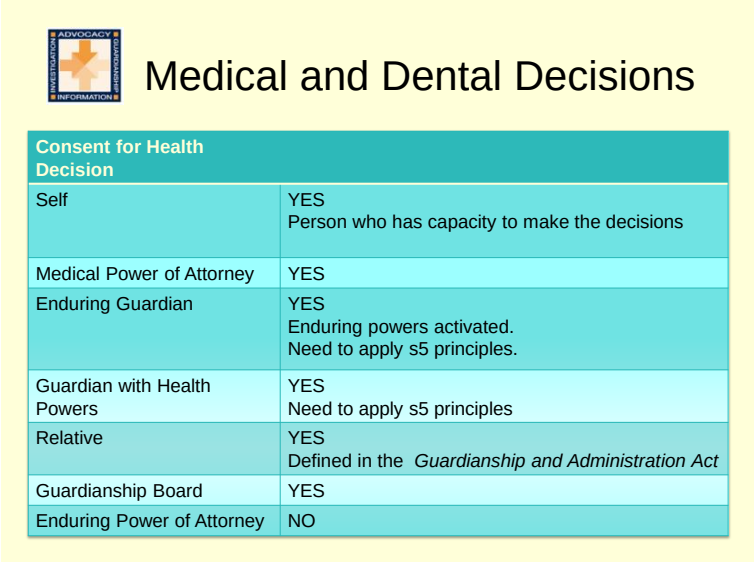
This can be very worrying for the decision maker, but of course, one way to avoid sleepless nights is to be confident that the decision has been well made even if the substitute decision maker is worried about the consequence. If it is truly what mum or dad would have wanted, it

can be justified. On the other hand, if it does vary from their wishes because the situation is different to what mum or dad had envisaged, then it can also be justified. Invariably though, such decisions need to be stepped through, and this is where support and advice to the decision maker can be needed.

In the future, we will see more substituted judgement decisions than best interests. The new health and personal advance directives will require substituted judgement. In the longer term, I expect that the principles of substituted judgement will also be applied to mental health law.

Already-appointed substitute decision makers — no matter who they are — are welcome to call our enquiry service for advice.

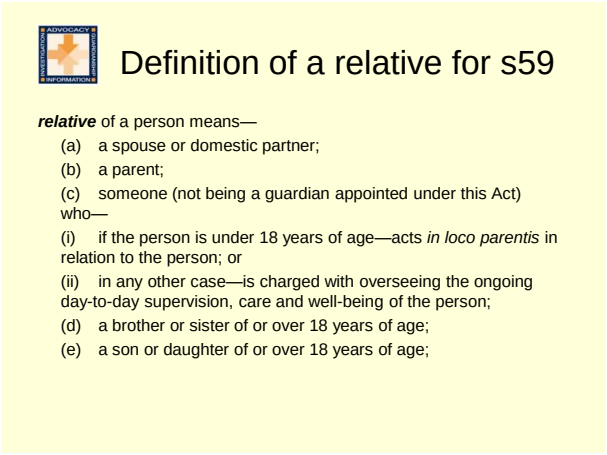
Medical and Dental Decisions



Consent for Health Decision	
Self	YES Person who has capacity to make the decisions
Medical Power of Attorney	YES
Enduring Guardian	YES Enduring powers activated. Need to apply s5 principles.
Guardian with Health Powers	YES Need to apply s5 principles
Relative	YES Defined in the *Guardianship and Administration Act*
Guardianship Board	YES
Enduring Power of Attorney	NO

This slide illustrates who can give consent for a medical and dental decision. At the bottom, I have noted that a person who possesses an Enduring Power of Attorney (EPA) cannot give consent to medical procedures. While this is obvious, it is a common misconception that families and friends have completed an EPA and consider that it covers more than legal and financial decisions. When the person with an EPA is also a relative as defined in the Act, it is generally still possible for that person to consent to a medical procedure, but of course, not all EPAs are relatives.

The table lists the role of Medical Power of Attorney, enduring guardian, as well as appointed guardian with health powers. In many situations, consent will be given by a relative. Given that the uptake of advance directives is still limited, aged care providers are frequently in a position of needing to obtain consent for a person who has developed dementia, and consent will be provided by a relative.



Any relative can be chosen. There is no order of precedence. Significantly, the Act allows for a person charged with the ongoing day-to-day supervision and wellbeing of the person to give consent.

In practice, in aged care this is translated as the Director of Nursing of a residential aged care facility as the person who gives consent. The provision is used when a person does not have other relatives able to make this decision. Its use in this way was confirmed by Parliament in 2005 by way of an amendment to the Act.

The Minister at the time was concerned that each time a person required consent (and did not have an actual relative who could consent) there would need to be a hearing before the Board. He noted that this presents an enormous challenge for the Guardianship Board, the Office of the Public Advocate, health service providers and people with mental incapacity. Such an approach, the Minister said could lead to unacceptable delays in access to treatment when substitute consent is provided.

The effect of this provision is to limit the need to appoint a health guardian for people in a facility who do not have a relative involved in their care. The Director of Nursing can provide the consent instead.

However, there is a conflict within the Act. The purpose of guardianship is to provide a decision maker who is independent of the provision of care. A service provider cannot be a guardian. Yet, the Act permits a service provider to make the same medical and dental decisions that a health guardian might make. In some situations, the Director of Nursing is independent of the care provided, when the care is delivered outside the residential aged care facility. For example, when a resident has a fall, requires a hip replacement in hospital, the Director of Nursing may provide consent for surgery for treatment delivered outside the nursing home and usually will do this if there are no other family available. On the other hand, in other situations there is not this separation: the Director of Nursing may consent to treatment that is then administered by themselves and staff on site. In some situations, this is appropriate; in others, there could be a conflict of interest.

How to deal with this tension was considered by the District Court in a decision in recent years. Our Office had appealed against the appointment of the Public Advocate as a limited guardian, arguing that existing informal arrangements were adequate. One purpose of the appeal was to gain clarification of the role of a Director of Nursing in consenting to medical treatment.

The appeal involved a man who had a mental illness, a significant physical disability, no family and during the course of the Appeal it became apparent that the Director of Nursing of the facility where he resided was reluctant to take on the role as 'relative' under the Act. The Appeal by our Office was unsuccessful, but the Court provided useful clarification as to when a Director of Nursing should give consent.

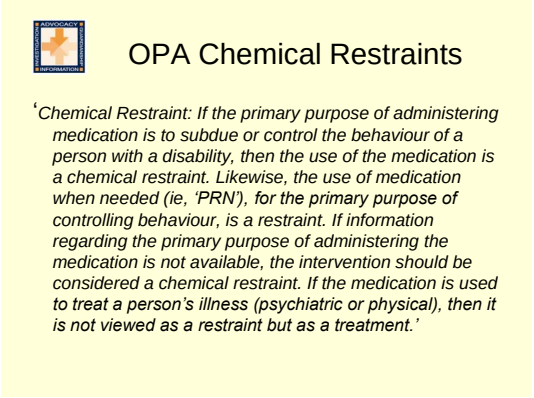
The Court noted the conflict in the Act. On the one hand, in appointing a guardian the Board has to consider any conflict of interest that might arise in the appointment —s50 (e). On the other hand, s59 — the provision that allows relatives to make decisions— permits the Director of Nursing to make decisions that might involve a real or perceived conflict of interest. The Court did not explore this further in terms of the legislation, but it highlights the need for a Director of Nursing to consider the potential for conflict-of-interest issues when consenting to a resident's treatment.

The Court held that it might be appropriate for a Director of Nursing to consent to medical treatment where only a few decisions of no particular significance were involved. The Court noted that a Director of Nursing, unlike a guardian, could refuse to be involved in a decision regarding treatment; and the health of the person might be put at risk if decisions of a serious or urgent nature were required but were not forthcoming in a timely way.

These are the criteria: few, and not particularly significant vs. frequent, perhaps on occasion serious and urgent.

If a situation changes, for example a Director of Nursing is making a few decisions, but then is uncomfortable making a specific decision, the option of one-off consent from the Guardianship Board is available, as well as the option of seeking a guardian's appointment.

This decision did not consider specific instances of conflict of interest, but I wish to raise one particular area — that of the administration of chemical restraint.



This year we have worked on the topic of restrictive practices in disability settings. We have worked closely with non-government and government providers and the peak body. There is a new restrictive practice policy on our website, which gives a useful summary of who can consent to what practices. We will do something similar with aged care next year.

This is our definition of chemical restraint. It is based on one used by a large NGO provider, but is consistent with definitions in the literature and in relevant laws interstate.

In essence, chemical restraint occurs when a person is administered a drug to control their behaviour, when it is not used to treat a diagnosed psychiatric or medical illness. I suggest similar considerations will apply in aged care.

Traditionally, restraint is thought of when there is crisis: a person might be held and administered medication. To do this not only requires a guardianship appointment, but powers under s32 (1) (c) which authorises the use of force as is reasonably necessary: the physical restraint, or threat of physical restraint, that precedes the administration of medication.

However, chemical restraint is broader than this. It can include psychotropic drugs given regularly as part of morning and evening medication. The person may accept these medications apparently willingly, alongside their cardiac medications or whatever other tablets they receive, but because of a mental incapacity they do not understand the nature of the medications they have been given. People can receive sedating medication for years this way. The key issue is whether it is treatment for an illness or it is behaviour control.

In South Australia, the administration of medication in this way, as part of routine treatment, that does not involve the use of force to administer, can be consented to either by a Medical Power of Attorney, an enduring guardian,an appointed guardian with health powers, or a relative. We do not have separate provisions to define chemical restraint as distinct from taking other types of medications. This means that at least in theory, a Director of Nursing can consent to chemical restraint.

In disability services, there is a similar use of the s59 provisions, so that the person in charge of a residence provides consent. In disability accommodation, it is the house manager who takes on this role. For sedating medication, we concluded in our disability policy that it is a conflict of interest for the house manager to give consent for such medication. It is preferable that a relative do this. When family are asked to give this consent, we would recommend that such important decisions only be made by relatives who are involved and engaged in their family member's life.

While we are to do more work with the aged sector, I suggest that this conflict-of-interest concern would apply in most similar situations in aged care where chemical restraint is administered. While there are some people with severe behavioural and psychological symptoms of dementia who will need medication irrespective of the environment, for others, as this audience will well know, the nature of the care environment can influence the dose of medication required, or even the need to use drug treatment at all. Having access to larger living areas, comfort rooms, diversional activities, increased staff numbers, and increased training can all minimise the amount of medication used.

I have no doubt that Directors of Nursing undertake such consent duties properly and with great care. Nevertheless, even with the most thoughtful consideration, it can be both a real and perceived conflict of interest to be the decision maker about sedative medication on the one hand, and the manager of staffing and budget on another. This is because the same behavioural problems might potentially be addressed in two ways: by increasing the dose of antipsychotic medication on one hand and using existing staff numbers, or on the other hand by decreasing antipsychotic medication and increasing staff numbers.

So, in reviewing clients I suggest that there should be particular vigilance to those prescribed antipsychotic and other sedative medications. If it is prescribed, who consented for it? Was the

person's family called when it was started by the visiting doctor? Was the family called when the dose was increased? Is the Director of Nursing is consenting to treatment? While it may be very appropriate for the Director to consent to a patient's antibiotic treatment for pneumonia, or antihypertensive drugs, this is likely not to be the case for chemical restraint.

As a policy position, it is reasonable to regard chemical restraint differently to most other routine medications. Consenting for a person to receive chemical restraint can be as significant a decision as consenting to surgery. It can be a treatment with benefits that can enable a person to be more settled and calmer. It is also a treatment associated with risks, such as causing further impairment in cognition, and increasing the risk for falls. While clear consent is needed for all health interventions, there is no requirement to get written consent to start medications and therefore to start chemical restraint. However, I would suggest that it would be still useful to document who has been spoken to, and who has given verbal consent for the use of a psychotropic medication in such a situation.

Accommodation Decisions

Accommodation

Consent for Accommodation Decision	
Self	YES Person who has capacity to make the decisions
Relatives	YES but only through Informal arrangements Cannot be implemented if the person disagrees NO formal power to consent to accommodation decisions
Medical Power of Attorney	NO
Enduring Power of Attorney	NO
Enduring Guardian	YES Enduring powers activated. Need to apply s5 principles. Cannot be implemented if the person refuses
Guardian with accommodation powers	YES Need to apply s5 pirinciples Cannot be implemented if the person refuses

Now we will discuss who can make an accommodation decision; either when there is no advance directive, or when an advance directive is in place. The only advance directive that permits accommodation decisions is the Enduring Power of Guardianship.

The first option, and the most ideal is that a person makes their **own decision**, either by themselves or with assistance or support in making that decision.

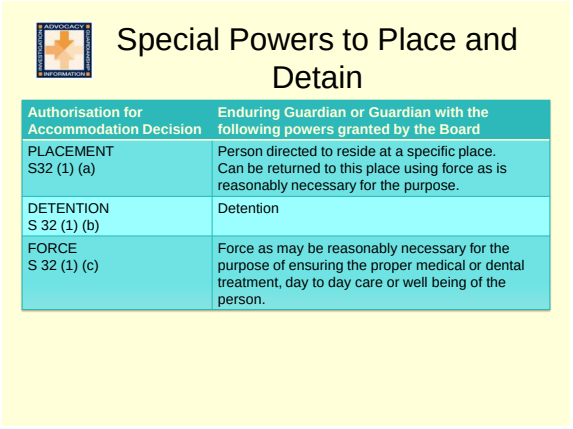
The next option is for relatives to make the decision using **informal arrangements**. The person concerned may not be able to make a decision, but can be happy for family to make arrangements on their behalf. Such informal arrangements work well when there is trust all round. If a person objects to a decision, or there is conflict between family members or others about the decision, then a formal appointment may need to be made. This usually involves applying to the Guardianship Board for a guardian to be appointed.

As noted, a Medical Power of Attorney's decision making is limited to medical and dental decisions, so they cannot make an accommodation decision. If a person needs to go to hospital,

the Medical Power of Attorney can be used to consent to hospital treatment, but cannot be used to make a person go to hospital.

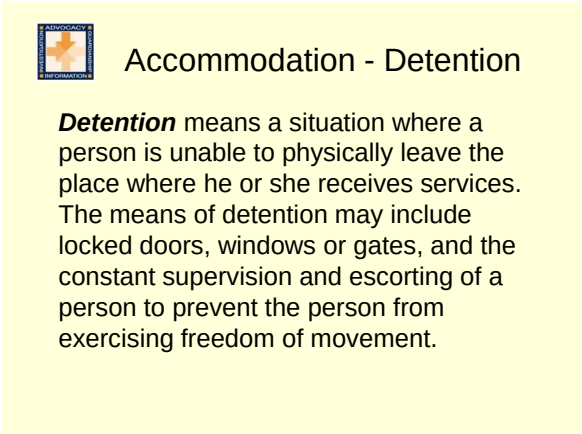
An Enduring Power of Attorney also cannot be used to make the decision. As you know, this power only covers financial and legal matters. If a person is moving into a nursing home, it can be used to put in place the financial arrangements after an accommodation decision has been made, but it does not provide the authority to make the accommodation decision.

An enduring guardian can make the decision, as can a guardian with accommodation powers appointed by the Guardianship Board. In both cases, a decision can be made, but the enduring guardian or the appointed guardian does not have the power to enforce the decision.



To do this, it is necessary for the enduring guardian or the appointed guardian to apply to the Guardianship Board for enforcement powers: these are listed under s32 of the *Guardianship and Administration Act 1*993. These powers include powers to direct where a person lives, authorise detention, or authorise the use of force as may be reasonably necessary. For the Board to grant these powers, it must be convinced that the health or safety of the person would be seriously at risk if these powers were not granted. You can see on this slide the different powers of placement, detention and force. If a person is placed they are directed to live at a certain address and can be returned to that address if the person leaves, but the person is not detained with this s 32 (1) (a) power. Detention requires s 32 (1) (b) to be invoked. When the Board authorises detention, it gives the person physically in charge of the protected person (in this case, the nursing home director) the power to detain.

I now wish to consider in more detail the topic of detention.



There is no legislative definition of detention in our Act. This definition projected on the slide is one that we have used in developing a policy with the disability sector. It is consistent with most dictionary definitions, so I hope you will agree that as a way for us to have a common understanding of detention, it is useful. Key elements include that a person is unable to physically leave a facility; or if people do leave a facility, they are constantly supervised or escorted.

However, a person is not automatically detained because a door is locked. Some people live behind a locked door but it will be opened for them any time they request. For this reason, to determine whether a person is detained or not, requires an analysis of each person's individual situation. A resident could be in a locked facility that has a key pad on the door. A resident is ***not*** detained if the person knows the code and can use the keypad to leave when he or she chooses. A resident might ***not*** be detained, if staff open the door for the resident when requested even if the person cannot use the key pad themselves. A resident ***is*** detained if they cannot come and go as they choose.

So, when is it necessary to request s32 powers of detention? The answer is, any time a person is detained. Otherwise, there is a risk of unlawful imprisonment of a resident.

In the past, practices were different. For people who were actively trying to leave a nursing home it was expected that an enduring guardian or appointed guardian have s32 powers to authorise detention. On the other hand, for people who were wanderers, such powers were not expected.

This was clarified by the Guardianship Board this year. Any person who is detained should be detained lawfully. This applies not just to people who are seeking to leave, but also to all people who are detained including people who are wandering risks.

A decision for a person to live in a secure unit cannot be made as a duty of care decision without lawful authority to make that decision. South Australia has clear statutory provisions in our *Guardianship and Administration Act*, so it is expected that such provisions be used.

So, to recap: the only way that a person can be legally detained at a residential aged care facility is by the use of s 32 powers. This requires a person to have either an enduring guardian or appointed guardian who then applies to the Board for those powers. To determine whether any individual in a closed unit is detained needs an individual analysis of each person's situation. People who are not allowed to leave at will, or to leave without an escort are most likely detained.

I recognise that this situation of needing to seek orders is not optimal.

This slide considers systems' responses.

The first is to do nothing, and to allow the traditional practice around the country of placing people in locked facilities on duty of care grounds. The problem with this is that person so placed does not have access to the right of appeal. In some other states, because guardianship law does not have detention provisions, facilities rely on "duty of care".

The second option is to rely on state-based guardianship provisions, such as those discussed. Currently we have no choice but to do this in South Australia, because it is the law. However, guardianship can be demanding on families and nursing homes; applications and documents need to be submitted. When detention orders are granted, they need to be reviewed after six months and then 12- monthly. If a person dies under a detention order, there is a requirement for a mandatory coronial inquest. There is a good argument that to use such provisions on large numbers of people in aged care is an excessive response: nevertheless, in the absence of alternatives, it is a response that we need to comply with, and it is the law.

The third option is to have a national mechanism: one that is commensurate to the need; one that gives rights of appeal to residents, but does not create a burden on families and aged care providers. This is what we would argue for. Such a solution could be linked to a beefed-up community visitors' scheme that checks on people's rights. The Productivity Commission has recommended that there be such a scheme, and we would suggest that it could be particularly useful in checking on the rights of people who are detained.

Lifestyle

Lifestyle (including access)

Consent for Lifestyle Decision	
Self	YES Person who has capacity to make the decisions
Relatives	YES but only through Informal arrangements Cannot be implemented if the person disagrees NO formal power to consent to lifestyle decisions
Medical Power of Attorney	NO
Enduring Power of Attorney	NO
Enduring Guardian	YES Enduring powers activated. Need to apply s5 principles. Cannot be implemented if the person refuses
Guardian with lifestyle powers	YES Need to apply s5 principles Cannot be implemented if the person refuses

The considerations in making a lifestyle decision are similar to those in making accommodation decisions. Relatives can make informal decisions, but the only substitute decision makers who can make a formal lifestyle decision are an enduring guardian, or an appointed guardian with lifestyle powers.

The need for enforcement powers for lifestyle decisions is less, but once again if a person objects — say, to receiving a care service — in some situations it may be necessary for a guardian to apply for s 32 (1) (c) powers to authorise the use of force.

Protection of rights

Finally, I wish to raise three policy matters, which could better protect the rights of older people in the future. The first concerns how mental capacity is understood; the second, supported decision making; and the third, adult protection.

Is this a definition of mental incapacity?

mental incapacity means the inability of a person to look after his or her own health,

safety or welfare or to manage his or her own affairs, as a result of—

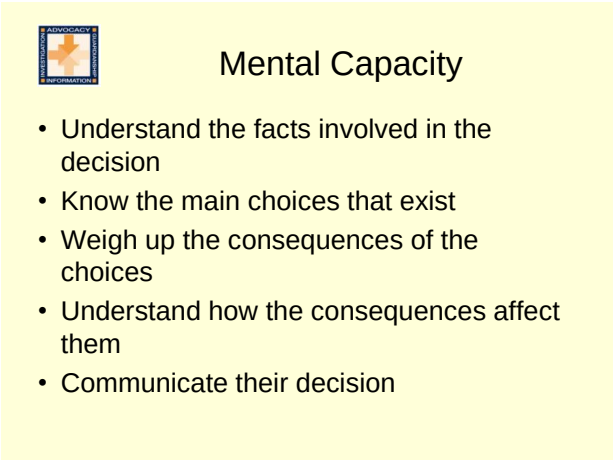
(a) any damage to, or any illness, disorder, imperfect or delayed development,

impairment or deterioration, of the brain or mind; or

(b) any physical illness or condition that renders the person unable to

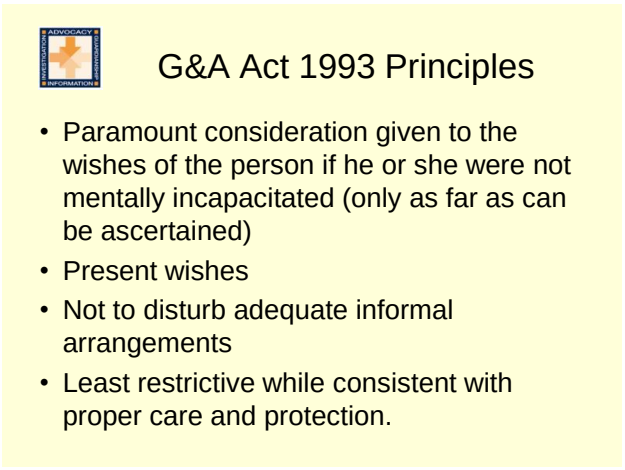
communicate his or her intentions or wishes in any manner whatsoever;

This is the definition of mental incapacity in the *Guardianship and Administration Act*. You will note it refers to an inability of a person to look after his or her own health, safety and welfare. This definition is not consistent with how mental capacity has been understood in the common law for many years, or with current right-based thinking. In fact, this is more a definition of disability than of mental incapacity.



This slide demonstrates the features of capacity as generally understood by the law, medicine and psychology. A very useful resource is the New South Wales Attorney General's Capacity Toolkit. The risk of our current definition of mental incapacity in South Australia is that it can promote a welfare view of guardianship. This can lead to more people being placed under guardianship for longer. A rights-based view narrows the use of guardianship.

For these reasons, we consider that not only does the definition of incapacity need to change in the Act, but the principles of the Act also need to be altered.



These are the current principles, which are well regarded: the substituted judgement principle; seeking a person's present wishes; not disturbing informal arrangements; and the least restrictive option. These are the principles that the Board must follow, as well as enduring guardians, guardians and administrators appointed under the Act.

It is our view that the following principles should be added. The first is a presumption of capacity. All adults should be assumed to have capacity. A person with a particular diagnosis or disability should not need to prove their capacity. The onus is on the person who alleges incapacity to make the case. This has been a case law principle for over 200 years.

The second principle is that mental capacity is decision-specific. It can be possible to make one decision, but not another. The High Court of Australia confirmed this principle in 1954.

The last principle is taken from the United Kingdom *Mental Capacity Act 2005*. People should only have a substitute decision maker if all practicable steps have been taken to help them make the decision themselves, without success.

This underpins the need to consider supported decision making, ensuring that people do have assistance and support in making their decisions. This is recognised in jurisdictions in Canada and the United Kingdom.

Further to this, the United Kingdom, Canada and the United States have rights-based systems of adult protection in place. This year our Office undertook a project with the University of South Australia to look at what a rights-based system of adult protection would look like. It was funded through the then Department for Families and Communities. We spoke with 130 workers from health, aged care, local councils and community services who provided services to older people. From this, a policy model was developed, similar to overseas best practice.

The feature of a rights-based model is that there is less emphasis in taking over the decision making ability of victims and potential victims of abuse and neglect. Guardianship still has a role, but the emphasis is on providing practical assistance to people at risk, similar to approaches used in responding to domestic violence. The model features a single elder-abuse helpline, and local protocols that are in place between health, aged care, police and justice, so that a practical local response including a home visit can be provided when needed. The system also provides specialist back-up to frontline staff. When abuse does occur, there is a stronger emphasis on prosecuting perpetrators.

Conclusion

- Substituted judgement principle
- The benefit of advance directives
- Implications of aged care providers
- Issues of
  - Director of Nursing as “relative”
  - Secure aged care
- Future reform

Thank you for the opportunity to present today.

In covering these areas, I trust that I have highlighted the benefit of existing legal provisions. South Australia has been a leader in the use of the substituted judgement principle for nearly 20 years. We do have advance directives already that work, and should be used. The situation will be even better with new streamlined advance directives with new legislation to be introduced into parliament.

However, it is also time to reconsider our *Guardianship and Administration Act 1993* for the future.

With respect to advance directives and *Guardianship and Administration Act* matters, our telephone enquiry service can provide information and advice related to individual situations.

Thank you