Advance Care Directives (Review) Amendment Bill 2021

Explanatory Discussion Paper

June 2021

Government of South Australia

SA Health

CONTENTS

1. INTRODUCTION

The purpose of this consultation is to seek feedback on the Advance Care Directives (Review) Amendment Bill 2021 (the Bill) (Appendix A) which proposes amendments to the *Advance Care Directives Act 2013* (the Act).

An Advance Care Directive is a legal document that empowers South Australians to record their values and wishes and make clear legal arrangements for future health care, end of life, preferred living arrangements and other personal matters.

The Review of the *Advance Care Directives Act 2013* was conducted by Professor Wendy Lacey in 2019 (Appendix B). During the Review, Professor Lacey consulted extensively with interested organisations, persons and professions; as well as members of the community. The Review made 29 recommendations and was tabled in Parliament on 1 August 2019. The South Australian Government's Response to the Review was tabled in Parliament on 23 July 2020 (Appendix C) and supported, in full or in principle, 22 of the recommendations, with further consultation proposed to inform the Government's response to Recommendation 29.

Accordingly, the draft Bill was prepared to implement those recommendations supported by the Government that require a legislative amendment to the Act.

The draft Bill aims to amend the Act to:

- make copies of Advance Care Directives available to health care professionals electronically;
- make it clearer that other Acts and laws still apply;
- clarify what should happen when a person with an Advance Care Directive comprising refusal of health care attempts suicide or self-harm;
- impose clearer requirements on interpreters;
- make it clear there is no limit on the number of substitute decision-makers that can be appointed;
- include provisions for listing substitute decision-makers in order of precedence; and
- strengthen how suspected abuse of adults who are vulnerable to abuse is identified during the resolution of disputes by the Public Advocate is reported and addressed.

This Discussion Paper provides an overview of the draft Bill and brief discussion that aims to assist in understanding the draft Bill's provisions and what they are intended to mean and do.

The Discussion Paper also seeks feedback on:

- how people with limited or impaired decision-making capacity can record their wishes for future health care;
- exploring the introduction of digital signatures for people signing Advance Care Directives; and
- reviewing the groups of people who can witness an Advance Care Directive.

This Discussion Paper is designed to be read in conjunction with the draft Bill (Appendix A). Section 2 of this Discussion Paper follows the same structure as the draft Bill so that you can read both documents at the same time.

The Discussion Paper sets out some questions that you may wish to consider in preparing written submissions. These questions are a prompt for thinking about particular provisions of the Bill. There is no obligation to answer any or all of them.

You are invited to comment on the areas of the Bill which you:

- are most interested in
- have concerns with
- wish to particularly recommend or endorse
- propose amendments to; or
- wish to make specific comment on.

Have your say

Your views on this legislation are welcomed and appreciated.

Submissions can be provided until close of business **Tuesday, 3 August 2021** by:

- completing the survey at YourSAy
- emailing your feedback to: Health.AdvanceCarePlanning@sa.gov.au
- Participating in our upcoming webinars. Keep an eye out on our YourSAy page for dates and times
- posting your written feedback to:

  Health Services Programs
  PO Box 287 Rundle Mall
  ADELAIDE SA 5000

2. ADVANCE CARE DIRECTIVES (REVIEW) AMENDMENT BILL 2021

2.1 SHORT TITLE

This clause provides for the title of the draft Bill.

This is a common technical requirement in legislation. It is not anticipated there is any need to provide feedback on this section.

2.2 COMMENCEMENT

This clause sets the date for the commencement of the draft Bill if it is passed by Parliament.

This is a common technical requirement in legislation. It is not anticipated there is any need to provide feedback on this section.

2.3 AMENDMENT PROVISIONS

This clause allows for amendments to be made to a specified Act, in this case the *Advance Care Directives Act 2013*.

This is a common technical requirement in legislation. It is not anticipated there is any need to provide feedback on this section.

2.4 AMENDMENT OF SECTION 3 – INTERPRETATION

Recommendation 17 of the Review:

Section 45 of the Act should be amended to require Office of the Public Advocate to discontinue a matter where a reasonable suspicion of elder abuse exists and refer the matter to South Australian Civil and Administrative Tribunal for determination. Office of the Public Advocate should be entitled to disclose the general basis of that suspicion in a written referral to South Australian Civil and Administrative Tribunal. Consideration should also be given to an amendment which requires Office of the Public Advocate to publish on its website, as well as notify all parties accessing the Dispute Resolution Service from the outset, that evidence of elder abuse will trigger a discontinuation of mediation and that a referral to South Australian Civil and Administrative Tribunal will follow.

Discussion:

This section of the draft Bill has been drafted to implement Recommendation 17 of the Review.

The purpose of this amendment is to ensure that the terms “abuse” and “vulnerable adult” are defined in the Act.

In the Review, Professor Lacey made a recommendation that the Public Advocate must refer a matter to South Australian Civil and Administrative Tribunal if the Public Advocate reasonably suspects or becomes aware that the matter consists of, or involves, elder abuse. The terms “abuse” and “vulnerable adult” are defined in this amendment because they are not currently defined in the Act.

A vulnerable adult is an adult person who, by reason of age, ill health, disability, social isolation, dependence on others or other disadvantage, is vulnerable to abuse. Abuse of a vulnerable adult means:

a) physical, sexual, emotional or psychological abuse of the vulnerable adult; or

b) financial abuse or exploitation of the vulnerable adult; or

c) neglect of the vulnerable adult; or

d) abuse, exploitation or neglect consisting of a person's omission to act in circumstances where the person owes a duty of care to the vulnerable adult; or

e) abuse or exploitation of a position of trust or authority existing between the vulnerable adult and another person; or

f) denial, without reasonable excuse, of the basic rights of the vulnerable adult.

Consultation questions to consider:

1. *Are the definitions of “abuse” and “vulnerable adult” appropriate?*

2.5 INSERTION OF SECTION 5A – REFERENCES TO ADVANCE CARE DIRECTIVE TO INCLUDE CERTAIN DIGITAL COPIES

Recommendation 5 of the Review:

The use of digital copies of certified Advance Care Directives should be both permissible and promoted within South Australia's hospitals. The Act should be amended to facilitate this process and provision should be made in the Act to ensure that medical practitioners and hospital staff are entitled to rely on the purported validity of an Advance Care Directive contained on a patient's My Health Record.

Discussion:

This section of the draft Bill has been drafted to implement Recommendation 5 of the Review.

The purpose of this amendment is to allow health practitioners to rely on a digital copy of an Advance Care Directive as a legally valid copy of that Advance Care Directive.

In the Review, Professor Lacey found that some health practitioners were reluctant to rely on digital copies of a certified Advance Care Directive. This amendment aims to address that reluctance by giving a stronger legislative basis for what can be considered a legal digital copy of an Advance Care Directive.

Under Regulation 9(2) of the *Advance Care Directives Regulations 2014,* the Minister for Health and Wellbeing can determine the way in which copies are made available electronically. For example, this may include health practitioners accessing copies of Advance Care Directives through a secure, authoritative electronic health record system, such as My Health Record or other medical records systems used in public hospitals or GP clinics.

My Health Record is a national secure online summary of an individual's health information that is patient controlled and accessible by authorised healthcare providers across Australia. SA Health is a registered healthcare provider within the My Health Record system that enables individual healthcare providers and other relevant employees to access the My Health Record system on the organisation's behalf when there is a clinical need to do so. As a registered provider, SA Health must comply with a range of obligations set out under legislation to protect the privacy of an individual's health information.

If this amendment is passed, the Minister for Health and Wellbeing will develop the regulations necessary to ensure that the My Health Record system and other appropriate health records systems are authorised for storing Advance Care Directives.

Consultation questions to consider:

2. *Do you support an amendment to allow health practitioners to rely on the legal validity of digital copies of Advance Care Directives in My Health Record and other health records systems?*

2.6 INSERTION OF SECTION 8A – INTERACTION WITH OTHER ACTS AND LAWS

Recommendation 3 of the Review:

The Act should be amended to make it expressly clear that it is not intended to operate to the exclusion of the common law. Directives which meet the common law requirements must be treated as legally valid. In addition, non-statutory directives, irrespective of form or whether they appear in a statutory Advance Care Directive, should be treated as relevant and highly persuasive, particularly when decisions are being made with regard to medical care and treatment, or personal preferences, at the end of life.

Discussion:

This section of the draft Bill has been drafted to implement Recommendation 3 of the Review.

The purpose of this amendment is to clarify that the *Advance Care Directives Act 2013* (the Act) is not intended to operate to the exclusion of the common law.

In the Review, Professor Lacey found that people express their wishes and preferences in a number of ways, including in letters, conversations and reflections, often in discussions with substitute decision-makers or treating doctors. Particularly at or towards the end of life, treating health practitioners are often faced with situations that are not strictly or literally dealt with in an Advance Care Directive. At that point, these types of discussions between family members become extremely important in determining the appropriate type of medical care and treatment. The Act, while promoting the use of the standard Advance Care Directive form, should not limit or underplay the importance of informal conversations or non-statutory directives.

Similarly, an unsigned or unwitnessed Advance Care Directive can still be used as an important tool and conversation starter with either the patient or the Substitute Decision-Makers, even though the Advance Care Directive would not be considered legally valid in accordance with the Act.

The provisions drafted in the Amendment Bill make it expressly clear the Act does not make any other Act or law invalid. The provisions also seek to make clear that a direction (however described) given by a person under another Act or law is not an Advance Care Directive for the purposes of this Act or any other Act.

<u>Voluntary Assisted Dying and Advance Care Directives</u>

The Voluntary Assisted Dying Bill recently passed both houses of Parliament. Once the new Act is proclaimed, amendments will automatically apply to the *Advance Care Directive Act 2013* (ACD Act). These amendments include:

- A provision that the ACD Act does not apply in relation to medical treatment that occurs as part of the Voluntary Assisted Dying process under the Voluntary Assisted Dying Act;
- A provision that an Advance Care Directive cannot constitute a request for Voluntary Assisted Dying. In other words, a person cannot trigger the Voluntary Assisted Dying provisions and lawfully access Voluntary Assisted Dying by making a request for it in their Advance Care Directive; and

- A provision that an Advance Care Directive does not authorise a Substitute Decision-Maker to make a decision, or to otherwise act in a manner, that is inconsistent with a request for Voluntary Assisted Dying made by the person who gave the Advance Care Directive. In other words, the Advance Care Directive cannot be used, and the Substitute Decision-Maker cannot prevent a request for Voluntary Assisted Dying made under the Voluntary Assisted Dying Act by using their powers under the ACD Act.

It is important to note that a person completing an Advance Care Directive is able to indicate their preferences/wishes in relation to Voluntary Assisted Dying in their Advance Care Directive, however these preferences and wishes will have no legal effect allowing a person to access Voluntary Assisted Dying, in accordance with the ACD Act. In order to access Voluntary Assisted Dying, the person will need to meet the requirements in accordance with the Voluntary Assisted Dying Act, if it passes.

Please see the frequently asked questions section on our YourSAy webpage for more information about Voluntary Assisted Dying and Advance Care Directives.

Consultation questions to consider:

3. *Do you have any concerns about the interaction between the Advance Care Directive Act 2013 and other Acts and laws?*

2.7 INSERTION OF SECTION 12A – EFFECT OF ADVANCE CARE DIRECTIVE ETC WHERE SUICIDE ATTEMPT OR SELF-HARM

If you experience distress on reading the content below, please see the support services listed in section 5 of this paper.

Recommendation 29 of the Review:

The Act must be amended to ensure that it is explicit, in the operative provisions of the Act, that an Advance Care Directive cannot be used as the basis for refusing life-saving treatment following an attempt to suicide or cause self-harm. The remainder of an otherwise valid Advance Care Directive must be preserved.

Discussion:

This section of the draft Bill has been drafted to implement Recommendation 29 of the Review.

In the Review, three separate cases were brought to Professor Lacey's attention that failed to recognise the original intent of the legislation to prevent an occurrence of an Advance Care Directive being applied to prevent the delivery of life-saving medical treatment following an attempt to suicide or self-harm.

This uncertainty was initially dealt with by the making of Regulation 12A of the Regulations under the Act. This regulation was gazetted on 11 July 2019 and enables health practitioners to provide life-saving treatment in circumstances when a person with an Advance Care Directive attempts suicide and their Advance Care Directive included a binding refusal of life-sustaining treatment. However, the Government indicated that this was an interim response, and an amendment to the Act would be introduced to allow Parliament the opportunity to clarify the law.

The Government also supported further consultation on Recommendation 29 of the Review before any legislative amendments are progressed. Accordingly, an amendment to implement Recommendation 29 has been included in the draft Bill for broad community consultation and feedback.

The purpose of this amendment is to clarify what should happen when a person with an Advance Care Directive comprising refusal of health care attempts suicide or self-harm. The amendment to legislation suggested by Professor Lacey is intended to recognise the original intent of the legislation, as well as the intention of Parliament, when passing the Act in 2013.

Apart from South Australia, Western Australia is currently the only other State which explicitly refers to attempted suicide in its legislation or regulations. Section 110ZIA, Division 2, Part 9D of the *Guardianship and Administration Act 1990* (WA) in relation to urgent treatment after attempted suicide, states 'the health professional may provide the treatment to the patient despite the patient having made an Advance Care Directive containing a treatment decision that is inconsistent with providing the treatment'[1].

[1] https://www.legislation.wa.gov.au/legislation/prod/filestore.nsf/FileURL/mrdoc_42676.pdf/$FILE/Guardianship%20and%20Administration%20Act%201990%20-%20%5B05-l0-00%5D.pdf?OpenElement (open with Google Chrome)

An Advance Care Directive is a written expression of a person's preferences in relation to health care, which can appoint a trusted substitute decision-maker, describe personal values, and make explicit decisions consenting to, or refusing, certain treatments.

When a person with an Advance Care Directive attempts suicide and refuses life-sustaining treatment, opinions are divided as to the degree to which health care staff should be bound by such a directive.

This discussion paper provides points to consider both in support of the amendment and against the amendment.

Considerations for making the amendment to the Act

Those supportive of the inclusion of an amendment to the Act highlight the preventability of suicide, and it is relevant to consider the causes of suicidal behaviour. The following extracts from the National Suicide Prevention Adviser's reports[2] refers to causes:

> "…*a range of the factors, especially in combination, can culminate in hopelessness and extreme emotional distress. The factors influencing a person's suicidal distress can be social, personal, financial or arise from other stressors in their lives. For some people, these stressors interact with mental illness and alcohol or other drug problems to heighten suicidal distress; for others they are the primary driver of distress. In some cases, suicidal behaviour is seen as a method of coping with trauma and distress or an action people take because the self-harming behaviours, they use to manage distress no longer provide sufficient emotional relief... For some people, suicidal behaviour is described in the context of complex mental illness and comorbidity in adolescence or early adulthood, ineffective or disconnected treatment at the time followed by social disadvantage and contact with the justice system. This pathway often described poorly treated mental illness as the catalyst for other harms and challenges. Given this context, it is recognised that providing the right kind of response is critical to changing people's thoughts about suicide so that they can see they have other options."*

In addition, suicidal ideas are characterised by ambivalence and changeability[3].

In this context, an existing Advance Care Directive intended for another purpose (such as a condition with a poor prognosis and quality of life) might instead be used after a suicide attempt, although the nature of the attempt, and any underlying mental illness, may be acute and treatable with a full recovery expected.

Alternatively, a person planning suicide may seek to put an Advance Care Directive in place, noting that some people although unwell and distressed can undertake methodological preparation for a suicide attempt, yet have a situation that will resolve with support and therapy.

Considerations for **not** making the amendment to the Act

Those concerned about making an amendment to the Act believe that any amendment that allows medical practitioners not to follow the binding provisions of an Advance Care Directive will undermine the legitimate wishes of an individual to refuse treatment, thereby undermining the intention of the Act and the principles of autonomy and self-determination.

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[2] National Suicide Prevention Adviser- final advice (2021), Department of Health, Australian Government. https://www.health.gov.au/resources/publications/national-suicide-prevention-adviser-final-advice Accessed 20th June 2021.

[3] Kapur N and Goldney R (2019) Suicide Prevention 3rd Ed. Oxford University Press, Oxford.

A recent paper on bioethical issues provides some additional insight into the complex nature of the arguments for both sides of the issue. A summary of these insights is provided below:

> *It is noted that not all suicide attempts are irrational and can be based on stable views rather than on impulse, that the decision to suicide can be informed and made without coercion, and that the person can appreciate the consequences of their actions.*
>
> *The passage of legislation for voluntary assisted dying in several Australian States supports the notion that the choice to end one's life can indeed be deliberate and rational. One aspect of rational suicide is that it comports to a stable goal, rather than being an impulsive act. The presence of an Advance Care Directive written in advance, refusing life-sustaining treatment, lends weight to the suggestion that a given attempt at suicide is part of an enduring preference for death, and it could be argued that a suicide attempt in which such an Advance Care Directive is present is more likely to be rational than one without it.*
>
> *The purpose of writing an Advance Care Directive is that it will be invoked at a time when the person cannot speak for themselves. To suggest that the Advance Care Directive can be ignored because the person attempting suicide does not have capacity, is to subvert the purpose of advance care planning altogether. By this measure, the lack of decision-making capacity could equally be used to ignore the directive in any and all situations in which the directive would have had a role.*
>
> *Some who suggest that an Advance Care Directive should not be binding after attempted suicide argue that the act of attempting suicide is irrational, and therefore the person does not have decision making capacity. It is also suggested that the unforeseeable nature of attempted suicide means that we cannot be certain that the person would have refused resuscitation in such a circumstance. However, it is suggested that attempted suicide is no less foreseeable than any other sudden illness.*

There are concerns that making this amendment to the Act removes people's autonomy and their right to refuse medical treatment. The right of a person to determine what medical treatment they do and do not want is a fundamental right for all competent adults and is a core value underpinning the Act. It is not a requirement that this is a decision with which other people would all agree or even that it is a rational decision by everyday standards. It is only required that a competent adult makes it for themselves about themselves.

A patient who has attempted suicide or committed self-harm who is conscious and verbally refuses medical treatment has the right to do so and retains that right even under this recommendation. A patient who enters hospital unconscious but with an unambiguous Advance Care Directive refusing life-sustaining treatment should have the same right.

Considerations for amending the Act

Clause 7 of the draft Bill provides an amendment for further consultation with the community to implement Recommendation 29. The amendment reflects Regulation 12A. If the amendment is passed Parliament, Regulation 12A becomes superfluous and is likely to be repealed.

Regulation 12A was written as an exemption for health practitioners from compliance with binding provisions in Advance Care Directives where the health practitioner believes on reasonable grounds that the person has attempted to commit suicide and the health care is directly related to that attempt.

The proposed clause 7 of the draft Bill:

- Renders 'of no effect' a provision in an Advance Care Directive comprising a refusal for particular health care arising out of or related to attempted suicide or self-harm; and
- is an express 'disapplication' of subsections 36 (1) and (4) of the Act to health practitioners in circumstances of attempted suicide or self-harm.

The amendment as it is drafted means that if a person with an Advance Care Directive attempts suicide or intentionally causes harm to themselves, a health practitioner is not required by law to follow any binding refusals of health care in that person's Advance Care Directive where they arise out of or relate to the attempted suicide or self-harm.

Clause 7 makes clear that the provision does not affect the remaining Advance Care Directive provisions (including refusals of health care other than that directly related to the attempted suicide).

The clause also adds an immunity provision for health practitioners against civil or criminal liability for refusing to comply with an Advance Care Directive provision in relevant circumstances envisaged in the clause.

Consultation questions to consider:

4. *After consideration of the discussion, which of the following options do you support:*
    a. *Making an amendment to the Act to make it clear that an Advance Care Directive cannot be used as the basis for refusing life-saving treatment following an attempt to suicide or cause self-harm?*
    b. *Removing Regulation 12A from the Advance Care Directives Regulations 2014, and no amendment made to the Act?*

2.8 AMENDMENT OF SECTION 14 – GIVING ADVANCE CARE DIRECTIVES WHERE ENGLISH NOT FIRST LANGUAGE

Recommendation 22 of the Review:

A new section of the Act is required which imposes clear requirements on interpreters. In particular, interpreters must be duly qualified as interpreters of the relevant language, they should be adult with capacity and they should be subject to similar requirements as apply to witnesses under section 15.

Discussion:

This section of the draft Bill has been drafted to implement Recommendation 22 of the Review.

The purpose of this amendment is impose requirements on interpreters.

In the Review, Professor Lacey found that there are no requirements that an interpreter be qualified as an interpreter, nor that they be an adult, or that they be independent of the person making the Advance Care Directive.

This amendment aims to impose requirements on interpreters to be:

a) duly qualified as interpreters of the relevant language;

b) an adult with capacity; and

c) subject to similar requirements as apply to witnesses under section 15, to ensure that interpreters cannot also:

    a. be Substitute Decision-Makers,

    b. have an interest in the estate of the person giving the Advance Care Directive,

    c. be a health practitioner responsible for the care of the person,

    d. occupy a position of authority by virtue of their employment in a hospital, aged care facility or other institution.

Consultation questions to consider:

5. *Do the proposed requirements on interpreters provide a reasonable minimum standard to for interpreters to prevent possible abuse or conflicts of interest?*

6. *Are there any other requirements that should be imposed on interpreters?*

2.9 AMENDMENT TO SECTION 21 – REQUIREMENTS IN RELATION TO APPOINTMENT OF SUBSTITUTE DECISION-MAKERS

Recommendation 8 of the Review:

The Act and the Advance Care Directive form should be amended to make it absolutely clear that there is no limit on the number of Substitute Decision-Makers that can be appointed.

Discussion:

This section of the draft Bill has been drafted to implement Recommendation 8 of the Review.

The purpose of this amendment is to explicitly state that there is no limit on the number of Substitute Decision-Makers that can be appointed.

In the Review, Professor Lacey found that the Advance Care Directive Form only provides space for three Substitute Decision-Makers, and that this was seen as a problematic limitation by members of the community, particularly in cases where families included more than three children.

If this amendment is passed, the Advance Care Directive Form will be updated to ensure that people are able to appoint any number of Substitute Decision-Makers.

Consultation questions to consider:

7. *Is there any reason to consider limiting the number of Substitute Decision-Makers that can be appointed?*

2.10 SUBSTITUTION OF SECTION 22 – SUBSTITUTE DECISION-MAKERS EMPOWERED SEPARATELY AND TOGETHER ETC

Recommendation 9 of the Review:

The wording in section 22 of the Act should be changed from 'jointly and severally' to 'separately and together'.

Recommendation 10 of the Review:

The Act and the Advance Care Directive form should be amended to enable people to have a hierarchy of Substitute Decision-Makers, with one or more preferred Substitute Decision-Makers, as well as alternate Substitute Decision-Makers (i.e. appointing a spouse as the preferred Substitute Decision-Maker and children as alternate Substitute Decision-Makers). All Substitute Decision-Maker appointments should be able to be exercised together and separately.

Discussion:

This section of the draft Bill has been drafted to implement Recommendations 9 and 10 of the Review.

The purpose of this amendment is to allow:

a) appointing Substitute Decision-Makers in order of precedence; or

b) limiting specific decisions to specific Substitute Decision-Makers;

c) appointing alternate Substitute Decision-Makers who can only make decisions when a specified Substitute Decision-Maker/s are not available.

In the Review, Professor Lacey frequently heard from individuals and lawyers of a preference to appoint their spouse as their preferred Substitute Decision-Maker, with their children appointed equally as alternate Substitute Decision-Makers.

These provisions will also allow Substitute Decision-Makers to be empowered to make decisions under an Advance Care Directive together and separately, unless a condition is placed on those Substitute Decision-Makers to make decisions in a different way.

Using a fictional case study as an example, Olivia has listed her husband John as first preferred Substitute Decision-Maker. John will be required to ensure that Olivia's wishes are known to the appropriate people at the appropriate time. Olivia has also listed her son Andrew, her daughter Susan, and another son Daniel as alternate Substitute Decision-Makers. Olivia would like all three children to have equal decision-making powers as alternate Substitute Decision-Makers. Olivia has specified in her Advance Care Directive that she would like Andrew, Susan and Daniel to make decisions, separately and together in the case that John is unable to act in the role of first preferred Substitute Decision-Maker.

Consultation questions to consider:

8. *Do you support the ability for people making an Advance Care Directive to establish an order of precedence of Substitute Decision-Makers?*

9. *How can a person making an Advance Care Directive establish a clear decision-making process to guide Substitute Decision-Makers?*

2.11 AMENDMENT OF SECTION 24 - EXERCISE OF POWERS BY SUBSTITUTE DECISION-MAKER

Recommendation 5 of the Review:

The use of digital copies of a certified Advance Care Directives should be both permissible and promoted within South Australia's hospitals. The Act should be amended to facilitate this process and provision should be made in the Act to ensure that medical practitioners and hospital staff are entitled to rely on the purported validity of an Advance Care Directive contained on a patient's My Health Record.

Discussion:

This section of the draft Bill has been drafted to implement Recommendation 5 of the Review.

The purpose of this amendment is to allow Substitute Decision-Makers to fulfil the requirement of producing an Advance Care Directive in cases when the health practitioner accesses an electronic copy of that Advance Care Directive in accordance with the requirements set out in the Regulations.

This amendment supports Clause 5 of the draft Bill, explained in Part 2.5 of this Discussion Paper, which aims to allow health practitioners to rely on a digital copy of an Advance Care Directive as a legally valid copy of that Advance Care Directive.

Consultation questions to consider:

10. *Do you support an amendment to allow health practitioners to rely on the legal validity of digital copies of Advance Care Directives if a hardcopy cannot be presented at the time of need?*

2.12 AMENDMENT OF SECTION 45—RESOLUTION OF DISPUTES BY PUBLIC ADVOCATE

Recommendation 17 of the Review:

Section 45 of the Act should be amended to require Office of the Public Advocate to discontinue a matter where a reasonable suspicion of elder abuse exists and refer the matter to South Australian Civil and Administrative Tribunal for determination. Office of the Public Advocate should be entitled to disclose the general basis of that suspicion in a written referral to South Australian Civil and Administrative Tribunal. Consideration should also be given to an amendment which requires Office of the Public Advocate to publish on its website, as well as notify all parties accessing the Dispute Resolution Service from the outset, that evidence of elder abuse will trigger a discontinuation of mediation and that a referral to South Australian Civil and Administrative Tribunal will follow.

Recommendation 18 of the Review:

The declaratory powers of Office of the Public Advocate under s 45(5)-(9) have never been used and should be repealed.

Discussion:

This section of the draft Bill has been drafted to implement Recommendations 17 and 18 of the Review.

The purpose of these amendments are to:

- require the Office of the Public Advocate to discontinue a matter where reasonable suspicion by Office of the Public Advocate staff of abuse of a vulnerable adult exists and refer the matter to South Australian Civil and Administrative Tribunal for determination.
- repeal declaratory powers of Office of the Public Advocate that have never been used.

Given the detailed investigation into these matters by Professor Lacey, it is suggested that members of the community who would like further background detail on the findings that led to these recommendations review Section 3.6 of the Review (Pages 69 – 79 of Appendix B).

Consultation questions to consider:

11. *Do you have any feedback in relation to the proposed changes to the powers of the Office of the Public Advocate?*

2.13 AMENDMENT OF SECTION 46—REFERRAL OF CERTAIN MATTERS TO TRIBUNAL

Discussion:

A minor amendment is required in this section to ensure that it does not limit the potential amendment proposed in Clause 12 of the draft Bill and is explained in Part 2.12 of this Discussion Paper.

It is not anticipated there is any need to provide feedback on this section.

2.14 SCHEDULE 1 - STATUTE LAW REVISION OF ADVANCE CARE DIRECTIVES ACT 2013

Discussion:

Schedule 1 of the draft Bill provides for statute law revision of the Act to make references to gender neutral i.e. replacing “his or her” with “their” or “he or she” with “the person”.

This section is considered general ‘housekeeping’ and is being rolled out in a phased approach for all South Australian legislation.

It is not anticipated there is any need to provide feedback on this section.

3. OTHER MATTERS FOR CONSULTATION

3.1 RECOMMENDATION 25: IMPAIRED DECISION-MAKING CAPACITY

Recommendation 25 of the Review:

The government should conduct a public consultation process and/or commission research for determining how persons with limited or impaired decision-making capacity can be facilitated to record and convey (including through supported decision making) their preferences for future medical care, accommodation and personal matters. The consultation must engage with the disability sector and be framed by a human rights-based approach.

Discussion:

If you are over 18 years old, in order to make legal documents and consent to medical treatment, you need to have decision-making capacity. Impaired decision-making capacity means that you are unable to manage parts of the decision-making process.

If you have impaired decision-making capacity, you may not be able to:

- Understand some or all of the information that is relevant to a decision
- Understand the consequences of a decision
- Remember the relevant information, even for a short time
- Use this information to make your decision; and
- Communicate your decision to others in some way[4].

The *Guardianship and Administration Act 1993* outlines principles to guide decision makers appointed under this legislation. Decision makers make substitute decisions on behalf of individuals who cannot do this for themselves. Whether or not you are appointed by an order of South Australian Civil and Administrative Tribunal, these principles should be taken into consideration when making decisions on behalf of someone who does not have the capacity to do so for themselves[5].

Recommendation 25 recommended that research be conducted into how persons with limited or impaired decision-making capacity can be facilitated to record and convey (including through supported decision making) their preferences for future medical care, accommodation and personal matters.

The NDIS Information, Linkages and Capacity Building (ILC) Project 'Living My Life', which launched in 2020 in partnership with South Australian Health and Medical Research Institute (SAHMRI), Office of the Public Advocate and SA Health, is one project that will provide insight into how people with impaired decision-making capacity, including psychosocial disability, are supported to exercise their legal capacity and access mainstream services in a way that supports their future health care wishes.

[4] http://www.opa.sa.gov.au/resources/fact_sheets
[5] http://www.opa.sa.gov.au/making_decisions_for_others/substitute_decision_making

The project will support between 50-150 people with impaired decision-making, including psychosocial disability who are under guardianship of the Public Advocate.

The project will run until March 2023 with activities that aim to support participants with impaired decision-making capacity who are at greatest risk of not being able to express and realise their life goals and exercise choice and control in accordance with the principles of the NDIS. Office of the Public Advocate, through SA Health Local Health Networks, will train staff to support people with impaired decision-making capacity and SAHMRI will offer resilience and wellbeing training to participants and supporters.

Through this project, Office of the Public Advocate have developed a supported decision-making model and a non-statutory Advance Care Planning document which does not specifically focus on end of life wishes, but a whole of life approach. In this context, a non-statutory document means not a legal Advance Care Directive under the Act. A non-statutory document could take form in a number of ways, such as a letter, a handwritten note, a pre-existing Advance Care Planning template or an unsigned or unwitnessed Advance Care Directive.

The use of non-statutory forms in SA is not new, and many are commonly used. The existing 'My Life Decisions' document, developed by a group of senior professionals in conjunction with the Office of the Public Advocate, is one example that is currently being used in SA. 'My Life Decisions' assists both people with and without decision making capacity to express their end of life wishes and records their values.

The Australian Capital Territory (ACT), Queensland (QLD) and Western Australia (WA) State Governments have produced non-statutory Advance Care Planning documents that can be used by people with impaired decision-making capacity. As an example, QLD's non-statutory Advance Care Planning program consists of a Statement of Choices form in two parts – form A for people who can make their own choices; and form B for people who cannot make their own health care decisions or who require support with decision making.

Recommendation 25 also recommends further consultation with the community. Through this consultation process, feedback from the community is sought on whether introducing a single, broadly supported non-statutory Advance Care Planning document in SA would be beneficial in facilitating how persons with limited or impaired decision making capacity can record or convey their preferences for future medical care, accommodation and personal matters.

Consultation questions to consider:

12. *How can persons with limited or impaired decision-making capacity record or convey their preferences for future medical care, accommodation and personal matters?*
13. *What would be the benefit of having a non-statutory Advance Care Planning document?*
14. *Do you have any concerns about non-statutory Advance Care Planning documents?*

3.2 RECOMMENDATION 27: DIGITAL SIGNATURES

Recommendation 27 of the Review:

The Department should investigate how the use of digital signatures could be implemented under the Act, and make appropriate amendments to the Act if required.

Discussion:

Further investigation has been undertaken in response to this Recommendation and it has been found that the use of electronic or digital signatures for the purposes of signing and witnessing an Advance Care Directive in South Australia is not permissible under current legislation.

A digital signature (D-Signature) is created through a process where a final electronic version of a document is sent to each signatory by a separate email and a signature is created by the software when each email recipient has completed "signing". Each signatory signs a different version of the document and there are unique tracking numbers and location data created for signatories.

An electronic signature (E-Signature), on the other hand, consists of an ink signature that has been scanned into a computer system for insertion (that is, copied and pasted) into future documents.

A paper prepared by the Local Government Association of South Australia (LGA) on the use of Electronic Signatures for the purpose of legally witnessing documents provides some useful commentary on issues with E-Signature and D-Signature technology and concludes that such technology should not be used.

These issues include:

a) most electronic signing software does not make provision for witnessing, they only allow for signatures to be entered in a specific order and location tracking. Further, each person usually signs a different version of the document, not the same version. This does not necessarily meet the legal requirements for witnessing documents.

b) Witnesses are required to be physically present at the time of witnessing a signatory's signature. While electronic signing technology may have location tracking functionality, this does not necessarily prove that the witness was physically present at the time of signing.

c) A witness should sign the document at the same time/immediately after the signatory. Where electronic signing technology is used there may be some delay between signatures.

Thus, for any documents that are legally required to be witnessed, the LGA recommend that E-Signatures and D-Signatures not be used[6].

In South Australia, while the *Electronic Communications Act 2000* (SA) (the EC Act) and the *Electronic Communications Regulations 2017* (the EC Regulations) generally permit legal transactions (including signatures) to be performed via electronic communication, the use of electronic signatures is not permitted where there is a requirement under law that a document is witnessed under signature of a person other than the author of the document[7].

[6] https://www.lga.sa.gov.au/__data/assets/pdf_file/0023/567320/Advice_Electronic-Signature-1.pdf
[7] *Electronic Communications Regulations 2017* (regulation 5 & 6)

In response to the COVID-19 pandemic, South Australia enacted omnibus legislation under the *COVID-19 Emergency Response Act 2020* that contains a general regulation-making power under section 16, relating to the "signing, witnessing, attestation, certification, stamping or other treatment of any document". However, at the time of writing, the only modifications made to an Act under section 16 with respect to witnessing documents, is the requirement to witness the signing of an instrument in accordance with section 267 of the *Real Property Act 1886*, which has since been suspended. There have been no modifications made to the EC Act or the ACD Act pursuant to this provision.

Broader permission for electronic signatures and remote witnessing or attestation, as has occurred in other jurisdictions, has not been enacted in South Australia during the COVID-19 pandemic[8].

In relation to remote witnessing, section 17 of the *COVID-19 Emergency Response Act 2020* provides that a requirement for two or more persons to be physically present will be satisfied if the persons meet or the transaction takes place remotely using audio link, audio-visual link or any other means of communication prescribed by the regulations. However, section 17(2) of this Act provides that this section does not apply in circumstances prescribed by the Regulations. Of relevance, the COVID-19 Emergency Response (Section 17) Regulations 2020[9] states that 'Section 17 of the Act does not apply to a requirement that a person be physically present to witness the signing, execution, certification or stamping of a document or to take any oath, affirmation or declaration in relation to a document', thereby preventing the kind of remote witnessing and attestation of signatures or verification of identity permitted in other States, such as NSW and Victoria.

In clinical settings, where an unsigned or unwitnessed Advance Care Directive is presented, such a document may still be used as an important tool and conversation starter with either the patient or the Substitute Decision-Makers, even though the Advance Care Directive would not be considered legally valid in accordance with the ACD Act. In cases where Substitute Decision-Makers have not been able to sign a person's Advance Care Directive, clinicians are still able to link with them via telephone or video link to discuss the Advance Care Directive holder's health care wishes. In this example, digital signatures would facilitate a stronger approach to confirming the Substitute Decision-Maker's acceptance of their role.

Order of signing Advance Care Directives

Currently, people who are completing an Advance Care Directive are required to:

c. fill in their form

d. have any appointed Substitute Decision-Maker/s sign

e. sign it themselves in front of a witness

f. have the witness sign the witness statement.

If appointed Substitute Decision-Makers are located interstate or overseas, it is required that the Advance Care Directive form is posted to the Substitute Decision-Maker/s, filled in, signed and returned to the Advance Care Directive holder. Substitute Decision-Maker/s must sign before the Advance Care Directive holder signs. Feedback received to date has questioned this order of signing because the process of posting to one or multiple Substitute Decision-Makers can be time consuming and a deterrent to completing Advance Care Directives.

[8] https://piperalderman.com.au/insight/electronic-signatures-remote-witnessing-and-covid-19/
[9] *COVID-19 Emergency Response (Section 17) Regulations 2020*

Consultation questions to consider:

15. *Should further amendments to relevant Acts be considered to enable the use of digital signatures in South Australia?*
16. *Are there any risks to consider for Advance Care Directive makers if their witnesses are not physically present to sign their Advance Care Directive, such as vulnerability to coercion or other types of abuse?*
17. *What issues are created by the current order of signing?*
18. *Is there an alternate order of signing that could be implemented?*
19. *Would legislating digital signatures for Substitute Decision-Makers and/or witnesses mitigate the need to amend the order of signing?*

3.3 RECOMMENDATION 28: LIST OF WITNESSES

Recommendation 28 of the Review:

Before any changes are made to the certification requirements surrounding Advance Care Directives, the Department should engage in a broader consultation with key stakeholders, taking into account the recommended changes to the list of authorised witnesses in this Report. Any consultation for this purpose should include the relevant bodies representing particular classes of witnesses, the Local Health Networks and the Law Society.

Discussion:

Recommendation 11 of the Review states that Schedule 1 of the Regulations needs to be amended and the list of suitable witnesses limited to:

a) Health practitioners*;*
b) Legal practitioners;
c) Judges and magistrates;
d) Social workers; and
e) Justices of the Peace.

The current list of witnesses is significantly longer (Appendix D).

Section 15(2) of the Act provides general circumstances under which a person cannot be a suitable witness, as follows:

However, a person cannot be a suitable witness in relation to a particular advance care directive—

a) if he or she is appointed under the advance care directive as a substitute decision-maker; or

b) if he or she has a direct or indirect interest in the estate of the person giving the advance care directive (whether as a beneficiary of the person's will or otherwise); or

c) if he or she is a health practitioner who is responsible (whether solely or with others) for the health care of the person giving the advance care directive; or

d) if he or she occupies a position of authority in a hospital, hospice, nursing home or other facility at which the person giving the advance care directive resides; or

e) in any other circumstances set out in the regulations in which a person cannot be a suitable witness in relation to a particular advance care directive.

Under s7(3)(a) of the Regulations:

For the purposes of the definition of suitable witness in section 15(4) of the Act, a suitable witness must satisfy the following requirements:

a) the suitable witness must be a competent adult;

b) the suitable witness must be a person, or a person of a class, included on the list of suitable witnesses set out in Schedule 1.

As the Act and Regulations do not prescribe detailed and exhaustive requirements to assess the suitability of witnesses, other than to name the classes of persons, the following principles have been developed to guide the decision making in considering the proposed refined list of suitable witnesses in Recommendation 11.

The draft principles for determining classes of persons to be included as suitable witnesses include:

- Ensure broad access across South Australia, including in regional SA
- Simplify the list where possible
- Remove those classes of persons less likely to be commonly used
- Include only classes of persons that require professional registration with their relevant body
- Classes of persons should be commonly accessible and available for all members of the general public to contact

Based on the above draft principles, the following list of suitable witnesses is proposed as a draft list for further consultation:

a) Health practitioners, as defined under the *Health Practitioner Regulation National Law (South Australia) Act 2010*
b) Justices of the Peace, as defined under the *Justices of the Peace Act 2005*
c) Legal practitioners, as defined under the *Legal Practitioners Act 1981*
d) Police Officers, as defined under the *Police Act 1998*
e) Social workers registered with Australian Association of Social Workers
f) Teachers registered with the Teachers Registration Board of South Australia.

It is also noted that a national process is underway for the registration of social workers under Health Practitioner Regulation National Law, and if and when this is passed, the requirement for the registration of social workers in this context would need to be updated to align with the National Law.

Additionally, under Recommendation 12 of the Review, it states that *Justices of the Peace and social workers should be required to complete a professional training course, approved by the Department for Health and Wellbeing, every 2 years. Such courses must address legal requirements under both the Advance Care Directives Act 2013 (SA) and the legal effects of the Office for the Ageing (Adult Safeguarding) Amendment Act 2018 (SA).*

The development of training will be explored for the complete list of witnesses, not just Justices of the Peace or social workers. It is anticipated that the training would be highly encouraged, if not mandated, to complete before an authorised witness becomes valid. This piece of work is being considered by the Advance Care Planning Oversight Group.

Consultation questions to consider:

20. *Do you agree with the draft guiding principles?*
21. *Do you agree with the proposed list of witnesses?*
22. *Do you have any further comments or concerns?*

4. PROVIDING FEEDBACK

Your views on this legislation are welcomed and appreciated.

Submissions can be provided until close of business **Tuesday, 3 August 2021** by:

- completing the survey at YourSAy
- emailing your feedback to: Health.AdvanceCarePlanning@sa.gov.au
- Participating in our upcoming webinars. Keep an eye out on our YourSAy page for dates and times
- posting your written feedback to:

  Health Services Programs
  PO Box 287 Rundle Mall
  ADELAIDE 5000 SA

5. HELP AND SUPPORT

This document, or discussion about the contents of this document, may cause distress or increased negative feelings. If this occurs to you or someone you care about, please seek support from the services below:

> Lifeline	13 11 14	www.lifeline.org.au
> Kids Help Line	1800 551 800	www.kidshelpline.com.au
> Mensline Australia	1300 789 978	www.Mensline.org.au
> Headspace	1800 650 890	www.eheadspace.org.au
> QLife	1800 184 527	https://qlife.org.au
> Beyond Blue info line	1300 224 636	www.beyondblue.org.au
> Suicide Call Back Service	1300 650 467	www.suicide.callbackservice.org.au
> Open Arms (Veterans and their families)	1800 011 046	www.openarms.gov.au
> South Australian Mental Health Triage (over 18 years)	131 465	
> Reach Out (for young people)		www.reachout.com

If you are bereaved by suicide:

> Standby Response Country South	0437 752 458
> Standby Response Country North	0438 728 644
> Living Beyond Suicide Metro and Adelaide Hills	1300 761 193
> Bereaved through Suicide	0488 440 287
> MOSH (Minimisation of Suicide Harm)	8377 0091

In an emergency call triple zero (000).

6. APPENDICES

A. Advance Care Directives (Review) Amendment Bill 2021
B. Review of the Advance Care Directives Act 2013
C. South Australian Government's Response to the Review
D. Advance Care Directives Regulations 2014 (see Schedule 1 – List of suitable witnesses, page 6)

For more information

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Government of South Australia
SA Health

Confidentiality-I1-A1

Interpreter