Office of the Public Advocate
Dispute Resolution Service

OPA Procedure
Mediation Model
& Practice Guidelines

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GLOSSARY OF TERMS

Advance Care Directive

An Advance Care Directive is a legally binding document where a person is able to write down his/her instructions, wishes and preferences for future health care, accommodation and personal matters and/ or to appoint one or more substitute decision makers, who are people chosen to make decisions on his/her behalf in any period of impaired decision making capacity, or as determined by the person.

Enduring Power of Attorney

An Enduring Power of Attorney (EPA) is a legal document that allows another person or persons to act on behalf of the person who made the EPA in financial and legal matters. An EPA does not give anyone authority to make accommodation, health or personal decisions.

Co - Mediation

Co - mediation is when two mediators work together during the mediation process. Co-mediation can be useful when the issues to be mediated are complex, the conflict is high and/or there are large number of participants taking part in the mediation.

Decision making

- *Autonomous Decision making*

  Is where no assistance or support is required, but assistance, support and advice may be sought by a person.

- *Assisted Decision making*

  Means that in coming to an autonomous decision, a person requires assistance with the collection of information, an explanation of options or the or communication of his/her wishes.

- *Supported Decision making*

  Means that a person relies upon the advice and assistance of others when making decisions. He/she can call upon a support network which consists of nominated family, friends or others to help them understand the choices available. Members of the support network can provide information, ideas and options so that the person can make his/her own decisions.

Decision making Capacity

Decision making capacity is assumed unless there is evidence to the contrary. The factors taken into account when considering if a person has decision making capacity include whether or not a person can:

- understand any information that may be relevant to the decision
- understand and weigh up the options
- understand the possible consequences of taking or not taking a particular decision
- retain information and remember the decision even if only for a short period of time
- communicate the decision.

Domain Specific Capacity

People are recognised to have capacity in one domain, for example in areas concerning health, but may have an incapacity in another domain, for instance in issues concerning finances. Each domain should be assessed separately[1].

Global capacity/Incapacity

If a person is considered to have global capacity they are considered to have the ability to make all of their decisions. If a person is considered to have global incapacity, the person is considered unable to make any decisions[2].

Guardianship Board

The Guardianship Board is a court like tribunal that has the power to make important decisions affecting the lives and property of people who have mental incapacity (also called decision making incapacity) in particular specified circumstances. The Guardianship Board's responsibilities are set out in the Guardianship and Administration Act 1993 and the Mental Health Act 2009.

Mediation

Mediation is a collaborative, voluntary, non - coercive problem solving process in which an independent mediator, who is non -judgemental and does not have authority to impose a solution, assists the participants to come together, discuss the issues in dispute and find acceptable solutions to those issues.

Participant

A participant is a person who is involved in the mediation process and who contributes to finding a mutually acceptable solution(s) to the area(s)of disagreement.

Person

This refers to the person who made the Advance Care Directive

Shuttle Mediation

Shuttle mediation is a process where the participants, with the assistance of a mediator, endeavour to reach an agreement without being physically brought together. Shuttle mediation can be used where one or more of the participants is fearful of being in the same room, such as where domestic violence has been present in a relationship, or other situations where there is fear of intimidation. Participants sit in separate rooms and the mediator moves between the rooms to carry information and settlement proposals back and forth between the participant. While the mediation begins with the participant in separate rooms, if appropriate and with the consent of all of the participants, the mediator can bring everyone together when an agreement is ready to be reached. Although shuttle mediation can be successful in situations of unequal power (perceived or actual) it does not afford the participants the ability to hear directly from each other and the mediator takes care not to inappropriately filter information when taking it to and fro.

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[1] Darzins, Molloy and Strang, 2000

[2] Darzins, Molloy and Strang, 2000

Substitute Decision Maker

A substitute decision maker is someone appointed by the person who has made an Advance Care Directive to make decisions in the event that he/she does not have the decision making capacity to do so. A substitute decision maker:

- must follow the principles of the Advance Care Directive Act and, as far as reasonably practicable, follow any instructions that the person has made in the Advance Care Directive
- must make a decision they believe the person would have made in the current circumstances
- is legally recognised as if they were the person who made the Advance Care Directive
- must be competent
- must not be a health practitioner responsible, directly or with others, for the health care of the person who gave the Advance Care Directive
- must not be a paid carer of the person who gave the Advance Care Directive.

1. INTRODUCTION

This is an internal Office of the Public Advocate (OPA) Document which has been developed to set out the procedure for, and to guide the practice of, the OPA's Dispute Resolution Service (DRS) to fulfil the role conferred upon the Office by the Advance Care Directives Act, 2013 and amendments made to the Guardianship and Administration Act,1993 and the Consent to Medical Treatment and Palliative Care Act, 1995.

The Document outlines:

- The procedure for the administration of the Dispute Resolution Service, including data collection.
- The mediation model developed to assist parties to resolve disputes
- Practice Guidelines to guide mediators working with the model.

This is not intended to be a static document as the procedures and practice will be under regular review and evaluation to ensure best practice and also that the DRS meets OPA's statutory responsibility and the needs of the people who use the service.

It is important to note that the model is not intended to be a rigid model, but one that can be adapted to suit the participants (especially those who require accommodations to enable their involvement) and complexity and urgency of the situation.

1.1 Aim of the OPA Dispute Resolution Service

The aim of the Office of the Public Advocate's Dispute Resolution Service is to enable participants who disagree about an advance care directive to come together in a collaborative way in a safe environment to discuss the issues that are in dispute and develop options to resolve the issues. The OPA uses mediation as the primary method for dispute resolution.

The mediation model developed for the OPA Service takes a rights based approach adhering to the principles of the Advance Care Directives Act, the principles underpinning mediation, Charter for Rights for Older People[3] and the Convention on the Rights of Persons with Disabilities[4]. The model is person-centred and places the person who made the advance care directive at the centre of the decision making process providing support to enable the participation of the person to the fullest extent of their abilities. The model ensures that the thoughts, views and wishes of the person are brought into the mediation even if she/he is not able to take part directly in the mediation.

[3] Appendix 2 - Adapted from the United Nations Principles for Older Persons, UN General Assembly, December 16, 1991, by Associate Professor, Wendy Lacey, Closing the Gaps Report (Vulnerable Adults Project, Office of the Public Advocate (SA) 2011.

[4] Appendix 3 - Convention on the Rights of Persons with Disabilities, United Nations.

Background

The Advance Care Directives Act (ACD Act) 2013 was passed by SA Parliament in April 2013 and is expected to commence in 2014. The ACD Act creates a single advance care directive to replace the existing Enduring Power of Guardianship, Medical Power of Attorney and Anticipatory Direction. The intent of the Act preserves the right of competent adults to direct, in advance, what quality of life means for them. This information and/or direction will inform others if there is a time when the adult is unable to make his/her own decisions thus enabling substitute - decision makers, health practitioners and others to make decisions based upon knowledge of an individual's preferences and values.

The ACD Act is underpinned by a set of overarching principles[5] supporting the right of people to make their own decisions for as long as possible, and if necessary, to be supported in making decisions if they have difficulty in doing so. If a circumstance occurs where a person in not able to make decisions even with support, her/his appointed substitute decision maker (if any appointed) must 'stand in the shoes' of that person and make decisions as the person would have done, prior to losing the capacity to make that decision. The Principles must be taken into account and applied in the administration, operation and enforcement of the Act, including in the resolution of disputes.

The Advance Care Directive Act, 2013, confers three roles on the Office of the Public Advocate, namely:

- Information and Advisory Service
- Declaration Service
- Dispute Resolution Service

[5] Appendix 1 Principles of the ACD Act 2013 (Section 10)

2. METHOD OF DISPUTE RESOLUTION - MEDIATION

As stated in the ACD Act, the OPA will use mediation as the method of dispute resolution.

2.1 Definition of Mediation

Mediation is a collaborative, voluntary, non-coercive problem solving process where an independent mediator, who is non-judgemental and does not have authority to impose a solution, assists the participants to come together, discuss the issues in dispute and to find acceptable solutions to those issues.

The voluntary, non-coercive process has the potential to enhance the rights of people who may have impaired decision making capacity (in respect to a particular decision or decisions) or vulnerability. This approach focuses on the person's autonomy, independence and control over decisions affecting their lives. The mediation process can be flexible and adapt to the needs of the participants, particularly the person who has made the Advance Care Directive. The OPA mediation model takes into account any physical and cognitive restrictions that may be experienced by the person and gives priority to ensuring that accommodations to enable her/ his participation are fully considered and provided.

The OPA mediation model is designed to:

- Bring the appropriate participants together
- Ensure that necessary accommodations are made to enable participation, as far as reasonably possible (including providing a supportive environment)
- Ensure clear information about the process is given to participants
- Assist participants to communicate with each other
- Assist participants to relay their issues to others
- Assist the participants to have a positive focus on the person who made the Advance Care Directive
- Assist the participants to focus on the issue/s in dispute and reach an appropriate agreement

2.3 Facilitative Mediation Style

The mediation model developed for the OPA Dispute Resolution Service is *based* on the Facilitative Style of mediation. This style is generally considered to be the most appropriate for mediation with vulnerable people, such as those who have impaired decision making capacity as it promotes the principles of empowerment, self-determination and voluntary participation of all involved. In facilitative mediation the mediator structures a process to assist those involved to come together, state their concerns, share relevant information and acknowledge and understand the views of others. A facilitative mediator assists participants to find their own solutions; to test the achievability of the solutions and to focus upon how any proposed agreement meets the needs of the participants, and of those effected by its outcome, most especially the person who made the Advance Care Directive.

Facilitative mediators predominately hold joint sessions so that all participants are able to hear the information and the points of view of others. However, in recognition of the needs and abilities of the diverse client groups who will use the OPA service, the model is adaptable to incorporate accommodations where necessary such as location of mediation meetings, method

of pre-mediations session and individual meetings to correct power imbalances, de-escalate conflict and check on the wellbeing of the participant wherever necessary.

In a facilitative model, the mediator should act only as a facilitator of the process rather than being an authority figure providing substantive advice or putting pressure on the participant to settle. The OPA mediator will follow these principles. However, during mediations at the OPA it may be necessary for the mediator to provide information and clarification on the relevant legislation, Guardianship Board process and the like, and assist the participant to form options based on specialised knowledge. In providing this type of information and assistance the mediator is acting in a facilitative role as distinct from an advisory role by not presenting as an authority figure, or being directive, but rather ensuring that the participants are able to make informed decisions and ethical agreements.

It is likely that a significant number of disputes about advance care directives coming to the OPA Dispute Resolution Service will involve the person who made the advance care directive and their family members and friends who have a close and continuing relationship with them. This means that mediations are likely to be multi - partied and intergenerational. To ensure best practice when mediating with multiple participant and complex situations that may have a significant level of conflict, the model described in this document has the ability to incorporate the use of co - mediators (when two mediators work together) and shuttle mediation (where the mediator assists the participant to make an agreement without being physically brought together).

3.1 Principles of Mediation

The OPA dispute resolution service is designed to be rights -based and person centred with a positive focus on the person who made the Advance Care Directive. To ensure this, the mediation model developed is underpinned by the following principles:

- *Voluntary participation*
- *Confidentiality*
- *Capacity*
- *Empowerment and self determination*
- *Impartiality / Neutrality*
- *Safety for participants*
- *Mediator competency*

Ethical issues are raised within these principles and need to be considered in relation to the participation of people who have, or are suspected to have, impaired decision making capacity in the mediation process.

Voluntary Participation

Mediation is viewed as a voluntary process and participants can leave at any time. All participants are encouraged to remain involved in the mediation process once it has begun, unless it is unsafe to do so, until an agreement is reached. If a participant wishes to withdraw from the process the mediator can speak with her/him privately to ascertain any issues that may be able to be satisfactorily dealt with to enable the participant to remain in the process or their views to be taken into consideration.

Confidentiality

The ACD Act, (Section 46) states that evidence of anything said or done in the course of mediation is not admissible in subsequent proceedings except by consent of all participants to the proceedings. A key feature and a basic principle of mediation is the confidential nature of the discussion that occurs within the mediation process. Confidentiality is important because it encourages disclosure of information from the participant and the display of attitudes and opinions without fear that these will be revealed in any public forum and/or future court or other proceedings.

Exceptions to Confidentiality

The OPA mediation service will observe the principle of confidentiality as set out in the Advance Care Directive Act and as a principle of mediation. Confidentiality extends to any information provided by the participant during the pre-mediation process and any individual meetings with the mediator.

An exception to confidentiality is if there is a disclosure of actual abuse or a potential threat to a person's safety during the mediation process (including to OPA staff) or if alerted to another criminal act.

Any exceptions to the adherence to confidentiality in relation to the mediation process will be clearly articulated in the written information about the dispute resolution service, including the agreement to mediate which will be signed by all participants. In addition, the mediator will refer to the confidentiality of the process and any exceptions to it in pre – mediation sessions and in the mediator's opening statement.

Decision Making Capacity (ASSESSMENT TOOLS TO BE DEVELOPED)

The most basic principle in regard to decision making capacity to make a particular decision is that capacity to make a particular decision must be presumed unless there is evidence to the contrary. The underlying philosophy of the ACD Act 2013 is to ensure that a person who has impaired decision- making capacity in respect to a particular decision is, as far as reasonably possible, empowered/supported to make their own decisions for as long as they are capable. Where a person is assessed as lacking capacity to make a specific decision and all attempts to support them to make their own decision have been unsuccessful, the substitute decision-maker is required to make decisions in accordance with the person's values and wishes and to follow any direction contained in the Advance Care Directive, as is reasonably practical.
Capacity is a decision-specific concept and is not 'all or nothing'. Decision making capacity is the ability to:

- Understand the information relevant to a decision or action
- Understand and weigh up the options
- Understand the possible consequences of taking or not taking a particular decision
- Retain information and remember the decision, even if only for a short period of time
- Communicate the decision

A person's capacity to be involved in the mediation process may not be the same as decision-making capacity in relation to making complex financial or health decisions. For instance, a person with impaired decision – making capacity may be able to take part in a mediation process where the mediator has made accommodations to assist/support their participation. It

is not the role of the mediator to evaluate which decisions a person can make but instead they should find ways to maximise the person's ability to participate by following a process that allows direct or indirect participation[6] (discussed further in the following section). The issue of decision making capacity/incapacity has been a controversial topic between some practitioners as 'mainstream' mediation assumes that participants have the capacity to examine facts and make rational choices and decisions[7]. However, mediators specialising in the area of family conflict involving older people state that some people with impaired decision making capacity are able to participate in the process as long as accommodations are made.

It would however be unethical for a mediator to include a person in the mediation process if they were clearly unable to follow the discussion or to understand the consequences of the decisions that were being made even with accommodations in place. The mediator, using her/his practice knowledge and experience when interacting with the person who made the Advance Care Directive, along with professional assessments provided to the mediator and information gained from other potential participants can make an informed decision about the most appropriate way of including the person who made the Advance Care Directive in the mediation process.

Empowerment / Self Determination

The key consideration in the development of the dispute resolution models for the OPA programme is to take a person - centred, rights based approach as intended by the ACD Act.

> *A person must be allowed to make their own decisions about their health care, residential and accommodation arrangements and personal affairs to the extent that they are able, and be supported to enable them to make such decisions for as long as they can. (Section 10 Advance Care Directive Act 2013)*

A rights based approach to dispute resolution adheres to the principles of empowerment and self-determination and so the person who has made the advance care directive must be given the opportunity to be involved in the mediation process to the full extent that they are willing and able to do so. An ethical consideration, however, is the extent to which a person who has impaired decision making capacity can be empowered in the dispute resolution process, particularly one that is multi - partied and involves family members with whom the person may depend on for care and support. It is not desirable for a vulnerable person to be directly involved in a mediation process where there is potential for them to be emotionally damaged by the conflict that they may perceive as being 'because of them'. On the other hand, neither is it desirable for a vulnerable person to be omitted from the mediation process when there are important decisions to be made about their lives. The mediator, giving full consideration to the information gained from the person who made the Advance Care Directive and other potential participants, must assess the most appropriate method of including the person in the mediation.

[6] Foxman et al

[7] Clarke & Davies, 1992; Kelly 1995

Inclusion of the Person who made the Advance Care Directive

The challenge for a just mediation process is to enable the participation of the person who made the Advance Care Directive in a mediation process that is set in an environment that will not harm the person emotionally or physically. Using the Assessment Form for the person who made the Advance Care Directive[8] the mediator must assess the most appropriate way for the person to be involved in the mediation process, by direct involvement, represented by an advocate or represented by the substitute decision maker (if any and if appropriate).

a) By Direct Involvement

If the mediator assesses this approach as appropriate, he/she will need to ensure that the level of conflict is minimised for the person to feel comfortable and able to participate.
Several accommodations may need to be made to ensure that the person who made the Advance Care Directive is empowered to take part in the mediation, such as;

- Having a support person to assist them before, during and following the mediation process. The role of the support person is not to take an active part in the mediation (i.e. give their own thoughts and opinions during the mediation) but to ensure that the person who made the Advance Care Directive is able to present their views and to assist the person if they need breaks throughout the mediation to digest information or have time out.

- Individual meetings can take place during the mediation session/s;
    - where the mediator can ensure the person who made the Advance Care Directive can understand the issues presented during the mediation and has been able to put forward their thoughts and views to the fullest extent possible
    - Where the mediator can ensure the person is not feeling coerced

- If a person feels flustered or unsure of their ability to state their issues, views and possible solutions, they can have assistance outside of the mediation session to write them down and to be supported to deliver these, either by themselves or having them read by a support person or the mediator.

- Shuttle mediation could be used for part or all of the mediation.

b) Represented by the Substitute Decision Maker

The person may have appointed one or more substitute decision makers of his/her choice when they completed their advance care directive.

If the dispute is not between the person who made the Advance Care Directive and the substitute - decision maker/s and the person does not have the ability/capacity to take part in the mediation (i.e. lacks decision making capacity) the substitute decision maker is legally viewed as being in place of the person.

If the dispute is about decisions and/or actions taken by the substitute decision maker(s)and the person who made the Advance Care Directive is not able and/`or willing to participate in the

[8] Appendix 4 - Assessment form - Person who made the ACD

mediation, the person who made the Advance Care Directive can be represented by an advocate.

c) Represented by an Advocate

Where the person with impaired decision making capacity cannot or will not participate in the mediation her/his interests may be represented by an advocate or other person whom they nominate. An advocate could be from a professional advocacy service or acting in a private capacity. If a person is unable to nominate an advocate (due to impaired capacity) it may be possible for the participants to agree on an appropriate advocate.

Neutrality / Impartiality

A founding principle of mediation is the premise that the mediator should be a neutral and impartial third party who assists interested participants in negotiating a conflict and has no interest in the outcome. People seek mediation, or agree to participate, because there are issues of conflict that the participants are not able to solve on their own. Participants to mediation often come with entrenched views that they are right and the opposing participants are wrong. Therefore the principle that the mediator is a neutral and impartial facilitator who follows a particular model of intervention, uses specific skills and strategies to assist the participants work through the issues is a most important founding principle of mediation.

Mediation for disputes about Advance Care Directives is not mainstream mediation. Although it draws heavily on the models and theories used in many mediation settings, the model has to include principles and practice guidelines with special considerations when working with people who have impaired decision making capacity and/or who are considered to be vulnerable.

An ethical consideration is where the principles of neutrality and impartiality sit when mediating disputes involving people with impaired decision making capacity. The mediator must ensure that all participants are able to have their views heard and understood and to be able to understand those of the other participants. In ensuring that this occurs the mediator may need to give more assistance and time to someone who may have difficulty in expressing themselves due to a cognitive impairment or communication difficulty. This could be perceived by other participants as the mediator giving favour to one participant over another and therefore as 'taking sides'. Under the ACD Act, substitute decisions need to be made with regard to a set of principles outlined in the legislation. The mediator, by giving clear information to all of the participants about the need to adhere to these principles and to provide a positive focus on participants who require additional assistance to take part in the mediation, will clarify the situation and preserve the independence of the mediator.

Conflict Of Interest

The mediator must disclose all potential conflicts of interest known to her/him that may, or may be seen to, affect the mediator's independence or impartiality during the mediation process. Together, the mediator and the participants must then decide if the mediation can go ahead with the mediator or if the mediator needs to be replaced.

Safety of the Participants - Emotional and Physical

The mediation process must ensure, as much as possible, safety for the participants.

- The mediation environment must be easily accessible for people who have a disability, such as wheel-chair access and aids to assist those with a vision and/or hearing impairment. The mediator (administration or intake officer) will assess the need for any accommodation to be made during the pre-mediation process.

- Pre - mediation screening processes must be in place to minimise risk to the participants

- The mediation room must be conducive to all of the above

- The mediator must use her/his skills to reduce conflict between the participant during the mediation process

- The mediator must use skills and techniques to ensure the participant are empowered, including accommodations (as far as reasonable) for the person who made the Advance Care Directive and other vulnerable participants

- The use of co - mediators and support persons should be considered.

Mediator Competency

To be added to document

3. THE OFFICE OF THE PUBLIC ADVOCATE DISPUTE RESOLUTION - PROCEDURE

Step 1 Referral Process

Referrals to the OPA will be made via three pathways:

1.1 *Through the OPA Information And Advisory Service*

- If appropriate to the situation, the information officer will give the person making the enquiry information about the mediation service.
- Written information about mediation will be available on the OPA web site, including links to information about Advance Care Directives and responsibilities of substitute decisions-makers, health practitioners and others (aged care workers etc) as well as to other relevant information on the Legal Services Commission website.
- Written information about mediation and the service[9] can be posted to the caller if they are not able to access the website.
- An application form[10] can be sent to the caller if they are not able to download it from the OPA website.

1.2 *Directly to the mediator*

It is likely that in some instances enquiries will be made directly to the mediator from service providers who know of the existence of the dispute resolution programme. In this circumstance the mediator will follow the steps outlined above.

1.3 *Urgent applications*

If the application is deemed urgent, an application for mediation can be taken over the phone, with the form being completed by the mediator or the information and advisory officer accurately translating the information from the applicant on to the application form.

1.4 *From the Guardianship Board* ***Protocols with the GB to be developed**

Under the ACD Act 2013, The Guardianship Board can refer any applications involving an Advance Care Directive to the OPA for mediation rather than directly proceeding to a formal hearing. Referrals can be made in two ways ;

a) Following a potential applicant's contact with the Board seeking advice on making an application to the Board which involves an Advance Care Directive

In this instance, the steps outlined in referrals to the OPA information and enquiry service will be followed.

[9] Appendix 5 - Mediation Information Sheet

[10] Appendix 6 - Application form

b) Following a written application being made to the Board.

An application to the Board would contain most of the information relevant for the OPA application thus eliminating the need for a further application to be completed.

1.5. OPA Data Base - CMS Recording

- In referrals received via 1 & 2, the Information Officer or Mediator will record the contact with the OPA as an 'enquiry', recording the information on CMS accordingly.
- If the Board refers an application to the OPA prior to a written application being lodged with the Board, the process outlined in 1 & 2 will be apply.
- If the Board refer a written application to the Board, the OPA administration order will open a file, allocating a number to the potential mediation case.

1.6 Confidentiality between the Dispute Resolution Service and Other Functions of the OPA

The Public Advocate has several main legislative responsibilities set out in the Guardianship and Administration Act, 1993. These include:

- Guardian of last resort
- Investigation
- Education
- Advocacy

Information discussed in the mediation process must not be used in subsequent proceedings except by the consent of all of the participants [11]. This means that information from the mediation process is not to be accessed and considered in any other function of the Office of the Public Advocate, including if the matter comes under, or is considered for, guardianship (including screenings), S28 investigations and advocacy cases.

1.7 De-Identification of Information

The dispute resolution programme will undergo on-going evaluation to ensure best practice (efficiency and effectiveness). The analysis of the data collected will include:

- Profile of those using the service
- Issues bringing the participants to mediation
- Agreements reached/not reached and why
- Guardianship applications referred /avoided
- feedback about the service (including complaints)

The data collected will be de-identified in all reports to ensure confidentiality for the participants.

[11] Advance Care Directives Act 2013

Step 2: Application Received

1. Upon receipt of an application, the OPA Administration Team will open a file on CMS which will generate a file number.

2. The Administration Team will open a physical file.

The application form will provide details about:

- the person who has made the advance care directive
- the applicant's perception of the person's decision making capacity
- the applicant's perception and the person's ability to directly take part in the mediation
- the Advance Care Directive – in what areas does it give authority and to whom does it give authority
- any assessments about the decision making capacity of the person who made the advance care directive
- An outline of the issue/s in dispute.
- What has been done to resolve this issue/s prior to the application to the OPA?
- Contact details for the participant and other participant, including the person who made the advance care directive
- Relationship of the applicant/ other participant to the person.
- Any concerns that the applicant may have about the participant meeting together.

Information contained in the application will give the mediator a first indication of whether the issues of dispute are able to be mediated - i.e. within the scope of the service; issues of safety and whether the process can continue to the next step.

The mediator will follow up the application with the applicant by telephone to:

- Confirm receipt
- clarify any information given
- have a discussion about the abilities of the person who made the Advance Care Directive to attend the mediation in person

Step 3: Invitation to Participate

3.1 Invitation to the person who has made the advance care directive

While it is possible that the person who has made the advance care directive is the one initiating the mediation (referred from an organisation such as ARAS) it is most likely that the person contacting the OPA service will be a family member, friend or service provider who is aware or involved in the dispute.

1 (a) If the person who made the advance care directive is the applicant, the procedure will be as stated in Stage 1.

1 (b) If the person who made the advance care directive did not initiate the contact with OPA they must be invited to participate as the issues are about their life. How this invitation is made will depend on a number of circumstances, including the information received

from the applicant with the mediator asking relevant questions about the person's current situation, including where they live and what support, if any, is being received.

In a rights based, person -centred approach it would seem appropriate to make the first contact with the person who made the Advance Care Directive before proceeding to contact the other participant. However, depending on the circumstance, early contact with the person may not be the most appropriate step to take. For instance, the person may not be aware of the dispute; the person's decision making capacity could be quite impaired (in cases such as a person with advance dementia); the person may be confused; distrustful of people not known to them or be resistant to the assistance of any service providers[12]

Initiating contact with the person who made the advance care directive needs to be approached with care and sensitivity. Often, applicants and/or other participants disagree on the abilities of the person to participate in the mediation. It is therefore prudent to consider gathering information about the person who made the advance care directive from the other participants involved and therefore provide a more accurate picture of the person's circumstances, prior to the mediator deciding how to make contact with the person. The information would be gathered from the participants during the pre - mediation sessions, which follow an invitation to participate.

The mediator will make an assessment based on information contained in the application, follow up conversation with the applicant and practice experience about how and when contact is made with the person who made the Advance Care Directive. The person should receive all of the information given to other participants and have it explained in a manner appropriate to their capacity to understand.

Invitation to the other interested participants

Invitations can be made to potential participants via letter/email or telephone call. The method of contact will depend on the situation presented to the mediator with consideration given to:

- ***The level of conflict***

If the level of conflict appears to be high, a formal letter of invitation (accompanied by relevant information) may be the most appropriate method of contact.

- ***The urgency of matter***

The time frame for resolution of the disagreement may necessitate the invitation being made via a phone call to each participant.

- ***Sensitivity of the matter***

The mediator must assess the most appropriate method of contact with the participants and consider any distress that may be experienced by a potential participant receiving an unexpected letter requesting his/her participation in mediation. While a phone call could also cause a level of anxiousness, the mediator would be able to address immediate anxieties and offer a detailed explanation of the mediation process and information about the application which may assist the potential participant and minimise any distress or anxiety experienced.

[12] This list is an example only. The trial of the models, will provide data to inform this section

Contact with the potential participant should:

- Briefly outline that an application has been made to the dispute resolution service.
- Invite the interested party to contact the mediator to discuss the application. If the invitation is delivered via telephone the mediator can offer a time for further contact if the potential participant does not want to, or is not able to, discuss the matter at the time of the call.
- Be accompanied by the range of information sent to the applicant. If the invitation is delivered by letter or email, the information should be attached. If the invitation is by phone call, an arrangement should be made to provide the potential participant with the information by email, letter or by directing to the web site.

STEP 4 Pre-Mediation Meetings (Intake and Screening)

Pre-mediation meetings refer to the individual meetings between the mediator and the potential participants prior to the joint mediation session. Pre-mediation sessions may be conducted over the telephone or in person, depending on the time frame required for decision making and the preferences and availability of the participants.

Pre mediation sessions, whether by phone or in person, will:

- assist to put the participants at ease by providing clear information about the mediation process.
- determine what help and support a person may require in order to engage as fully as possible with the mediation process – including
- assist to identify any decision making capacity issues
- ensure that the voice of the person is included in the process, assisting him/her to identify the issue/s in dispute
- identify issues that can and cannot be mediated
- ensure that appropriate participants to mediation have been identified and determine who should be at the meeting
- identify dynamics between participant
- determine if any participant have any disability or capacity issues that require accommodation during the process.
- ensure that all participants understand their role at mediation and its aim
- screen for abuse, issues of power imbalance and safety.

4.1 *Process for making pre – mediation appointments*

Appointments for pre – mediation sessions, either in person or by telephone can be made by the mediator, the information officer or administrative officer of the service.

To enable full participation and informed decision making during the mediation process it may be necessary or useful for participants to be referred to appropriate sources where they can seek information on specific issues pertaining to their situation. For instance, one or more of the participants may want to contact Legal Services Commission for information about Advance Care Directives Legislation to ensure that they have information independent of the OPA service.

4.2 Pre - Mediation session with the Person who made the Advance Care Directive

The mediator has to make an assessment about how to conduct a pre - mediation session with the person who made the advance care directive using the information gathered and the mediator's practice experience.

The mediator could meet the person at the OPA Office, or if more appropriate at a venue more suitable for the person , where they would feel more at ease, such as their home (in their own home or supported accommodation) or another familiar place.

A circumstance could occur, where the invitation to participate in the mediation and the pre-mediation with the person who made the advance care directive are actually undertaken during the one meeting.

It is important for the mediator to meet the person who made the Advance Care Directive as long as the person is not opposed to doing so, even if they won't be directly involved in the mediation. It is important for the mediator to have a 'picture' of the person that the process is centred around.

STEP 5 . Assessment - How to involve the person who made the Advance Care Directive in the mediation process.

The mediator must ensure that the person who made the Advance Care Directive receives the support that they need to enable them, as far as reasonably practicable, to take part in the mediation.

Taking part in the mediation does not mean that the person has to be directly involved in the meeting (physically present) but may be included by indirect involvement via an advocate who speaks on their behalf and ensures that their thoughts, views, wishes & values are very much present and considered in developing solutions to the dispute.

Using the Participant Assessment Form (appendix 4) the mediator must assess the most appropriate way of involving the person who made the Advance Care Directive in the mediation process. The assessment of how to involve the person in the mediation process is guided by speaking / meeting with the person and other potential participants involve and in consultation with any service providers who have a good knowledge of the person and the circumstances in dispute (if appropriate). – check this form – It has changed since this was written.

STEP 6. Co - Mediators

The mediator must make an assessment about the use of co-mediators in the mediation. Co-mediation is when two mediators work together during the mediation process. If mediators are to work together there must be good preparation and communication between mediators to ensure a cohesive way of working that will enhance the mediation and not detract from it. Prior to the mediation sessions, the mediators must decide how they will conduct the mediation session including if there is a lead mediator and how they will confer during the sessions.
Co- mediation is useful when the issues to be mediated are complex; the conflict is high and there are a large number of participant taking part in the mediation.

NB: Although the assessment of a co-mediator is listed in this step, it may be evident from the receipt of the application that a co-mediator should be used. If so, then the mediators must consider how to divide the work. For instance, each speaking with a number of the participant during the pre-mediation phase.

STEP 7 Confirmation and agreement to mediate

Following the pre–mediation process if the mediator considers that mediation is appropriate and the participants agree to go ahead, a written agreement to mediate should be completed and signed by all participant. This ensures that the participant understand the terms and conditions of the mediation, such as the confidentiality of oral and written communication and the right of the participant to cease their participation or for the mediator to terminate the mediation [13].

Letters of confirmation should be sent to all participant clearly stating:

- The date, time and location for the mediation.
- That an agreement to mediate is enclosed
- Asking the participant to sign and return the agreement (either by post or by bringing it to the mediation.
- An agreement to mediate should accompany the letter of confirmation

The letters and agreements can be 'standard documents' with the template on the CMS. These can be sent out by Administration staff.

STEP 8 Arrangements for the meeting

The mediator will arrange a time and place for the meeting, which if possible should take place at the OPA.

8.1 Location /Environment

The mediation:

- should take place in a private setting, i.e. in the conference room or a meeting room
- be free from interruptions and disturbance
- Have appropriate safety / security considerations (duress alarm with mediator adhering to OPA OH&S policy)
- should be fully accessible for any participants with disabilities
- may need to consider the use of separate waiting areas if necessary - perhaps in another meeting room, or at the Guardianship Board with their permission. It is hoped that this would not be necessary as it would indicate a level of conflict between the participant that may indicate a risk/safety level that is not be conducive to mediation, but requires a more formal process such as a formal Board hearing.

[13] CCEL 2012

8.2 Time Frame

It is most likely that mediation involving family members will take place in one session only, due to restraints in time, availability and distance for a number of participants.

The time frame and number of mediation sessions will depend on the complexity of the issues to be mediated as well as the mediator's duty to accommodate the needs of the participants to allow them to engage fully in the joint session, such as making meetings shorter to enable the inclusion of an older person who may tire, become confused or lose focus if the meeting goes for a longer time.

It is envisaged that mediation sessions (including set up preparations) would fit into a morning or afternoon 'session', for example 9:00 - 12:30 or 1:30 - 4:00pm. As stated above these times may need to be altered depending on the situation.

8.3 After - hours mediation

While after hours mediation sessions could be considered, there are OH&S issues that would require additional staff to ensure safety for all participants if they were conducted at the OPA office. Another venue may offer the necessary

PART 4 MEDIATION MODEL AND PRACTICE GUIDELINES

The mediation model described is a guide to take the mediator through the necessary stages in mediation.

Stage 1: Introductory / Establishment Phase

Opening Statement

The opening statement can set the tone of the mediation and therefore must be carefully thought out and delivered well. There is a significant amount of information that needs to be given in the opening statement, so it is important not to be given as a 'mediator monologue' but in a friendly yet professional tone, encompassing all participant. The language used throughout the mediation must be appropriate to the participants and jargon should be avoided, as should the use of acronyms that are not well known to all of the participant. The following is not a script as such, but a guide to the elements needed in an opening statement.

- Mediator welcomes the participant and thanks them for coming, emphasising that this indicates willingness to work together to find solution to the issues.
- It is useful in the opening statement to make mention of the fact that it is not unusual for family members to find themselves in disagreement. Such a statement can assist to normalise the situation for the participants and assist to eliminate any element of 'shame' that may hinder a productive process.
- The mediator clarifies the principles of the Act which guides the dispute resolution process. This is also a good opportunity for the mediator to discuss (in lay terms) the mediator's impartiality and neutrality in the context of upholding the rights of the person who made the Advance Care Directive. For instance, the mediator could indicate that she /he may appear to be giving more attention to the person who made the Advance Care Directive, ensuring that this person is supported to raise issues and give views on the conflict as it affects them.
- The mediator clarifies the process and the mediator's role and establishes ground rules for the mediation.
- The mediator reminds participants of the Agreement to Mediate and ensures that all participants have understood and signed it.
- The Mediator checks that all participant understand the process and are willing to continue.

STAGE: 2 Defining and Clarifying the issues

The mediator facilitates communication, promotes understanding, helps participant to focus on their interests rather than their positions, and encourages a creative approach to problem-solving to help the participant reach their own agreement. The nature of the mediation session varies depending on the issues to be mediated and the needs of the participant. During this step it is likely the participant will direct their comments to the mediator rather than to each other due to the conflict.

The mediator;

- asks each participant to explain their concerns / state their issues, letting them speak without interruption.

- summarises this information after each participant has presented their view, to ensure that they have understood the issues correctly and to acknowledge the concerns and feelings of each participant.

The conflict has the potential to get heated at this stage (and indeed at other stages) as the participant relay their views of the issues in conflict, and may leave no doubt as to the anger, distress, frustration that go with them. The mediator should ensure that they keep control of the process, intervening gently but firmly, if the participant do not each other to state their issues and concerns.

It is important for the mediator to allow sufficient time for this step, resisting the temptation to leap into agenda setting. This may be the first time that the participant are hearing each other's concerns and to hear the depth of feelings that go with them.

Stage 3: Agenda Setting, Prioritising and Planning

To prioritise the issues for discussion, the mediator will:

- ensure that the participants lead the development of the agenda and the priority in which issues will be discussed
- ensure that some participant don't dominate the setting of the agenda to reflect their own issues
- help the participants to link issues if appropriate
- help the participants to prioritise the issues and agree an order in which they are to be discussed. It may be necessary for participants to be given the chance to resolve some issues before others can be discussed to prevent them from being overwhelmed, particularly in the case of the person who has impaired decision making. For instance, if a party has a 'long list' of issues aimed at one particular participant, the latter may feel dominated and weighed down by the accusations or concerns resulting in them feeling able to take further part in the mediation,

During this stage (and indeed throughout the mediation) it is likely that participant will raise past disagreements and grievances. It is important for the mediator to keep the process on track. While the mediator should discourage participants from dwelling in the past , it will most likely be necessary for them to speak about the past at some level in order to explain their view on how the current issues have arisen.

The mediator must take a non - judgemental approach to the participants and the issues raised.

Stage 4 Discussing The Issues And Exploring Options

The mediator will continually focus the participants on the rights, views and needs of the person who gave the Advance Care Directive as they work through the issues in the agenda.

- The mediator should encourage participants to discuss each issue in the order set out in the agreed agenda. Even with an agenda, it is unlikely that the discussion process will be linear. It is more likely that there participants will want to go back to their held positions and beliefs with the potential to hinder the forward movement of the process. The

mediator will need to assist participant to become 'unstuck' from the past issues and focus on how the situation can change in the future. It is important that the mediator does not trivialise the effect of the past issues on the participant but to acknowledge the issues and focus the participants to explore ways of moving beyond these issues and find new ways to make collective decisions.

- During this stage the mediator should encourage the participant to speak to each other rather than through the mediator.
- The mediator listens for agreement on issues and highlights the agreement to focus on the positives of the interaction and the willingness of the participant to agree.
- During this stage, the mediator will encourage participants to focus on interests (what each party needs) rather than on positions – what each party wants. However, the mediator must consistently remind the participants to focus on the needs / wants of the person who made the Advance Care Directive, especially if they are not directly involved in the mediation process.
- The mediator will encourage participants to be creative and explore options that meet everyone's needs and interests again reminding participants that the focus is on the person who made the Advance Care Directive
- The mediator will focus the participants wherever necessary on the agreement to mediate and any other ground rules that were established at the beginning of the mediator. This includes being respectful, listening to other without interruption etc.
- If the conflict is becoming heated, the mediator should speak in a calm but authoritative voice, reminding the participants that she/he is in control of the process and that matters need to calm down for the mediation to continue. If the person who made the Advance Care Directive is in the room, the mediator may call a time out / short break, to break intensity of the situation. The mediator should let the participants know why the time out is being called. During the break the mediator could consider the use of individual meetings (described below).

Stage 5: Finding solutions and coming to agreement

The mediator will encourage participants to build on the options that they have developed during the process and from these to develop solutions that meet everyone's needs. Two important processes happen at this stage:

- Participants are empowered to find their own solutions that work.
- Participants work in partnership (even if they don't recognise that this is what is happening) collaborating to find solutions that are beneficial to everyone.

The mediator can white board any options that have been raised and any agreements reached. This visually highlights the participant success in being able to work together to solve parts of their dispute and so acts to encourage further development of options that can lead to final solutions.

The mediator helps the participants test the achievability of the solutions they have developed, with particular reference to the person who made the Advance Care Directive. The mediator can ask the participants what the suggested options would mean for the person and also for them.

Again, continually focus the participants on the rights of the person who made the Advance Care Directive.

Stage 6 Individual Meetings

It is sometimes necessary for participants to meet with the mediator individually throughout the mediation. The mediator may decide to hold individual meetings if the mediation reaches a disagreement that cannot be resolved or if the conflict is becoming heated. Individual meetings can provide a 'time out' and provide an opportunity for the participants to calm and settle and thus de - escalate a level of conflict that is not conducive to the emotional safety of the participant.

Individual meetings can also empower those participants who struggle with the analysis of information provided in the mediation and check that the communication is appropriate.

The use of individual meetings should be carefully considered to avoid unnecessary disruption to the process.

Individual meetings can be useful if the mediator has doubts about any of the participant' understanding of proposed solutions / agreements and ensure that they do not feel intimidated or coerced into accepting the agreements.

Shuttle mediation could be considered if the levels of conflict escalate to a point where the mediation process is not able to continue. In a facilitative model, if the conflict escalates beyond an acceptable level, the mediator could suggest that the participant separate into different rooms and shuttle mediation could be used until the situation has calmed. The use of the shuttle method could be used if the person who made the Advance Care Directive is directly involved and is becoming overwhelmed or distressed by the conflict. The person could be separated physically from the other participant and supported by a support person while the mediator takes information between the main body of the mediation and the person who made the Advance Care Directive.

Stage 7 Termination of Mediation

The desired outcome is that mediation will end in a timely manner with an agreement that all participant are willing to accept. However the mediation could be terminated without the desired conclusion being met due to issues such as:

- One of the participant is unwilling to continue (it should be stated in written and verbal information that participation is voluntary and participant can leave the process at any time). The mediator should use an individual meeting to speak to the person/s who wishes to withdraw from mediation about the issues that led them to make this decision and enquire if there are any changes to be made that would assist them to continue with the process.
- The level of the conflict makes proceeding unsafe and the process is likely to harm one or more of the participant
- a participant is unable to take part effectively, despite having the appropriate help and support
- if, despite the best efforts of the mediator, power imbalances are not able to be addressed
- any agreement proposed by the participants is unreasonable
- any agreement proposed by the participants may be harmful to any of the participant

If mediation terminates before participants have settled their differences, the mediator should refer the participants for support from other professional services as appropriate. This includes referral (with contact details) to counselling, legal advice or to the Guardianship Board.

Stage 8 The Mediation Agreement

An agreement should be written on the white board (albeit in draft form) during the mediation session. This agreement can be printed from the whiteboard and signed by the participant to ensure that it is the agreement they have all have agreed to.

The agreement will be drawn up on appropriate letter head, and sent to each party as soon as possible. The document should literally mirror the agreement written on the white board during the mediation.

In the interim, a copy of the white board agreement, can be given to the participant

8.1 Time Frames within the Agreement

- An agreement could contain actions by one or more of the participant that need to be completed within a certain time. For instance, a copy of a report given to all participant by --/--/-- (date).

- An agreement could contain a review date (and a process for review)

The use of provisional agreements could be considered if the participant (particularly the person who made the Advance Care Directive) would like some to consider the matters that have been agreed.

If the mediator has a concern about any of the participants being coerced, or not fully understanding an agreement that they are a party to (particularly the person who made the Advance Care Directive) the mediator should not make the agreement. However, there could be a time where it is difficult to fully ascertain if all of the participant are comfortable with the agreement, or if further information needed to be gathered by any of the participant, prior to the final agreement being made. In such cases a provisional or interim agreement could be made by the participant. Such an agreement should state that it is a provisional or interim agreement and any time limits to the agreement and process for review.

The agreements made in the mediation are not legally binding, however, it is hoped that they are made in good faith and would be respected and followed.

8.2 Improper Agreements

In facilitative mediation model, the participants determine the outcome and formulate the agreement. However, the mediator has an ethical responsibility to ensure that the agreement reached is ethically sound and not detrimental to the person who has made the Advance Care Directive. The agreement must fit with the principles of the Advance Care Directive Act.

Stage 9 Data Collection

Data collection implemented for the Dispute Resolution Service will give an indication of the number of:

- enquiries to the service about Advance Care Directives - how may referred to LSC about completion /how many about the application of Advance Care Directives/decisions
- hits on the website - downloaded forms etc
- application forms sent to interested participant by post or email
- applications received
- relationship of applicant to the person who made the Advance Care Directive
- applications proceeding to the ' invitation to attend mediation stage' after assessment for appropriateness
- applications that did not proceed to the 'invitation to mediation stage' and reasons they did not proceed
- applications that did not proceed to mediation - and the reason they did not proceed
- mediations that took place
- mediations that were terminated without agreement
- mediations where agreements were reached
- mediations that were referred to the Guardianship Board and why
- referrals from the Guardianship Board to OPA and why
- referrals to other organisations following mediation

Demographic information will indicate

- Gender of client who made the Advance Care Directive
- Age of client who made the Advance Care Directive
- Ethnic origin of person who made the Advance Care Directive
- Relationship of person who made the Advance Care Directive with the substitute decision maker
- Area/s of authority given to the substitute / decision maker, if any
- No appointed decision-maker and if a dispute resulted in a guardian being appointed for the person
- Living arrangements of the person who made the Advance Care Directive
- Assessment of decision making capacity
- Who made the referral

10 Evaluation

10.1 Initial Evaluation From The Participant Attending Mediation

Following the mediation session/s, the participant will be invited to fill out a survey form about their experience of the process. There will be two forms:

a) for the person who made the Advance Care Directive[14]

b) for the applicant and other participant to the dispute[15]

[14] Appendix

[15] Appendix

- The participant will be encouraged to complete the form directly following the mediation but will also have the option of returning these by post.
- Assistance by an OPA staff member (not the mediator) will be given to anyone requiring help to complete the forms.
- The information collected will be recorded and analysed by the dispute resolution team using the template developed for this purpose.
- Reports will be provided to the Public Advocate on a monthly basis and discussed to assess any alterations to the service.

10.2 Initial evaluation from the mediator

Following the mediation the mediator will complete a report that will include:

- Who made the referral
- The number of participant attending the mediation session
- How the person who made the Advance Care Directive was included in the mediation
- If the person was not directly involved, to what extent was their voice brought into the mediation
- Identify any constraints or barriers to the person's views, thoughts, wishes and needs being brought into the mediation
- The extent to which the mediator was able to focus the participant on:
  - the rights of the person who made the Advance Care Directive
  - The principles of the ACD Act
  - The responsibilities of the participant in regard to the person who made the ACD
  - The responsibilities of the substitute decision maker/s
- The level of conflict between the participant
- Was there any abuse of the person who made the Advance Care Directive suspected by any of the participant - how was this addressed
- The extent to which the communication between the participant changed (improved/deteriorated) during the mediation session.
- Overall, what worked well and what didn't during the mediation
- What would have strengthened / improved the mediation

10.3 After a three month period:

the participant will be asked to complete a follow - up survey.

10.3.1 Survey with accompanying letter/email will be sent to the participant involved in mediation (other than the person who made the Advance Care Directive).

The participant will be given the option of:

a) completing the survey form and returning it by mail[16].

b) making a time to speak with an OPA staff member (other than the mediator) to complete the form and provide any additional information. This contact could be made via telephone or in person at the OPA Office.

10.3.2 Evaluation with the person who made the Advance Care Directive will be depend on an number of considerations, including the method used to include the person in the mediation process:

a) If directly involved, the process described above may be appropriate for the person who made the Advance Care Directive. If a support person assisted the person during the mediation process, she/ he may be able to assist the person to complete the form.

b) If the person was indirectly involved, the advocate/substitute decision maker who represented her/him will be asked to fill out the survey, preferably in consultation with the person.

The form can be emailed/posted to the OPA or can be completed with an OPA staff member (not the mediator) over by telephone or in person in the OPA Office.

The information collected will be recorded and analysed by the dispute resolution team using the template developed for this purpose.

Reports will be provided to the Public Advocate every three months and discussed to assess any alterations to the service.

10.4 Independent Evaluation

The OPA Dispute resolution service should be independently evaluated 12 months from the commencement of the Service.

In addition to an evaluation process developed by the evaluator, she/ he will have full access to the surveys received and reports to the Public Advocate.

[16] To be developed

10.5 Feedback and Complaints Procedure

Office of the Public Advocate Complaints Policy

Complaints or feedback (both positive and negative) about the mediation service should be to the mediator in the first instance as this may resolve the issue with no need to proceed further.

If the complainant does not wish to speak with the mediator, then the complaint can be made to the Public Advocate. Complaints to the Public Advocate can be made over the phone, in writing or in person.

Written notification will be given to the person making the complaint within seven days. The concerns will be investigated with a written response sent to the complainant within 21 days. If this time line is not able to be achieved the person making the complaint will be advised of the progress to date.

If the person making the complaint would like someone other than the Public Advocate to address the complaint, they can contact the State Ombudsman's Office in regard to the matter.

APPENDIX 1. PRINCIPLES OF THE ADVANCE CARE DIRECTIVE BILL (SECTION 10)[17]

The following Principles must be taken into account in connection with the administration, operation and enforcement of the Act (including, to avoid doubt, the resolution of disputes under Part 7)

10—Principles : The following principles must be taken into account in connection with the administration, operation and enforcement of this Act (including, to avoid doubt, the resolution of disputes under Part 7): (a) an Advance Care Directive enables a competent adult to make decisions about his or her future health care, residential and accommodation arrangements and personal affairs either by stating their own wishes and instructions or through 1 or more substitute decision-makers; (b) a competent adult can decide what constitutes quality of life for him or her and can express that in advance in an Advance Care Directive; (c) State to the contrary, to be presumed to have full decision making capacity in respect of decisions about his or her health care, residential and accommodation arrangements and personal affairs; (d) a person must be allowed to make their own decisions about their health care, residential and accommodation arrangements and personal affairs to the extent that they are able, and be supported to enable them to make such decisions for as long as they can; (e) autonomy can be exercised by making self-determined decisions, delegating decision making to others, making collaborative decisions within a family or community, or a combination of any of these, according to a person's culture, background, history, spiritual or religious beliefs; (f) subject to this Act, an Advance Care Directive, and each substitute decision-maker appointed under an Advance Care Directive, has the same authority as the person who gave the Advance Care Directive had when he or she had full decision making capacity;	(g) a decision made by a person on behalf of another in accordance with this Act— (i) must, as far as is reasonably practicable, reflect the decision that the person would have made in the circumstances; and (ii) must, in the absence of any specific instructions or expressed views of the person, be consistent with the proper care of the person and the protection of his or her interests; and (iii) must not, as far as is reasonably practicable, restrict the basic rights and freedoms of the person; (h) in the event of a dispute arising in relation to an Advance Care Directive, the wishes (whether expressed or implied) of the person who gave the Advance Care Directive are of paramount importance and should, insofar as is reasonably practicable, be given effect; (i)subject to this Act, in determining the wishes of a person who gave an Advance Care Directive in relation to a particular matter, consideration may be given to— (i)any past wishes expressed by the person in relation to the matter; and (ii)the person's values as displayed or expressed during the whole or any part of his or her life; and (iii)any other matter that is relevant in determining the wishes of the person in relation to the matter.

[17] ACDs Bill, 2012. Section 10 (SA Parliament)

APPENDIX 2 CHARTER OF RIGHTS AND FREEDOMS OF OLDER PERSONS[18]

Older persons are entitled to respect and protection of their basic rights and freedoms, and bear a corresponding obligation to respect and protect the rights and freedoms of others. All older persons have the following rights and freedoms:[19]

- To be treated with dignity and humanity
- To exercise personal self-determination
- To freedom of movement, including the right to choose their place of residence
- To freedom from torture or other forms of cruel, inhuman or degrading treatment
- To liberty and security of the person
- To freedom from exploitation and physical, social, psychological and sexual abuse
- To freedom from discrimination of all kinds
- To recognition as a person before the law
- To equality before the law
- To life
- To adequate food, clothing and shelter
- To enjoy the highest attainable standards of physical and mental health
- To freedom from arbitrary or unlawful interferences with his/her privacy, family, home or correspondence
- To family life and to have their family unit respected by others, including governments
- To freedom of association
- To participate in the social and cultural life of the community
- To freedom of thought, conscience and religion
- To freedom of opinion and expression
-
- To freedom from arbitrary or unlawful interferences with his/her privacy, family, home or correspondence
- To family life and to have their family unit respected by others, including governments
- To freedom of association
- To participate in the social and cultural life of the community
- To freedom of thought, conscience and religion
- To freedom of opinion and expression

[18] Adapted from the United Nations Principles for Older Persons, UN General Assembly adopted on December 16, 1991 by Assoc. Professor Wendy Lacey, Closing the Gaps Report (Vulnerable Adults Project, Office of the Public Advocate 2011)

[19] Human rights are not absolute, but may only be subject to reasonable limits in accordance with law as can be demonstrably justified in a free and democratic society. Given the absence of human rights legislation in South Australia, any framework for adult protection would be best served through the express inclusion of these fundamental rights and freedoms. This could be achieved through their inclusion either in the body of a policy or statute, or as an appendix or schedule. They could also be adopted in a stand-alone but non-binding Charter (itself adopted as a policy instrument) which would be separate from any protocol, law or policy.

Appendix 3 CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITES[20]

Article 1 - Purpose

The purpose of the present convention is to promote, project and ensure that the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities and to promoted respect for their inherent dignity.

Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.

Article 3 - General Principles

The principles of the present Convention shall be:

a) Respect for inherent dignity, individual autonomy including the freedom to make one's own choices and independence of persons;
b) Non discrimination;
c) Full and effective participation and inclusion in society;
d) Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;
e) Equality of opportunity
f) Accessibility;
g) Equality between men and women
h) Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

Article 5 - Equality and non- discrimination

1. States Participant recognise that all persons are equal before and under the law and are entitled without any discrimination to the equal protection and equal benefit of the law.
2. States Participant shall prohibit all discrimination on the basis of disability and guarantee to persons with disabilities equal and effective legal protection against discrimination on all grounds.
3. In order to promote equality and eliminate discrimination, States Participant shall take all appropriate steps to ensure that reasonable accommodation is provided.
4. Specific measures which are necessary to accelerate or achieve de facto equality of persons with disabilities shall not be considered discrimination under the terms of the present convention.

Article 16 - Freedom from exploitation, violence and abuse

1. States participant shall take all appropriate legislative, administrative, social , educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender - based aspects.

2. States participant shall also take all appropriate measures to prevent all forms of exploitation, violence and abuse by ensuring inter alia, appropriate forms of gender-and age- sensitive assistance and support for persons with disabilities and their families and caregivers, including through the provision of information and education on how to avoid, recognise and support instances of exploitation, violence and abuse. States Participant shall ensure that protection services are age, gender and disability sensitive.

3. In order to prevent the occurrence of all forms of exploitation, violence and abuse. States participant shall ensure that all facilities and programmes designed to serve persons with disabilities are effectively monitored by independent authorities.

4. States participant shall take all appropriate measures to promote the physical, cognitive and psychological recovery, rehabilitation and social reintegration of person with disabilities who become victims of any form of exploitation, violence or abuse, including through the provision of protection services. Such recovery and reintegration shall take place in an environment that fosters the health, welfare, self-respect, dignity and autonomy of the person and takes into account gender and aged specific needs.

5. States Participant shall put in place effective legislation and policies, including women and child focused legislation and polices to ensure that instances of exploitation, violence and abuse against persons with disabilities are identified, investigated and, where appropriate, prosecuted.

[20] From A Guide for Elder Abuse Protocols, Elder Abuse Prevention Unit, UnitingCare Community and Queensland Gvt. Department of Communities

Full convention http://www.un.org/disabilities/convention/conventionfull.shtml

Model: Intuitively, you build a model to represent "something", and that something could be a building, or some solution that you have in mind. In other words, a model is a simplified version of something so that you can better analyse or visualise.
Framework: It is not a model of something. A framework is a loosely defined structure of ideas, principles, methods, and people. The purpose of a framework is that if you need to build something, or solve some problem, you can use the framework as your guide, but, of course, you have to fill in the details in the model, in order to reach on a concrete solution.