



OFFICE OF THE PUBLIC ADVOCATE



ANNUAL REPORT 2013

The Public Advocate is an Independent Official accountable to the Parliament of South Australia

South Australian Office of the Public Advocate Annual Report 2013

ISSN 1837-5480 (Print)

ISSN 1837-5499 (Online)

Front Cover: Daffodil Dreams by Keverne John Moyle

Exhibition notes from "Stories, Perspectives Art Exhibition 2013" Purple Orange, SALA

This piece is about the artist's favourite story The Wizard of Oz. The artist moved from house to house as a child and living with Asperger's Syndrome meant he felt very unsettled. The painting represents his desire to settle down in a safe place with his constant companion, his dog, Jack. The St Deverne Daffodils symbolise the artist's English heritage.

Office of the Public Advocate
ABC Building
Level 7, 85 North East Road
Collinswood SA 5082

Phone: 08 8342 8200

Fax: 08 8342 8250

Email: opasa@opa.sa.gov.au

ABN No: 21 587 257 523

30 September 2013

The Hon. John Rau MP
Attorney-General
45 Pirie Street
ADELAIDE SA 5000

Dear Mr Attorney

I have the honour to present to you the nineteenth Annual Report of the Public Advocate, as per the provisions of Section 24 of the *Guardianship and Administration Act 1993*.

This Report covers the period from 1 July 2012 to 30 June 2013. Part A is an overview of major matters arising during the year, and includes a review of programs, consideration of unmet need, and advocacy positions taken by the Office. Part B provides statistical data on direct client services provided by our Office.

Yours Sincerely

A handwritten signature in black ink that reads "John Brayley". The signature is written in a cursive, flowing style.

John Brayley
PUBLIC ADVOCATE

Office of the Public Advocate Annual Report

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Introduction

The 2013 Annual Report of the Office of the Public Advocate is divided into two parts.

Part A comprises a commentary on the general functions of the Public Advocate as described in Section 21 of the *Guardianship and Administration Act 1993*. These functions include program review, analysing unmet need or inappropriately met need, promoting rights, monitoring legislation and monitoring the implementation of the *Guardianship and Administration Act*.

Part B summarises the nature and level of services provided to individuals and families by the Office of the Public Advocate. These services include advocacy, guardianship, investigation and education activities.

This year's report describes progress in the uptake of supported decision making — the process where people with a decision making disability are supported to make their own decisions rather than have decisions made for them, as a vehicle for ensuring people retain autonomy and personal control in their lives wherever possible. This features in the implementation of policy and legislation at both a Commonwealth and State level, with requirements to respect autonomy and provide support now part of the National Disability Insurance Scheme, individualised funding in South Australia, the *Advance Care Directives Act 2013*, and new amendments to South Australia's *Disability Services Act 1993*.

This Annual Report makes the case for legislative recognition of supported decision making in the *Guardianship and Administration Act 1993*, which could be achieved by aligning its principles with those of the new *Advance Care Directives Act 2013*. This can then uphold the autonomy of more people.

During the year, we have seen progress in Elder Abuse policy, as the State drafts a rights-based policy in this area. While we have been pleased with this progress, the current policy does not go far enough. The Closing the Gaps report, prepared by this Office in conjunction with a team from the University of South Australia and looking at the needs of vulnerable older adults, recommended the enactment of adult protection legislation to ensure a coordinated, reliable and effective response. We hope that any new policy can define expectations for what older people should receive to prevent and respond to abuse, and that this is a stepping stone to new laws.

At the same time, guardianship appointments to our Office have significantly increased, with a 50% increase in two years, a phenomenon at odds with state, national and international directions which have sought to limit the role of guardianship. We remain proud of the guardianship work we do, which can be essential for many people. Other people though would be better served by alternative measures to guardianship. For example for people at risk of abuse, where we know that there is evidence of the effectiveness of proactive adult protection responses that link professional social work interventions to justice services, and the full range of agencies that assist older people. There are good reasons to actively consider funding rights-based approaches that have been effective in other countries, than to continue with current approaches which may ultimately be unsustainable, and not reach all those in need.

This year, the report further considers gaps in forensic mental health care, and a new topic: the rights of public sector workers who experience a mental illness.

Part A:

General Functions of the Public Advocate

Including Program Review, Analysing Unmet Need, Promoting Rights and Interests, and Monitoring the Act

Reviewing Programs and Identifying Unmet Need

Disability Services

Guardianship and Administration Act 1993

Section 21 (1) The functions of the Public Advocate are—

- (a) to keep under review, within both the public and the private sector, all programmes designed to meet the needs of mentally incapacitated persons;
- (b) to identify any areas of unmet needs, or inappropriately met needs, of mentally incapacitated persons and to recommend to the Minister the development of programmes for meeting those needs or the improvement of existing programmes;

Introduction

For the disability sector, 2012–2013 has been a landmark year as legislation, plans and infrastructure have been put in place for DisabilityCare Australia (DCA).

While this is highly positive, there are still so many unanswered questions from the perspective of this Office. First, the scheme is intended to provide choice and control for people with disabilities and their families. Will the scheme's apparent commitment to supported decision making wherever possible be delivered or could the commitment in legislation and rules not be matched by actual changes in practice? Will people and their families be empowered, or will power still remain with government, professionals and providers because of what an overseas expert has described as "the centralised bureaucratic nature of the scheme?" (Duffy, 2012).

Second, there is a group of people who do not themselves seek a service, but need 'active engagement' by services to provide help. An assertive approach is not coercive, in that the person receiving a service still has choices and consents to services. Some people with intellectual disability, brain injury, autism and persistent psychiatric disability, including those who are at risk of self-neglect, homelessness or imprisonment, may not initially seek a service, but when presented with services, they come to value support that has been assertively offered and delivered. How can DisabilityCare Australia, which has its origins in an insurance model where consumers make claims and seek services, ensure that this group does not miss out? It is known that this is a group that can underuse their health entitlements through Medicare Australia, so there is a need to ensure that these people do not underuse their support entitlements through DisabilityCare Australia.

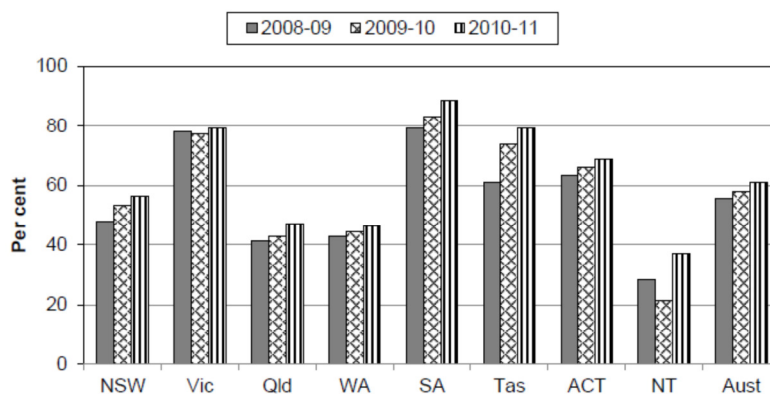
Third, in South Australia, the scheme is being trialled for children but not for adults, so direct experience of the scheme assisting adults will not occur until 2018. There will still be valuable lessons from the trial with children that will apply to all age groups. Yet some of the answers will need to be gleaned from interstate DisabilityCare Australia trials for adults. For example, we hope that DCA will help adults who belong to the dual diagnosis group — people who have both a disability and persistent mental illness, who currently can fall through the gap between underfunded disability and mental health services. Because DCA is inclusive of people with an ongoing psychiatric disability, people in the dual diagnosis group will have all their needs met from the one scheme. However, we will not know until 2018 how and to what extent these important theoretical benefits might be realised.

Each year in the Annual Report, we have reviewed Disability Services provision from the Productivity Commission's data on unmet need. This continues to be a relevant exercise as the responsibility for the delivery and funding of disability services remains the responsibility of the State Government. In future years, any data used for this purpose will need to be age-adjusted to exclude children receiving care through DCA.

Update on service use and unmet need

The Productivity Commission's 2013 Report describes services in 2010–2011 provided under the National Disability Agreement (Productivity Commission, 2013). South Australia again in these latest data has the highest rate of access to government-funded specialist disability services. Over 80% of the potential number of users accessed a service, compared to a national figure of 61.2%. This is illustrated in the next figure.

Figure 14.5 Users of NDA specialist disability services as a proportion of the estimated potential population^{a, b, c}



^a See section 14.7 for information on how the potential population is defined. ^b Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues. ^c The scope of the potential population for 2008-09, 2009-10 and 2010-11 has changed and is substantially lower than the potential population reported in the 2012 Report and earlier editions. Data for 2008-09, 2009-10 and 2010-11 are not comparable to those for previous years. See details in box 14.4.

Figure A1: Users of NDA (National Disability Agreement) services as a proportion of the estimated potential population (Reproduction of Figure 14.5, Productivity Commission, 2012)

With respect to the level of unmet need, in 2012 the methodology for estimating the potential population was refined, for both new data, and backcast on old data. While now 15–20% of the potential population for services are not receiving any, this is considerably less than the former, much higher estimate of the number of people who might need a service, which meant that only 45–50% of the population in need was catered for.

Each year, we have looked at what we see as a corollary statistic — the funding allocated per user. As noted before, while South Australia can be pleased with the high rate of access to services, government expenditure per user is still reported to be lower in South Australia than in other states.

Figure 14.29 Estimated annual government expenditure per user of NDA State and Territory administered services, 2010-11^{a, b, c, d}

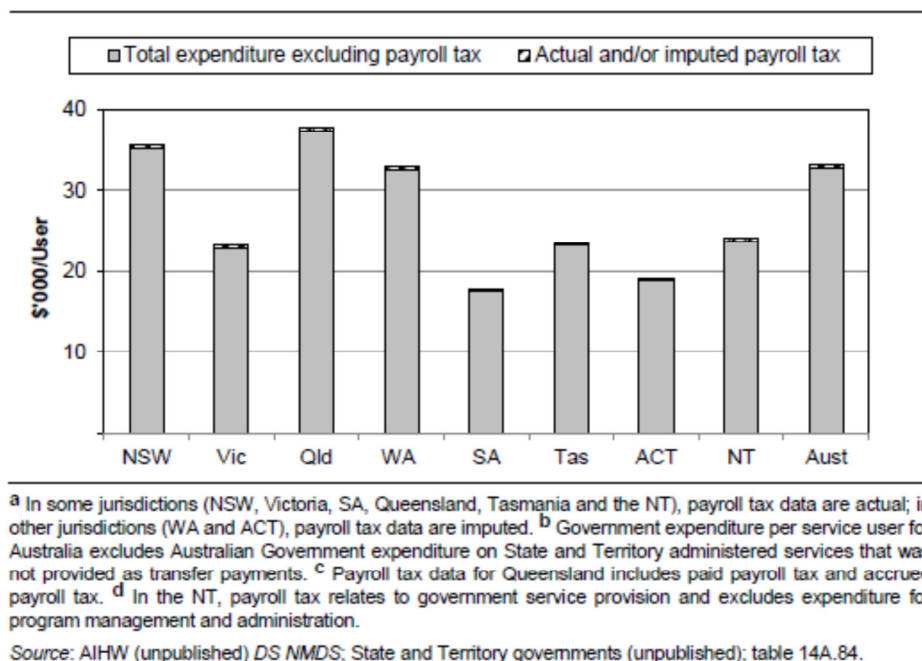


Figure A2. Estimated annual government expenditure per user of NDA (National Disability Agreement) State and Territory Administered Services (Reproduction of Figure 14.29 of the Productivity Commission 2012)

Unmet need data

South Australia had been releasing unmet need data on a 6-monthly basis since 2008, and since 2012, this information has been released monthly.

As at June 2013, there were 2809 people on the unmet needs list, up from 2763 the year before. 1384 were on Category 1 (last year 1190) and 908 on Category 2 (last year 1028). The definitions of urgency of need are as follows:

Category 1: Critical (homeless/immediate and high risk of harm to self or others);

Category 2: Evident (risk of harm to self or others/ risk of homelessness);

Category 3: Potential (deteriorating health and/or ability of a consumer or carer); and

Category 4: Desirable (enhancement of quality of life).

Services described include: *Supported Accommodation* — this comprises clients who are referred to the Accommodation Placement Panel; *Personal Support* — it describes clients requiring up to a maximum 50 hours per week in-home support. If the number of hours is greater than this, the need is considered to be for supported accommodation; *Respite*; *Community Access* — includes day options (daytime activity), learning and life skills development, recreation and community access; and *Community Support* — includes a range of therapies and interventions.

Figure A3 charts unmet need over time for all four categories of service. Figure A4 demonstrates the ongoing increase in the Category 1 unmet needs list. As at June 2013, 539 people are on the Category 1 list waiting for supported accommodation, a small reduction compared to the 543 clients in this group last year.

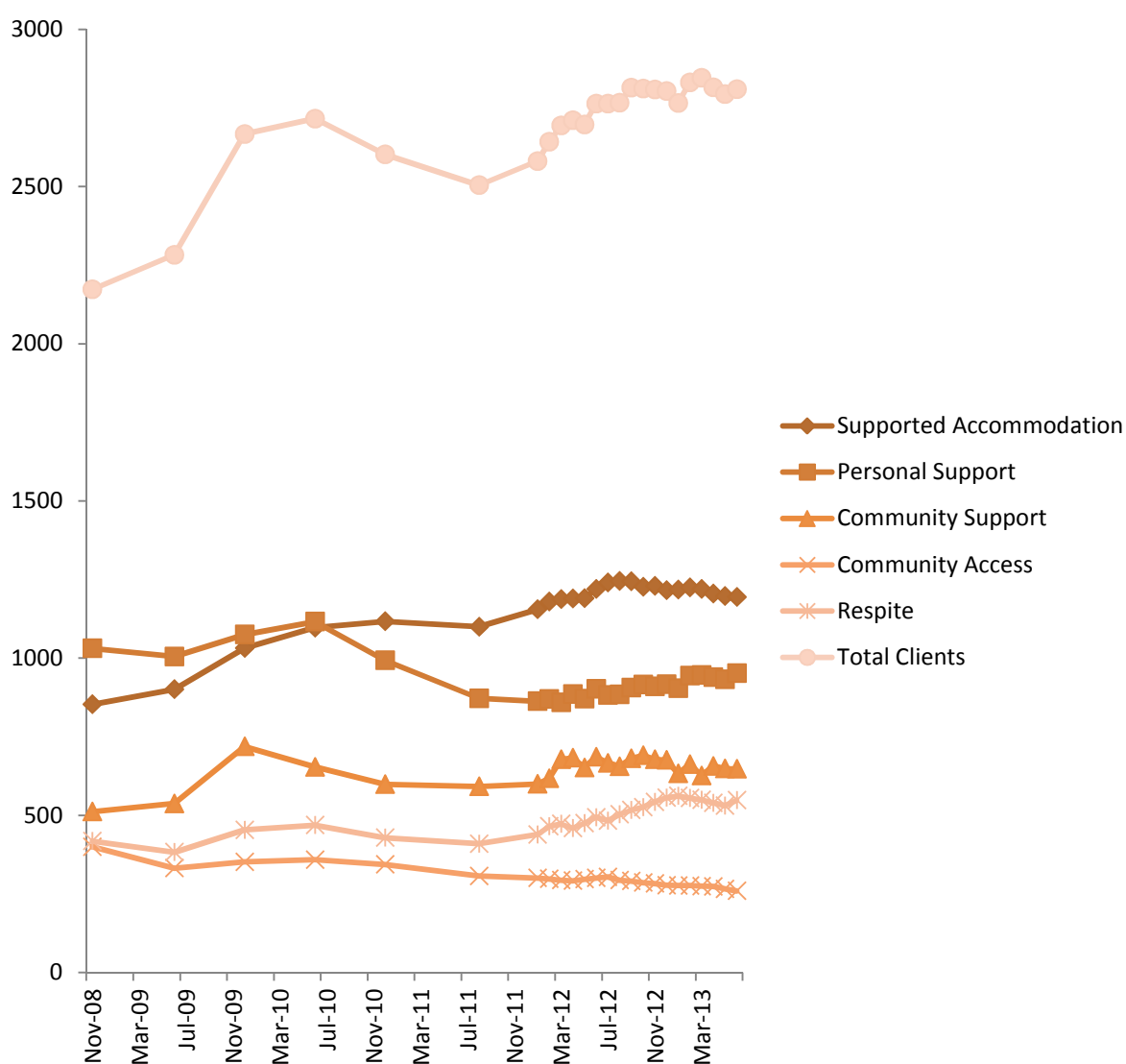


Figure A3. Increase in unmet need list November 2008 to June 2013, for clients in all categories

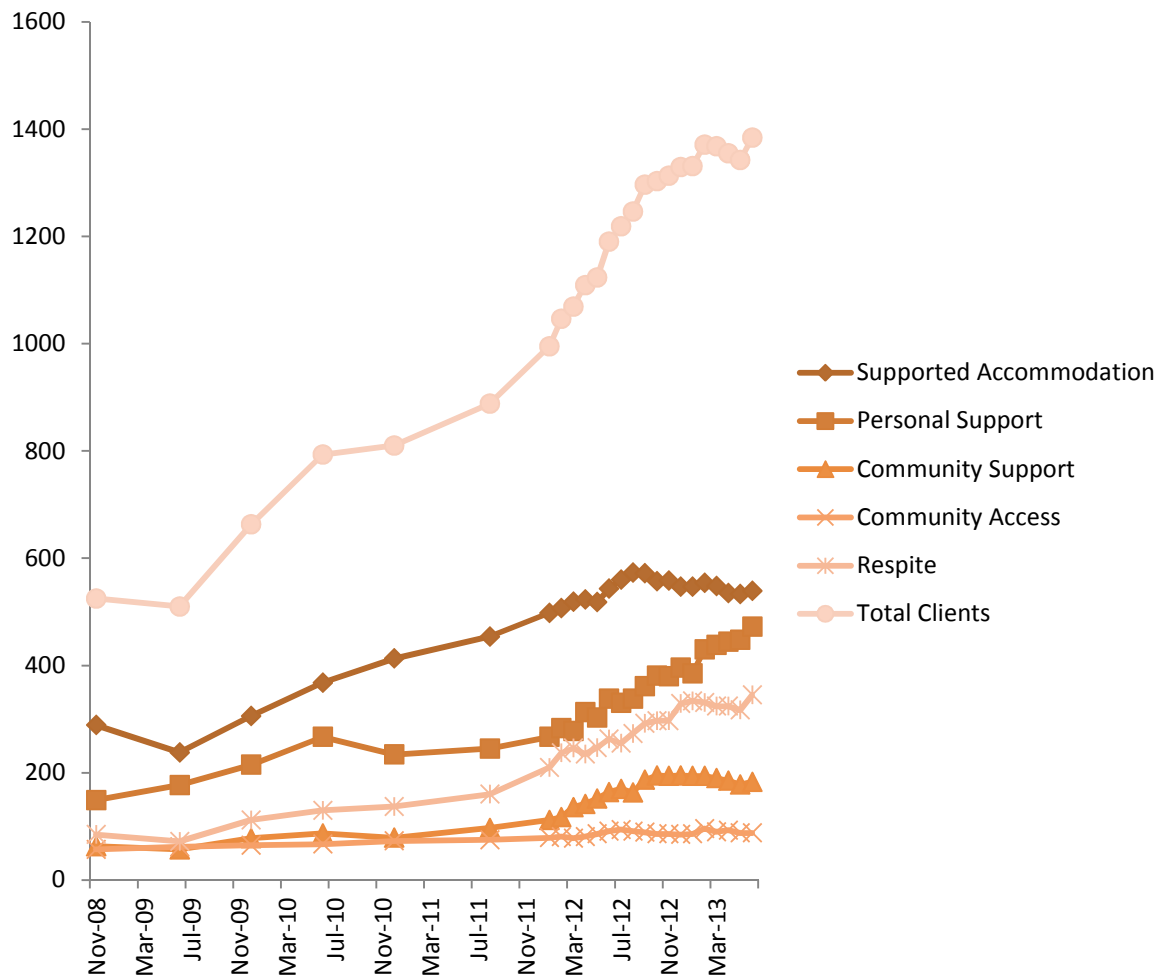


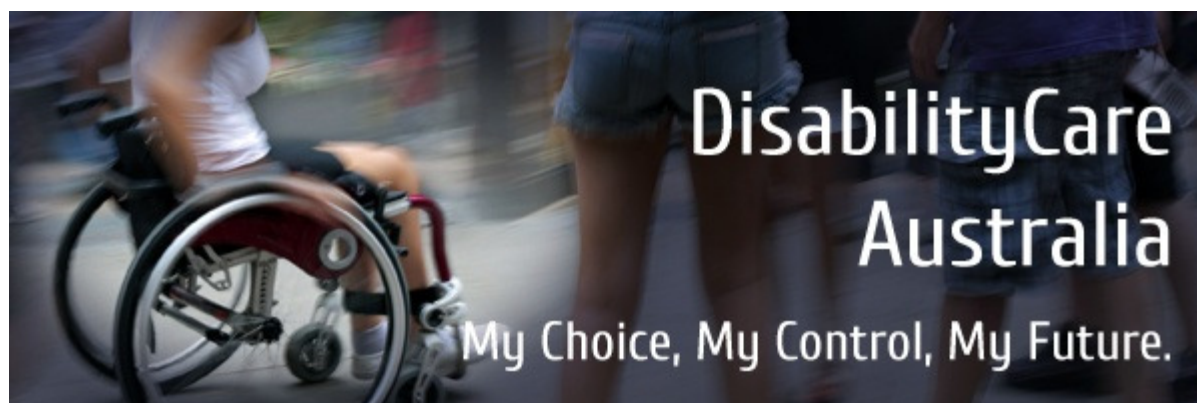
Figure A4. Increase in unmet need list November 2008 to June 2013, for clients in Category 1

The recommendation of the Social Inclusion Board was that the Category 1 and 2 lists need to be funded within one budget cycle (Priority Action Recommendation 2, Social Inclusion Board, 2011). If this were accepted, the needs of people who have a disability who are at risk of harm to themselves or others, or who are homeless or at risk of homelessness would be met by June 2013.

In spite of increased funding allocations to disability services occurring both now and in future years, this priority action has not been addressed.

The ongoing unmet need, particularly in the two highest and at-risk categories on this list (Categories 1 and 2, Critical and Evident risk) is a significant cause for concern, particularly as we believe that the people on this list are mostly adults, who as a group will not be eligible for the entitlement provisions of DisabilityCare Australia, until 2018.

Supported Decision Making and DisabilityCare Australia



Acknowledgement: Image taken from a flyer for the DisabilityCare Australia Conference held in June 2013

Introduction

Supported Decision Making is a key principle in the operation of the National Disability Insurance Scheme (NDIS). The *National Disability Insurance Scheme Act 2013* provides, among other objects, that people are supported to exercise choice and control over the planning and delivery of supports (Australian Parliament, 2013). A principle of the Act is that people with disability have the same rights as other members of Australian society to be able to determine their own best interests, including the right to exercise choice and control, and to engage as equal partners in decisions that will affect their lives, to the full extent of their capacity (Australian Government, 2013a).

This focus on supported decision making in the core documents underpinning the NDIS is welcome, particularly as for many people, the processes around the NDIS will encompass key decisions that a person might make about their life, not unlike the types of decisions made by people in the South Australian Supported Decision Making trial.

Elsewhere in this report, under the section on Promoting Rights, we have made recommendations on how supported decision making can be implemented on a community-wide basis using a population model, and made recommendations for law reform in state guardianship law to recognise supported decision-making agreements.

The provision of disability supports is fundamental to a person's life. Major decisions need to be made by a participant, not just about the specific services purchased in a plan, but what personal goals and aspirations a plan will support. Therefore, the reference to supported decision making in NDIS legislation and associated rules could be as important as the reference to supported decision making in state-based guardianship and administration legislation.

There will always be a question about the implementation of the Objects and Principles in such an Act. However, we will need to observe what happens at a distance. Because the South Australian roll-out of the NDIS is focused entirely on children, which in itself is a good program, we will not as a state develop the experience of supporting people to make their own decisions about disability services delivered by DisabilityCare Australia (i.e., the NDIS). There will be opportunities for local experience through individualised funding programs delivered by the

Department for Communities and Social Inclusion (DCSI), and of course, the opportunity to receive reports of supported decision making from states that have trials involving adults.

This section first considers the NDIS Nominee Rules, as they might determine the operation of supported and substitute decision making. Then we discuss two projects from the Practical Design Fund for the NDIS commissioned by the Department for Families, Housing, Community Services and Indigenous Affairs.

NDIS Nominee Rules

The NDIS Nominee Rules (Australian Government 2013b), set out the rules for others to act on behalf of a person.

The Centrelink term ‘nominee’ describes a person who can act on behalf of another in dealing with the agency (DisabilityCare Australia). The rules define a plan nominee, who can do any act that a participant might undertake, and a correspondence nominee who has a narrower range of duties such as requesting information or receiving notices from the agency.

The Nominee Rules are very similar to guardianship and administration legislation. The nominee is appointed as a last resort. Decision making capacity is assumed, and it is not necessary to appoint a nominee “where it is possible to support, and build the capacity of, participants to make their own decisions for the purposes of the NDIS” (Australian Government 2013 (b), s 3.1).

A nominee can be appointed at the request of a participant or by the Chief Executive. A plan nominee appointed at the request of a participant can only act if it is not possible for the participant to do or be supported to do the act himself or herself, or if the participant does not want to do the act. A plan nominee appointed by the Chief Executive can only act if the nominee considers that the participant is not capable of doing the act.

The Chief Executive can specify limitations on the instrument of appointment, in a similar way that a Guardianship and Administration order might be limited. The rules state that as an example, “the appointment might be restricted so as to prevent the nominee from specifying the goals, objectives and aspirations of the participant. In such a case, the nominee might still have authority with respect to the management of the funding under a plan” (Australian Government 2013 (b), s 3.8).

The rule also contains a “duty to apply their best endeavours to developing the capacity of the participant to make their own decisions, where possible to a point where a nominee is no longer necessary” (Australian Government 2013(b), s5.10).

To implement this, DisabilityCare Australia has operational guidelines for Supporting Participant’s Decision Making (Australia, 2013). These make clear that some people may wish to be supported as they make decisions and DCA will support the person’s decision making process through facilitating natural supports, acknowledging and respecting advocacy, maintaining a person-centred approach, providing information, and helping a person develop capacity. The guidelines distinguish between supported decision making, and substitute decision making by nominees, and refer to the duty of plan nominees to support the participant make his or her own decisions wherever possible.

Overall, the NDIS is to be commended on its recognition of supported decision making as a vehicle to give people with disability choice and control.

In early 2013, the Public Advocate met with David Bowen, the Chief Executive of the NDIS Transition Agency, and Nick Hartland of the Department for Families, Community Services and Indigenous Affairs, and presented the outcomes of the South Australian Supported Decision Making Project.

The NDIS Nominee Rules and the Stepped Model of Supported and Substitute Decision Making

In March 2013, the Office of the Public Advocate provided feedback on the draft Nominee Rules that were developed at the time (Office of the Public Advocate, 2013).

While pleased to see the important objectives and principles relating to supported decision making incorporated into the Act and the Nominee Rules, we were concerned about their implementation. The solution that we put forward was to separate the multiple functions of plan nominees into separate appointments: to be explicit when a plan nominee is appointed in a support role and might act on and communicate decisions, but not make the decisions; and when appointed in a substitute role where the nominee is empowered to make the decision as well as communicate it and act on it. We also suggested separating the financial management power from the personal decision making power, as some people might need practical help to manage the finances and therefore still need a nominee, but not want to give the nominee authority to decide on services and accommodation. Hence, the single-plan nominee, as originally put forward in our proposal would be divided into three types: (1) Plan nominee (supported decision making), (2) Plan nominee (substitute decision making), and (3) Plan nominee (financial management).



Although not stated at the time, the appointment of a Plan nominee (supported decision making) would not be required for supported decision making to occur, as it can happen without such an appointment. However, if a supporter needs to act on and communicate the decision, then a formal appointment could assist, of course limited to the support role.

This suggestion of creating three types of appointment was not taken up. However, in the final version of the Nominee Rules, the power of the Chief Executive to specify limitations in the plan nominee's powers was expanded upon, and the Rules give the example of the Chief Executive limiting the nominee's power to determine personal goals, objectives and aspirations for the individual, while separating this from the management of finances, and permitting this to occur. As well, the Chief Executive has discretion to select more than one nominee, and limit the areas in which each nominee operates.

We think these additional considerations added to the Rules are important, although we would hope that the Chief Executive in using these powers in accordance with the principles of the Act, would be able to put in place arrangements that the person with a disability wants, when that person might otherwise have difficulty expressing their view because of family conflict or some other reason.

As was seen in the South Australian Supported Decision Making trial, some people need more than one supporter. For example, if a young adult wants to move out of home to live independently and this wish is opposed by a parent, the young person might choose a supporter outside of the family to make this decision, but be happy to have parental support for less contentious decisions. Also, with respect to the allocation of substitute decision-making responsibility: it is not uncommon to have substitute decision makers for accommodation and lifestyle decisions (the remit of guardians) and different ones for financial management (the remit of administrators).

The settings for the NDIS are now in place. A lot will depend on how the facilitation staff of DisabilityCare Australia implement the Act, the Rules, and apply the operational guidelines. It may work. If it does, it will give people with intellectual disability, brain injury and autism spectrum disorders the personal choice and control intended by the Act; particularly, as traditional assumptions that many people cannot make decisions need to be overcome. We think this should be carefully considered in the evaluations of the trial sites. Should this not be happening, then a reconsideration of the more granular definitions of distinct plan nominee appointments for supported decision making, substitute decision making and financial management would merit consideration.

Practical Design Fund Projects

This section considers two projects that specifically considered the needs of people with cognitive disability and the NDIS. The first looked at unintended consequences and safeguards. The second looked at services for people with an intellectual disability who are in contact with the criminal justice system.

Unintended Consequences and Safeguards of Self-managed Supports

This project is a detailed and comprehensive review of what might go wrong in the implementation of DisabilityCare Australia, and how this can be prevented (Lumin Collaborative, 2013). It has been authored by Professor Richard Bruggeman and Ms Colleen Johnson, and considered key risks, based on national and international research. These include support planning, monitoring, evaluation and quality assurance.

Their discussions supported the need nationally, for what can be a time consuming and iterative process, to permit people to be involved in decision making to the maximum extent possible. They refer positively to the work of our own Supported Decision Making team and committee:

Firstly we note the ground-breaking work of the South Australian Public Advocate on supported decision-making, and the determination of the scheme to include people to the maximum extent possible in the decision making process. This leads to the second point: that for some, achieving the 'maximum extent' might require a time-consuming and iterative process. This has been reinforced in our discussions with individuals, families, advocates and the 'linking' agencies we have visited. They have emphasised that developing trust and respect is essential to getting it right. Thirdly, we wonder whether all people will fit neatly into the 'plan/allocate resources/ make services happen' model, or whether for some the journey of discovery will dictate a more flexible approach (Lumin Collaborative, 2013).

Later in the report, the authors refer to risk management considerations that have diminished the personal authority of people with cognitive disabilities to make decisions affecting their lives.

An additional issue for many people with disabilities, particularly cognitive disabilities, is an excessive concern for their safety, often at the expense of development and personal sovereignty. Learning can be a very risky business and many people with disabilities have not been allowed to take those risks. Indeed, within the disability sector, many recognise this clash between safety and development as one of the key philosophical touchstones of disability supports.

The time taken to empower individuals may be less in the future, as more people gain confidence, and attitudinal and environmental barriers in the community are overcome. In the interim, there is a risk that rights might be seen to be upheld because of the very structure of individualised funding, but without a concerted effort to assist and support people to make decisions, those with cognitive disabilities may not realise all the benefits of the scheme.

With respect to quality and safeguarding, the Lumin Collaborative dispelled the notion that market forces would resolve these issues. The report reviewed the risks of abuse and exploitation of people who experience disabilities and recommended that there be nationally consistent adult protection measures, facilitated by the development of interagency agreements in each jurisdiction.

People with intellectual disability in contact with the criminal justice system

This project was undertaken by Jim Simpson of the NSW Council for Intellectual Disability. Our Office would endorse key recommendations of the report (NSW Council for Intellectual Disability, 2013).

This report notes that offenders with an intellectual disability, who can have unstable and inappropriate accommodation placements and high support needs, are unlikely to seek out the NDIS. They can be reluctant to identify themselves as experiencing a disability, an observation we also hear in South Australia from those who work in the courts.

To meet the needs of this group, DCA will need to provide active outreach and engagement by the scheme staff, and/or active linkages with those working in the justice system. Court diversion and early intervention schemes may have key roles (NSW Council for Intellectual Disability, 2013).

The report notes that for DCA, the central issue is functional capacity and there will be flexibility in not applying a rigid cut-off based on arbitrary IQ scores.

This is also a group that can experience co-morbid mental illness and needs effective linkages with mental health services.

At this Office, we agree with the need for assertive outreach services that connect with, and assist people who might otherwise themselves not see the need to seek care. It is possible to do this while still respecting the decision making autonomy of the person who is being engaged, and such models can provide an effective practical form of intervention. Some people may not have others to suggest as nominees, and offering a useful effective

intervention, such as good supported accommodation, can provide for outcomes that cannot be obtained by taking over decision making through guardianship and forcing an outcome.

Summary

Supported Decision Making provides a strategy to ensure that people who have a cognitive disability can have maximum choice and control as they participate in the NDIS. The principles are in the NDIS Act and in the Nominee Rules.

This is a very positive development, and its success will depend on the work of DCA facilitators in upholding key principles. Careful consideration and evaluation of the NDIS pilots in other Australian states will provide valuable learning about the operation of the scheme when it commences operating for adults in South Australia from 2018.

The program will also need to offer an assertive response to people with an intellectual disability in contact with the criminal justice system, who may need services proactively offered to them.

Reviewing Programs and Identifying Unmet Need

Mental Health

Introduction:

In our 2012 Annual Report, we considered Progress in Mental Health Reform (pages 44–48) and saw the need for a review, to consider the operation of the South Australian Stepping Up model and benchmarking of services for people with a mental illness (Office of the Public Advocate, 2012).

This year, Minister Snelling commissioned an independent review by Ernst and Young (EY) of South Australia's stepped system of care; a review that would also describe how mental health services respond in times of high demand.

The following discussion considers this review in the context of the National Mental Health Commission's National Report Card on Mental Health and Suicide Prevention, released in late 2012, and its broad recommendations about planning mental health services.

The point for the future is that both service planning and reviews such as the EY report could be potentially more effective if there was national agreement on service models and targets. National agreement is needed on what the service components should be that make up a comprehensive, integrated, mental health service and what the target should be for the volumes of each level of intervention that is provided.

Progress in jurisdictions can then be judged against an agreed target, rather than the average performance of other jurisdictions, the statistical comparator currently relied on in reviews such as that of the South Australian EY report.

National Mental Health Reform

The Commission in its Report Card recommended that all governments must prioritise the development and implementation of a nationally agreed mental-health planning framework. The framework should tell us what services people should get regardless of where they live (National Mental Health Commission, 2012). The Commission expands on this: "It must give a clear picture of the appropriate coverage, levels and range of mental health services needed at a regional level along with the workforce mix needed to deliver it."

The Commission also says that governments must be brave enough to set goals and targets for improving mental health and reducing suicide. The Commission wants the Council of Australian Governments (COAG) to give it the role of monitoring progress.

South Australia has a respected framework, the Stepping Up model, which in turn is conceptually based on the Tolkien II model of the World Health Organization Collaborating Centre for Classification and Mental Health (Andrews & the Tolkien II team, 2006). Collectively, this type of work can form both a conceptual and statistical basis for developing a national framework

that not only covers 24-hour residential type services and wards, but the full range of community interventions.

Ernst and Young Report

The Ernst and Young report endorsed the South Australian Stepping Up report from 2007, noting that its basis and assumptions compare favourably with current evidence-based practice but that it has encountered a clinically risk-averse culture in some community and acute mental health services, increasing the likelihood of referral for admission and reducing the potential for early discharge. Amongst other strategies, EY see the need for a comprehensive cultural and change-management strategy to achieve change.

While the EY report was triggered by concerns about access to acute beds, in a stepped model, each level of care needs to be adequately resourced, or there is a risk of excessive demand on inpatient beds. This applies to all the types of 24-hour alternative places, whether they be short term for people in crisis, medium term for rehabilitation or longer term for slower rehabilitation and support. All these interventions can keep people out of hospital.

In other words, in considering the adequacy of hospital bed numbers, it is just as relevant to look at access to residential 24-hour bed numbers, as at hospital bed numbers.

This Office in past annual reports has been concerned about access to 24-hour supported accommodation, so given that the EY report endorsed the Social Inclusion Board stepped model, we particularly focused on the topic of supported accommodation. However, we consider that without a national framework and agreed targets of what should be the appropriate coverage, levels and range, it is difficult to draw conclusions using existing national data sources such as those available to EY, which rely on averages across states.

In providing supporting evidence, EY have created the following table which compares different forms of care in South Australia with the average of other jurisdictions.

Grouping	Including	Total number beds	Beds per 100,000 population	National average
Social housing	N/A	243	24.6	N/A
Supported accommodation	Metro	59	6.0	N/A
Residential 24/7	CRC, ICC (excluding non-Facility beds in Country), Burnside HASP	125	12.7	6.0
Adult Acute	Hospital (Inpatient) plus state-wide beds.	220	22.3	24.3
Secure	Glenside	40	4.0	N/A
2 Forensic	James Nash and Glenside	40	3.2	N/A

From Ernst and Young, 2013

National averages were obtained by EY from the 2013 Mental Health Services in Australia report, and use the approach of that report in defining 24-hour residential care.

Looking at the EY analysis, South Australia can be seen to be better off for residential 24-hour care than the national average, and has slightly fewer inpatient beds.

This Office is not critical of this EY approach to analysing evidence, in that it is consistent with the national approach to classifying and counting bed types, and uses averages and not targets because that is all we have. These national definitions do not correspond to those in the South Australian stepped model, which is more granular in defining different sub-types of 24-hour residential care, so national definitions do not necessarily reflect how our systems are operating against the model.

This discussion will particularly focus on access to 24-hour residential beds, an alternative to inpatient care that if not operating well, can lead to greater demand on psychiatric hospital acute beds.

The need to use targets and not national averages in the future

Notwithstanding that the main work of an integrated mental health service is in its community team, access to 24-hour care either in community residential settings or in hospital is necessary for acute care, rehabilitation and for a small number of people, for their ongoing accommodation. For the latter group, this might be for up to two years of slow, gradual rehabilitation (the figure used by Andrews et al. in their report), but sometimes much longer. This Office has monitored the development of 24-hour bed numbers in our 2009, 2010 and 2011 annual reports, as the Stepping Up model has been implemented.

The EY report notes that “SA has a higher level of residential 24/7 beds than the national average at 12.7 beds per 100,000 versus the national average of 6 beds”.

However, what use is this comparison? To illustrate the limitation of comparing averages, below are some further data from the AIHW that we believe are from the same data set used by EY.

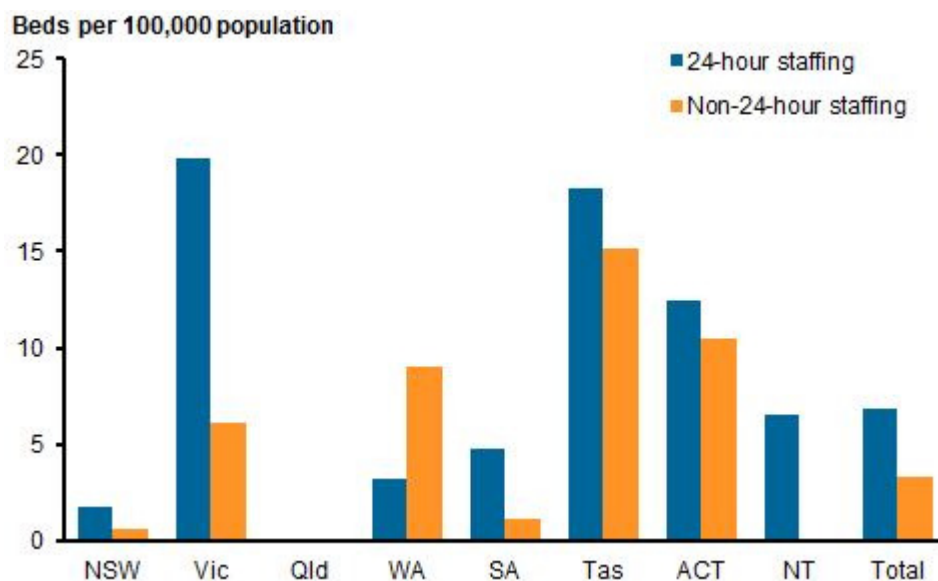


Figure A5: Residential mental health service beds per 100,000 population per target population and hours staffed, states and territories 2010–11 (graph reproduced from AIHW, 2013)

While the national average for 24-hour beds may be six, this was affected by the poor performance of South Australia that year when we had fewer than 5 beds per 100,000 for 24-hour care prior to much of the Stepping Up roll-out. Victoria had the highest rate in 2010–2011, approaching 20 beds per 100,000 people, with Tasmania close behind.

From our viewpoint, it is not possible to get much additional information from these comparisons, as states not only vary according to the number of places, but also the proportion that are 24-hour staffed, and the proportion allocated to different age groups (older people vs. ‘general’ beds.)

From our Office’s viewpoint, this illustrates the benefit of comparing performance against a target rather than an average, and having targets for each level of care, for each target population.

It is still our view that the Stepping Up response was correct, and more high-level supported accommodation should be operating now. Based on the Stepping Up model, there is a need for more sites that can deliver 24-hour supported care.

For completeness, below is the graph comparing specialised mental health hospital beds per 100,000 by target population for states and territories in 2010–2011, taken from the Mental Health Services in Australia report (AIHW, 2013).

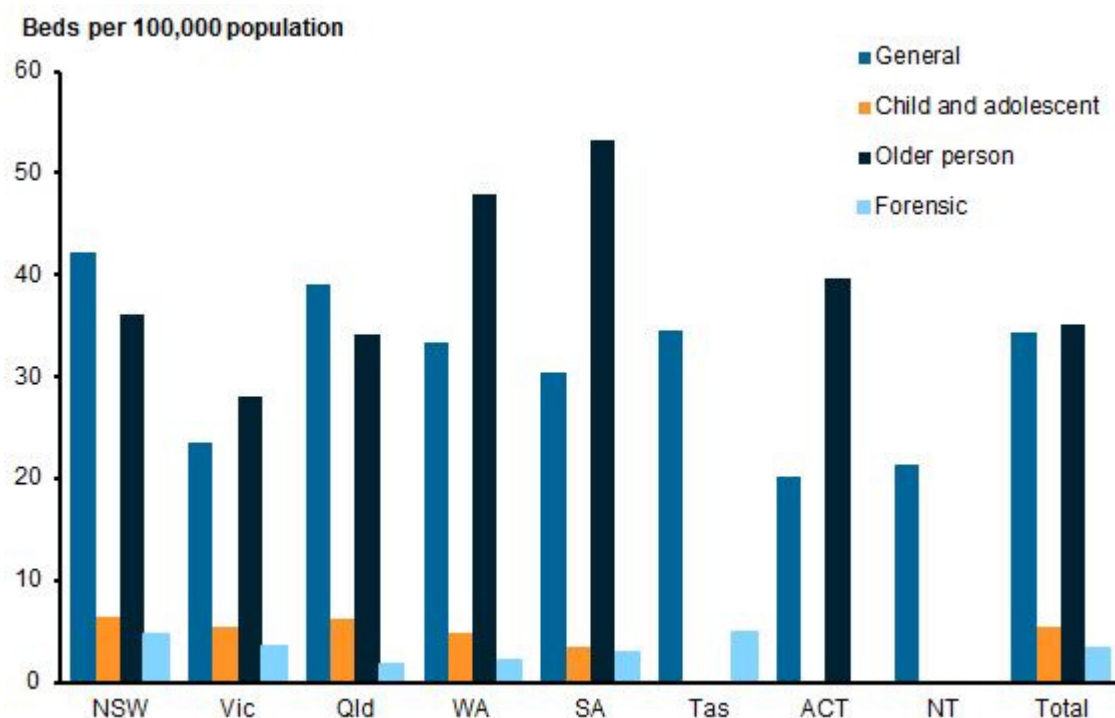


Fig A6 Public sector specialised mental health hospital beds per 100,000 population, by target population, states and territories, 2010–11 (reproduced from AIHW, 2013)

This graph once again illustrates the limitation of using averages in bed rates for any age group or service type, given the significant variation between states.

The need to base data collection and analysis on a service framework

This is the Stepping Up framework for 24-hour care that we are familiar with.

Figure 13: Facility-based services in a functioning adult stepped system of care²⁶

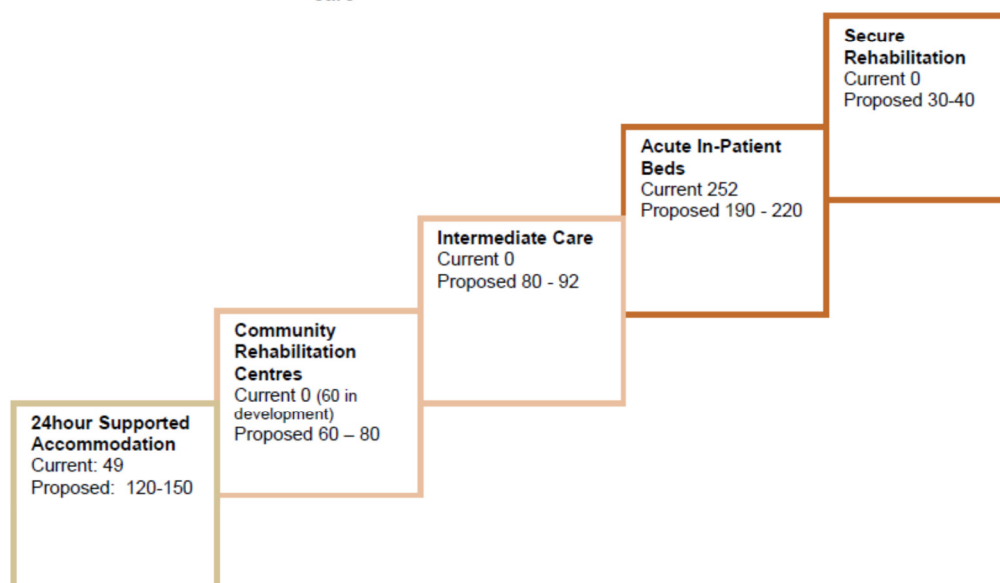


Fig A7 From Social Inclusion Board, 2007

Government targets were within the ranges quoted above and were reproduced on page 26 of our Annual Report 2010. There were to be 73 24-hour supported accommodation places.

As can be seen, the stepped model requires 30–40 places for people to receive secure rehabilitation. The EY report correctly notes that no national average exist for this type of accommodation. The model of secure rehabilitation being based on the operation of similar units in Victoria (for example, those described by the Department of Human Services, 2007). The traditional target group of such units are consumers who have severe ongoing or recurrent symptoms, co-morbid conditions, difficult behaviours, are prone to relapse, and often have a history of multiple admissions (Department of Human Services, 2007).

Although described as “secure” in the Stepping Up and the EY reports, the 40 South Australian beds as established are not all secure, with some of the pods operating as non-secure open units.

This might seem to be a positive, if it means that care is being delivered successfully in a least restrictive open environment to the same group of clients that are admitted to secure units interstate.

However, the concern is that this is not the case, and that a different group of clients may be occupying some of these beds. The Stepping Up report considered that the traditional South Australian model of operating open extended-care beds was no longer appropriate — rather, long-stay resources needed to be shifted into the provision of both secure rehabilitation and care and 24-hour supported accommodation.

Therefore, it is possible that some of the people now in open ward-based rehabilitation accommodation might otherwise be living in 24-hour community supported accommodation, if the places were available, and the model of care was robust enough to cater to the needs of this group. These needs include on-site psychosocial support but often also significant physical care needs, as some of the people in this group have co-morbid physical illnesses and conditions such as diabetes, respiratory illness, heart disease or incontinence.

If this were the case, then it is likely that some of the people with complex needs currently using acute beds might then be able to access secure rehabilitation services. There can be significant flow-on effects between these steps in the stepped model, which could ultimately mean freeing up acute beds and reducing waits in emergency departments.

We think this discussion supports the proposition of the National Mental Health Commission for a nationally agreed planning framework. This will then facilitate future review exercises such as the EY report, given the need to consider the adequacy of operation of specific steps.

Follow-up on mental health funding announcements

The National Mental Health Commission recommended that governments must ensure that announced mental health funding is spent on mental health as promised (National Mental Health Commission, 2012).

The EY report refers to current plans to increase the bed capacity in South Australia. A joint Australian and South Australian government statement in March 2011 announced an investment of an additional \$79.4m for mental health in this state over four years. (These

excellent initiatives that would serve to bolster South Australia's stepped plan were listed in our 2011 Annual Report (pages 43–44)). These initiatives will cover a range of types: crisis respite beds, community rehabilitation beds, youth sub-acute 'bed equivalents' in a hospital or community setting and forensic beds.

While some have proceeded, such as the forensic services, others have been delayed. Of even greater concern is the uncertainty about what will happen to these services, and we understand there is a real possibility that some services may cease to operate when Commonwealth funding stops after the four-year allocation has been spent.

The South Australian Government is to be commended in adjusting its plans and proceeding anyway, even with this uncertainty. Services that were originally to be delivered from purpose-built facilities, will operate from facilities leased from non-government organisations.

In our view, once again this demonstrates the benefits of a service plan and in this case, clear funding responsibilities for State and Commonwealth governments. While it is welcome when the Commonwealth provided additional funds in 2011, if a service is needed now, it is unlikely to be unnecessary after four years.

While the National Mental Health Commission was particularly concerned that funds might be diverted from mental health, which is not the case in this situation, their recommendation of independent yearly reporting of expenditure that is then compared with announced expenditure, would allow for such situations to be monitored.

Use of data in assessing performance

The EY report uses published data sources that are mostly publicly available, to draw its conclusions found in the first part of the report about bed numbers for the state.

We appreciate that this was a quick review.

Yet there is still a need for more analysis, using population-based modelling—in recent times, this work has been occurring in New South Wales and Queensland. In South Australia, epidemiologists have developed expertise in statistically analysing client demand and access to beds.

Furthermore, there are some rather simple statistics related to re-presentations for either hospital admission or emergency department attendance that have in the past been used as an indirect measure of the effectiveness of community interventions.

Stepping Up was very effective in taking data and converting them to information, and one example of this is their analysis of data of readmission to hospital. They used 2004–05 data to analyse readmissions to designated psychiatric units, shown in the table that follows.

Number of admissions	7900 admissions
Number of people admitted	4400
Number of people who had TWO admissions	879
Number of people who had THREE admissions	333
Number of people who had FOUR admissions	154
Number of people who had FIVE or more admissions	193

Table A9: Number of people admitted to designated psychiatric beds in 2004–2005 (Social Inclusion Board, 2007)

Stepping Up considered that having three or more admissions was a strong marker for people with complex needs. A focus of the report is adequate care for people with chronic and complex needs, which in turn can prevent unnecessary inpatient admissions.

It would be of great interest to look at this statistic again at the conclusion of implementation of Stepping Up recommendations to see if the number is lower.

Presentation to emergency departments by existing mental health consumers was a statistic of interest to the late Dr Margaret Tobin. Ideally, presentations by existing clients could be prevented or minimised. If relapse does occur, it should be detected earlier and a community response offered. The key emergency-demand management policy of the time required comprehensive relapse prevention plans for all known mental health consumers with a degree of instability in the history of their illness (Department of Health, 2002).

This then suggests a review of those prevention plans and their effectiveness could be useful.

These are just two simple statistics that can assist with system diagnosis that have been used in the past and could assist in the future, supplementing the use of published data in the EY report. Incidentally, the Commission recommends that data must be rationalised and that the right data be collected.

Risk averseness

Finally, it is worth commenting on the observation from EY that “a clinically risk averse culture” exists in some community and acute mental health services contributing to the bed demand.

Ernst and Young are not inferring that clinical staff become risk takers about their clients’ wellbeing.

Risk cannot simply be accepted or ignored, but needs to be managed effectively— either in the community setting or if necessary, in inpatient care.

Most mental health clinicians we meet are committed, dedicated and skilled. They are more than willing to either deliver a community alternative or refer the client to one. The problem does not rest with them as individuals. Nor with the consumers and carers who sometime contact our Office because a bed is unavailable and they have been turned away. Many who see themselves at risk, but not severely unwell, would readily accept community follow-up.

The problem then becomes one of service design and operation. It relates to the flexibility of existing services to avert crises and respond to crises for existing as well as new consumers, and also the availability of sufficient community crisis alternatives to hospital care.

Ultimately, the effective management of risk, without overusing hospital, needs good access to the necessary services at the right time. This is where national population-based targets, an agreed service model and performance measurement can help to problem-solve and improve individual services.

Summary

This discussion has considered the analysis of the current operation of South Australia's mental health system in the recent independent Ernst Young (EY) report, in the context of the need to improve the way Australian mental health services are planned and delivered, as put forward by the National Mental Health Commission.

The Commission has made many recommendations, but in the context of reviewing South Australia's mental health plan, three particular recommendations are highlighted:

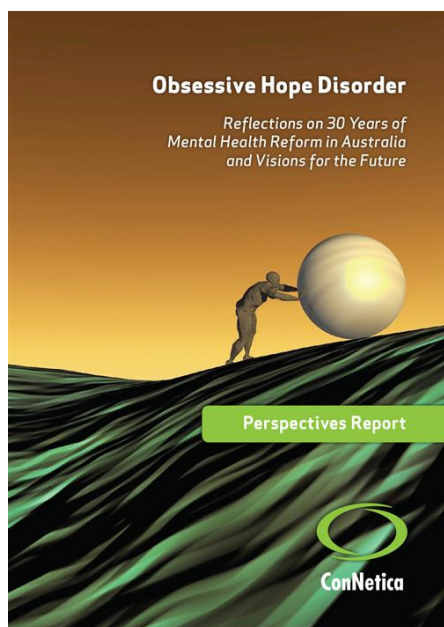
- Having a framework that gives a clear picture of service coverage, the levels and range of mental health services needed at a regional level, along with the workforce needed to deliver it
- The need to set goals and targets for improving mental health and reducing suicide
- The need to have independent yearly reporting of expenditure.

In this context:

- The EY report, in the absence of a national framework, could have compared current hospital and community bed numbers with those proposed in the Social Inclusion Board's framework.
- This would be preferable to using averages from the Mental Health Services Report that compress three different types of supported accommodation into one statistic, and because of this do not give an accurate picture of performance in each of the three areas.
- The analysis in this section concludes that a shortage of 24-hour supported accommodation as originally required in the Stepping Up plan, but not delivered, is contributing to acute bed shortage. While this is only one of many factors, it is a factor that comes out of analysis of numbers against the Stepping Up framework rather than national averages.
- The delayed delivery of some residential services planned in 2011 reflects the uncertainty of future funding beyond a current four-year Commonwealth-State agreement. It is excellent that these initiatives will proceed, but certainty is still needed that these services will continue in the medium to longer term.

Promoting Rights and Interests

Mental Health and Human Rights



A landmark report “Obsessive Hope Disorder: Reflections on 30 years of mental health reform in Australia” was launched in August 2013 by Brian Burdekin AO, former Human Rights and Equal Opportunity Commissioner, Professor David Richmond, author of the Richmond Report, and Adjunct Professor John Mendoza, former chair of the National Advisory Council on Mental Health. The report can be obtained at this link <http://bit.ly/18WMGxB>.

The Public Advocate was invited to provide a personal reflection on Mental Health Reform for this report. This is reprinted below with permission of the publishers of the report.

In 2012, the South Australian Office of the Public Advocate conducted a telephone call-in inviting people who had experienced or witnessed past abuse in psychiatric hospitals to phone our Office. Fourteen people responded, describing episodes of emotional, sexual and physical abuse in psychiatric hospitals occurring from the 1960s to the late 1980s. A lack of respect for the person was a common factor in these reports. We thought this small number was significant; while the abuse of children in state care has been well documented, much less is known about the abuse in the old mental hospitals of children and adults who either had a psychiatric illness or a disability, who without community care were forced to live for long periods in these closed settings.

It is tempting to look back and see these events as an artefact of history, particularly when looking at how services have changed from then to now. Yet abuse in modern settings still exists, but it takes different forms, and its presence is closely linked to a general lack of recognition of human rights.

In Australia, mental health reform has been driven by the recovery model. This is well regarded but in many overseas countries, the recovery model was implemented on the foundation of human rights for all citizens, codified in charters or legislation. Recovery’s mantra for people

with mental illness of “a life worth living” will more readily be realised in a society that upholds values of equality, dignity and respect. If this is the foundation, people with mental illness do not need to argue for special treatment or seek sympathy when asking for funding, but just expect and receive equality of opportunity along with everyone else.

Social and economic rights such as access to health care, housing and education and training, can keep a person well and provide personal fulfilment. If these rights are not upheld it can lead to the unnecessary loss of civil rights. For a person with a mental illness, this can take the form of community treatment orders, civil detention, and restrictive practices that in many instances might have been avoided if necessary care and support had been available in the first place.

Upholding human rights is scientific and makes economic sense. It is scientific because it involves providing evidence-based interventions such as assertive community treatment, and holistic approaches that consumers want— therapies that address the psychological and social needs of a whole person, not biological treatments alone. It makes economic sense because providing for a person’s needs properly can cut down an endless cycle of re-presentations to hospital, prison and other costly services.

Upholding human rights can also keep a person safe. Maximising independence and personal control and decision making will ultimately be protective if a person is empowered to take action to protect themselves. Even when involuntary treatment is invoked, strategies such as supported decision making can maximise a person’s autonomy and personal authority by ensuring that people are supported to make their own decision where possible, rather than having decisions made by others.

I began this commentary by referring to traumatising abuses in the past. The loss of rights today can create different risks. Living in an underfunded boarding house can limit a person’s privacy, personal safety, and rehabilitation. A cycle of homelessness and incarceration can have devastating effects on a person’s health and longevity, as can lack of access to good, general health care.

Underfunded forensic mental health systems struggle to keep up with the treatment needs of mentally ill offenders, failing to uphold National Forensic Mental Health Principles which promise equivalence of services to the non-offender; an ideal that should be delivered, but frequently is not. Abuse can also occur through a person being subject to avoidable instances of mechanical restraint, physical restraint or seclusion. In today’s hospital setting, women remain at risk as they were in the past, even though enhanced sexual safety could be readily delivered through practice changes, and providing women-only areas in inpatient settings.

Since 2000, South Australia has seen the highs and lows of reform. The high from the galvanising leadership of the late Dr Margaret Tobin was tragically cut short following her assassination. After a period of uncertainty, interest in mental health across government surged in South Australia, led by the Social Inclusion Board based in the Department of the Premier and Cabinet. New community services, new stepped community residential care, and new wards have been part of this work. I had the privilege to work as State Director of Mental Health in the mid-2000s at this exciting time of future planning, and putting in place the first steps of a new model.

Yet for all the work done back then and since by governments, we are likely to look back with concern about large ongoing gaps, rather than take pride in successful reforms. Particularly when we see individual rights not upheld, and people suffering unnecessarily. In South Australia we now need a new plan, but if we could anchor this work in a human rights framework, we would be more likely to get our responses right. Human rights should be the cornerstone of everything we as a community do for people with mental illness — including developing policy, writing plans, operationally managing services and coalface practice.

Upholding equality, dignity and respect can promise better outcomes and personal safety for all people with mental illness. Rights would be upheld, abuses prevented, and the need to depend on the rights' protecting role of the Office of the Public Advocate reduced.

Reproduced with permission "Obsessive Hope Disorder Report".

Promoting Rights and Interests

Forensic Mental Health

Introduction

Our 2012 Annual Report (pages 20–35) considered the incidence of mental illness in correctional settings, and advocated a planned population-based approach. A population-based plan could provide necessary prevention, early intervention, acute treatment and rehabilitation services to this group, by assessing need and the matching service response to this need. Forensic mental health services should uphold the National Forensic Mental Health Principles, including Principle 1, “equivalence to the non-offender” that requires the delivery of services that provide the same availability, access and quality of mental health care as that provided to the general population.

This year, we wish to consider issues which relate to the operation of a particular section of the *Criminal Law Consolidation Act 1935* (CLCA) Part 8A. Section 269 V of the CLCA, describes the requirements for the custody, supervision and care of a defendant who has been found mentally incompetent to commit an offence, or is mentally unfit to stand trial and gives the Minister the power to direct that a defendant be kept in custody in prison.

Prison vs. hospital

Section 269 V of the CLCA states that if a person is committed to detention as a forensic patient, then that person is in the custody of the Minister for Mental Health, and the Minister may give directions for the custody, supervision and care of the defendant.

Section 269 V (2) (b) of the CLCA permits that the Minister direct that a forensic patient be kept in custody in a prison.

One reason that a forensic patient might be kept in custody in prison is if there is insufficient bed capacity at the forensic hospital, James Nash House. A person might be eligible for care in a hospital bed, but then waits in a prison until a hospital bed is available.

However, there can be another reason. High-risk patients, who in other states would be managed in hospital, in South Australia can be transferred to prison because of limitations in the forensic system. The inability of James Nash House to provide high level care which can be delivered in forensic systems in other states is a problem which has received little attention. Once a patient is transferred to prison, there is no longer nursing supervision, and the principal means of managing high-risk patients is through the use of prolonged seclusion in a cell — for periods of up to 22 hours a day.

The inadequacies of the physical design of James Nash House

The general inadequacies of the design of James Nash House were first highlighted by Dr Margaret Tobin, over ten years ago. She was concerned about the welfare of women and younger patients in the James Nash environment.

The Government's description of the James Nash facility is as follows:

James Nash House has been operating since the mid 1980's and resembles a prison more than a health facility. Although it was the first of its type in Australia to provide forensic mental health treatment in a dedicated facility, it is now outdated and the facilities are not in line with modern treatment principles. In recent years the design of modern forensic mental health facilities interstate and overseas has seen a move away from the correctional and custodial type facilities to a secure health campus facility with a specific focus on mental health recovery (SA Government, 2007).

Details of these limitations were discussed in our 2010 Annual Report (pages 97–101) and from a patient perspective in our 2009 Annual Report (pages 66–70).

The difficulty is that the prison-like design of both Aldgate and Birdwood wards means that on the one hand it is not a modern forensic hospital environment that might prevent behaviours of concern, while on the other it is not a particularly effective 'prison environment' for containing difficult behaviour when it happens. Overall, this creates risks for both patients and staff.

The occasional need to transfer a patient to prison is just one manifestation of the design limitations of James Nash House. At times the unit will continue to manage patients who in other states would be placed in a 'high secure' setting. While these patients stay on the unit, safety is maintained by secluding the patient in their 'cell' in James Nash House, for long periods of time, which in itself is anti-therapeutic.

Another consequence has been extra security costs. Our forensic system ideally should be spending any extra dollars it has on more clinical staff across its operation — for example, to provide adequate occupational therapy input in the inpatient unit, or extra nursing input to its prison in-reach. However, this year it has been common to find instead extra security staff employed. While we understand that these security staff have been deployed following serious incidents in the present facility, this is an extra cost that in all likelihood could be avoided if better facilities were available.

For example, modern design principles manage to have effective security, lines of sight and other features, while providing a therapeutic space. More physical space in communal areas can reduce the tension that develops when unwell people are confined together in a limited area.

There is a related but different issue of behaviours of concern by patients who have a primary disability rather than a mental illness. People in forensic custody who primarily experience an intellectual disability, autism spectrum disorder or brain injury are best placed in a purpose-designed disability setting with other people who have a disability and are cared for by disability trained staff, not a mental health setting with mental health patients and mental health trained staff. A disability unit can deliver positive behaviour support programs and other strategies used by disability practitioners to prevent and manage aggressive behaviour and limit the use of

restrictive practices such as seclusion and restraint. We do not have a separate disability unit in South Australia.

Recently it has been estimated that a quarter of the James Nash House inpatients have been forensic disability clients rather than forensic mental health clients, often in custody because they are “unfit to plead”. There are many different reasons why this group needs care in a specialist forensic disability but preventing aggression and reduced use of restrictive practices are significant reasons.

Finally, a further security issue in the last year was the technical failure of the James Nash House duress alarm system in mid-2012, which resulted in a partial lock-down of patients while a new system was installed. This situation caused concern to patients and their families, as well as the apprehension of staff who should have confidence that a duress system will work.

Supervision and care of people with high needs

The forensic systems in other jurisdictions, both interstate and overseas, are able to cope with the needs of ‘high secure’ patients, as discussed above. These patients are either managed with difficulty at James Nash House or occasionally transferred to prison.

There is some debate about how to plan for these needs, in particular whether maximum security forensic unit is needed.

New South Wales and the United Kingdom use maximum-security units, as well as medium secure units. James Nash House offers medium secure care only. New South Wales has The Forensic Hospital, a 135-bed stand-alone high secure mental health facility (NSW Justice Health, 2013), that works as part of a system with the Long Bay Hospital’s 40 mental health beds and three medium-secure forensic mental health facilities (NSW Health, 2012). While New South Wales has capacity problems, that state is considered to have a comprehensive span of services ranging from high secure care to community forensic services.

The United Kingdom has hospitals providing high security care, called special hospitals (e.g. Broadmoor Hospital), which treat people with mental illness and personality disorders who represent a high degree of risk to themselves or others (West London Mental Health Trust, 2013).

New Zealand has taken a different approach to this high-risk group. The OPA understands from its discussions in the sector that special hospitals in New Zealand were closed in the late 1990s because they were considered to be contrary to good practice. There is a risk that patients, who are not liked for whatever reason, may be transferred to those places. New Zealand has instead managed its special patients in ‘medium secure’ units.

There are two potential ways forward for South Australia.

Following the New South Wales and United Kingdom approach, we might choose to build some high secure forensic mental-health capacity, which could be a distinct high secure unit that is part of the James Nash complex.

Alternatively, it is possible that newly built medium secure units are able to manage this patient group, in the same way the New Zealand units do. We assume that this would be through a combination of good physical design, adequate staffing, and excellent programs.

Either way, we should not continue operating as we do. The current ‘making do’ manner of managing difficult situations and behaviours on a medium secure unit that has an inadequate design is not good for either patients or staff.

CLCA s 269V (2) (b) The process of making a Ministerial Directive

Section 269V (1) of the CLCA gives the Minister power to issue directions for the custody, supervision and care of a defendant.

Section 269V (2) (a) allows the Minister to place the defendant under the care, custody and supervision of another, and s 269V (2) (b) allows the Minister to direct, if there is no practicable alternative, that a forensic patient be kept in custody in prison.

For completeness, it is relevant to note that s269V (3) divides supervisory responsibilities for conditions on which a person is released on licence between the Parole Board and the Minister. However, this particular section of the discussion only concerns people in custody, not on licence, and therefore applies only to s269V (1) and (2).

We have argued, as occurs elsewhere, the South Australian forensic mental health system should be self-sufficient, and should not rely on prisons to manage patients who are considered to be at high risk, or are in prison because of limited bed capacity in James Nash House.

Nevertheless, for the time being, it is likely that directions under this provision will continue to be made. The Office of the Public Advocate has formed the following view, having taken advice on the matter.

First, we consider that the Minister, in order to meet the requirements of this section, should have to consider properly, and come to a view as to whether there is truly any practical alternative to ‘custody in prison’ for any particular patient.

We consider that simply referring to the existence of a ‘waiting list’ is in itself an inadequate response to the statutory requirement. Otherwise, there is a risk that a waiting list might be used as a reason for a person staying in prison when in fact other reasons apply.

In making this decision, we consider the Minister should offer the patient and his or her advocates the opportunity to be heard before the decision is made. The decision to imprison a person is such a significant one, that we consider there should be an opportunity for submissions to be made.

This does not happen now.

Second, the Minister should consider what directions he should give about a patient’s custody, supervision and care. The practice has been to give directions with respect to custody only, but not specify supervision and care arrangements.

We consider that there exists a general misconception as to the meaning of the Minister's direction that a patient be kept in prison. Custody in a prison does not mean custody as a prisoner. If a forensic patient is kept in custody in a prison, then the patient should still have access to the types of therapy and rehabilitation programs that a forensic patient in custody in a mental health ward would usually receive.

The Minister, and therefore the forensic system, has continuing responsibilities for the supervision and care arrangements of such patients. This will be reflected if the Directive considers not just custody, but care and supervision as is expected by the CLCA. This will ensure that patients do not inadvertently become prisoners through a misunderstanding of the Ministerial direction.

Ultimately, our Office does not wish to see any patients transferred to prison unless, like any citizen, they have been convicted of an offence and have become a prisoner, and no longer need inpatient care. Yet, if transfer provisions are to be used for patients, hopefully this will be for the shortest possible periods only, and the above process should be followed.

If a Directive is put in place without a proper process of enquiry and decision making, and if it is not worded to meet the requirements of the CLCA, then there will not be a lawful basis for a forensic patient's detention in prison instead of hospital.

As yet, there has neither been agreement or disagreement expressed by the Government to the Office of the Public Advocate's position, although we hope that the approach we describe will be used.

Delegation of the s 269V (1) and (2) Powers to the Chief Executive

Traditionally, the power of the Minister to direct that a patient be held in gaol has been non-delegable.

The power is a significant one: the Minister makes a decision with respect to the imprisonment of an individual, a decision usually made in other circumstances by a court of law. It is also a power that is infrequently used. The use of a senior decision maker also helps separate the decision from any perceived conflict of interest related to the management of services.

At the Office of the Public Advocate, we saw this level of decision making at the Ministerial level as appropriate. The Minister, more than an Official, can be in a position to challenge what is practicable, and might fund alternatives if they are to be created.

It was with some surprise that the Public Advocate learned in April 2013, that the authority of the Minister to decide if a patient can be imprisoned had been delegated to the Chief Executive. Our concern is not with the well-respected Chief Executive who is now making these decisions. Rather, it is with the principle that such a decision should be made by a Minister, not an Official, and the previous interpretation of the Act prior to the amendment that this should occur.

An amendment to the *CLCA* in 2010 allowed for the s269V power to be delegated.

It is significant that we were not aware of this amendment, given the importance that we had placed on Ministerial decision making, and the change this amendment brought about.

However, there is an interesting story behind this, as the amendment was not introduced with the situation of adults in James Nash House in mind, but was part of the *Statutes Amendment (Recidivist Young Offenders and Youth Parole Board) Act 2009*, legislation of the (then) Attorney-General.

While our Office can advocate for people of all ages, we have not had a client advocacy role for young offenders with mental illness or disability, so it is understandable that we were not involved or consulted in the preparation of this Act.

The amendment added s269 (4), which permits the Minister or the Parole Board to delegate a power or function under this section, and s269 (5) which sets conditions for this delegation.

The second reading explanation of this Bill was tabled on the 13 May 2009. Just for clarity, it is relevant to note the context of this amendment:

This Bill arises from the Government's concern about the harm done by a small number of young offenders who persist in serious crime despite our best attempts at diversion and rehabilitation. They are few in number but cause disproportionate harm.

With respect to the amendments to s269 (4) and (5):

There is also an amendment to the Criminal Law Consolidation Act 1935 to make clear that the supervisory powers of the Minister and the Parole Board over a mentally - incompetent person can be delegated. This will permit, in particular, the delegation of supervisory powers over a youth who is unfit to stand trial or who has been found mentally incompetent to have committed an offence, to an appropriate officer of the Department for Families and Communities, or some other suitable person or body to exercise supervision over youths.

This delegation seems very reasonable as explained in Parliament — as the example describes delegation to staff of another department and an appropriate body. The subsequent parliamentary debate focused on youth justice matters.

This amendment commenced on 27 June 2010. The Delegation to the Chief Executive of s269V (1) and (2) powers was made on the 8 December 2010.

This then raises the question of what Parliament intended — seemingly an amendment to benefit one group, in this case young forensic patients who need supervision and care, may disadvantage another group; adults who might be transferred to prison, possibly Yatala Prison G Division, if that decision might now seem less critical, and no longer requiring the Minister's personal attention.

With respect to our concern that this outcome might not have been the intended result of the youth-related amendments, the Public Advocate understands that the principles of statutory interpretation require that the intention of Parliament be primarily ascertained from the wording of a statute itself. Courts can only have recourse to secondary material such as the second reading speeches like those quoted above, where the Act is unclear on its face. Similarly, this Office understands that the naming of an Act (in this case the *Statutes Amendment (Recidivist*

Young Offenders) Act 2009) may assist in the interpretation of its intended operation, and it will not confine or alter the provisions where wording is clear on its face.

Sections 269V (4) and (5) are clear on their face. Therefore the Minister is entitled to delegate this power. Our Office will be raising this matter with the Minister as a matter of policy, because we believe the Minister should make such significant decisions.

Mental Impairment Defence, and planning of forensic hospital capacity

The Sentencing Advisory Council is currently considering the operation of the mental impairment provisions of the CLCA.

There is an important community debate on these matters to be had, which will determine people's criminal responsibility.

However, irrespective of the outcome of this review, this is unlikely to alter the need for existing forensic mental health services to operate, and their future expansion.

For example, in the legal discussion about the frequency of use of the mental impairment defence, reference has been made to the United Kingdom experience, where, there are fewer cases of the successful use of a mental impairment defence for the entire population of that country than for South Australia (Hunt, 2013).

This is a very appropriate point to make in a legal context, but cannot be extrapolated to a mental-health service planning discussion.

This is because, while people are more likely to be convicted in the United Kingdom, their Mental Health Act 1983 has specific sections related to patients involved in criminal proceedings or under sentence, an approach not used in Australian jurisdictions. Section 37 of the Act gives power to the court to order a hospital admission or guardianship, and s 41 gives power to the courts to restrict discharge, while s42 gives power to the Secretary of State to cease the restriction if it is no longer required to protect the public from serious harm. Clinically recognised mental disorders in the United Kingdom Mental Health Act include personality disorders, eating disorders, autistic spectrum disorders, mental illnesses such as depression, bipolar disorder and schizophrenia, and learning disabilities (Crown Prosecution Service, 2013).

Our Office has not analysed the pros and cons of the United Kingdom system, compared to the Australian approach. One clear benefit is the aligning of forensic orders with civil orders and the involvement of a mental health review tribunal. It would be of interest to see which system makes best use of its clinical resources.

With respect to forensic mental health care, services are still needed, irrespective of what the approach is to the mental impairment defence — it is just that there is a different legislative mechanism for ensuring that forensic patients who need hospital care receive it.

Summary

This year's report elaborates on a particular issue related to the management of high risk clients at James Nash House. It can be read in conjunction with the more detailed discussion published in our 2012 Annual Report (pages 20–35).

It is our view that:

- The Forensic Mental Health system should be self-sufficient, and should not rely on prisons to manage patients either because beds are unavailable or a person is considered to be at high risk.
- Other forensic systems have an ability to manage high-risk complex patients. They do this either by building and operating 'high secure' hospital units, or equipping 'medium secure' units to safely care for high risk patients through excellent practice.
- The current South Australian approach of managing difficult situations and behaviours on a medium secure unit that has an inadequate design is not good for patients or staff.
- Notwithstanding our view that prison should not be used for forensic patients, if a Directive is to be made by the Minister, then it should be made after adequate enquiries into why hospital is not practicable. The patient and his or her advocates should be heard before the decision is made. The Directive should consider the patient's custody, care and supervision, not just custody. Custody in a prison does not mean custody as a prisoner, and this is often misunderstood.
- It is the view of this Office that such a critical decision should only be made by the Minister and not be delegated. While the latter is legal, we consider as a matter of policy that it should not be done.

Promoting Rights and Interests

Mental Illness and the Public Sector Workplace

Introduction: Required Psychiatric Examinations

This year the Office assisted with a rights and ethics issue to do with the power of an employer to require a staff member to undergo a psychiatric examination. Usually such assessments are compelled through the *Mental Health Act 2009* and the *Guardianship and Administration Act 1993* but these are not the only pieces of legislation that can require a person to undertake a psychiatric examination. The *Public Sector Act 2009* can require a public sector employee to be examined by a psychiatrist. If they refuse the required examination, the employee can be suspended without pay, which in our view makes such an examination coerced.

Section 56 of the *Public Sector Act 2009* says the following:

56—Power to require medical examination

- (1) If—
 - (a) an employee of a public sector agency is not performing the employee's duties satisfactorily; and
 - (b) it appears to the agency that the employee's unsatisfactory performance may be caused by mental or physical incapacity,the agency may require the employee to undergo a medical examination by a medical practitioner selected by the employee from a panel of medical practitioners nominated by the agency.
- (2) If an employee refuses or fails, without reasonable excuse, to submit to a medical examination as required under subsection (1), the public sector agency may suspend the employee from duty (without remuneration and accrual of leave rights) until the employee submits to a medical examination as required by the agency.
- (3) The public sector agency must—
 - (a) furnish the employee with a copy of any report on the results of a medical examination required under this section; and
 - (b) before taking any action on the basis of the report, allow the employee a period of not less than 14 days from the date of the employee's receipt of the report to furnish the agency with any medical reports obtained by the employee on his or her mental or physical condition.

A person who has had such an examination, and found to have a mental incapacity to perform his or her duties satisfactorily, might potentially have their employment terminated through the provision of the *Public Sector Act 2009*, s54 (1) (b). The Office of the Public Advocate provided assistance in this matter to three government employees. The Hon. Rob Brokenshire MLC had raised this matter with the Government along with officers of the Public Service Association. The OPA was pleased to see the quick action taken in response to these issues by the Employment Minister Michael O'Brien, and the Public Sector Commissioner Warren McCann and his Office, who issued new guidelines to limit and better control the use of this contentious s56 provision. The Office of the Employee Ombudsman had a significant role bringing together alleged victims of the excessive use of this provision, and at one point briefing the Public Advocate.

A similar problem to s56 exists for non-health care employees who are employed under the *Health Care Act 2008* and are subject to provisions of the SA Health (Health Care Act) Human Resources Manual, section 4-1-14. The provisions in this Manual are similar in nature to those in the *Public Sector Act*, but ambiguously worded.

Section 4-1-14 states:

An employee may be requested to submit him or herself as required by his or her employer to a legally qualified medical practitioner for examination on matters relating to appointment of staff and employees seeking sick leave or further sick leave entitlements.

Approval of the Department for Health and Ageing must be obtained before arranging medical examinations for other purposes including resignation or termination of employment on medical grounds.

This section is currently being re-written. While it is the understanding of OPA that a Health Act employer can compel an employee to undergo a medical examination, the manual needs to be updated to remove unhelpful terminology which makes it unclear whether it is a request or an expectation, and better articulate the rights of employer and employee. This work is happening now.

Examples of people affected by *Public Sector Act 2009* s56 or similar provisions

The client matters considered by this Office brought up a range of issues:

- An employee was dismissed, based on a psychiatric report. The dismissal was later reversed through conciliation with Public Sector Association advocacy, participation by the Public Advocate in this conciliation and then further assistance by the Employee Ombudsman.
- The appropriateness of departments receiving and storing psychiatric reports which can be detailed and personal, and contain information that employers would not usually know. We were informed that the reports form an official record by operation of the *State Records Act 1997*, and therefore it is necessary for them to be kept until the employee is 85 years old. This particularly concerned people who were directed to undergo examinations before the new guidelines limiting the use of s56, who could rightly assume that a report would not have been requested under the new guidelines.
- The way in which the technical conclusions in psychiatric reports are interpreted and acted upon by departments. Public sector agencies, when considering psychiatric reports do not have the same expertise available, as say the Guardianship Board, which sits with a lawyer, a professional and a community member who together consider and apply the expert evidence.
- A decision by one employer to conclude that a diagnosis of a 'personality trait' by a psychiatrist, which was based on an employer's account of an employee's behaviour, is a cause of mental incapacity. This is inconsistent with standard psychiatric nomenclature which separates personality traits that we all have, from disorders.
- Referral for psychiatric assessment of staff who have raised matters of bullying or other systemic issues affecting clients of those staff members.

- The ambiguity of the Health (Health Care Act) Human Resources Manual. It refers to the medical examination as both a 'request' and a 'requirement.'

Employee psychiatric examination: systemic factors

Insofar as these psychiatric assessments were directed, they can be seen as coercive. Section 56 (2) states that if an employee refuses, or fails without reasonable excuse to submit to a medical examination as required, the public sector agency may suspend the employee from duty (without remuneration and accrual of leave rights) until the employee submits to a medical examination as required by the agency.

Coercive psychiatric assessments by their very nature are intrusive and cover very personal material. It is useful to compare this *Public Sector Act* requirement with other state legislation where an assessment can be required.

In the civil context, involuntary mental health assessments are usually authorised under the provisions of the *Mental Health Act 2009* which can also authorise treatment as well as assessment. For an involuntary psychiatrist assessment to occur, a person needs to appear to have a mental illness and the person requires treatment for the person's own protection from harm (including harm involved in the continuation or deterioration of the person's condition) or for the protection of others from harm.

The *Guardianship and Administration Act (GAA) 1993* is another piece of legislation that can be used to seek an involuntary psychiatric report. Before the Guardianship Board can issue a warrant under s15, it has to be given information on oath that reasonable grounds exist for suspecting that the person to whom the warrant relates has a mental incapacity. This provision is hardly ever used.

When personal information is collected under either the *Mental Health Act 2009* or the *Guardianship and Administration Act 1993*, it is subject to the strict confidentiality provisions of those Acts and is generally only shared with other professionals who are assisting the patient — not an employer.

Section 56 of the *Public Sector Act 2009* gives significant powers to an employer to require an assessment that affects the rights of a person who has a mental illness or is suspected of having a mental illness. However, it does not provide the same protections as the other examples of legislation as to when it will be implemented, and how reports will be understood or acted upon. In issuing guidelines, the Commissioner for Public Sector Employment has set limits to minimise the unnecessary use of this coercive measure and to make the use of this section an action of last resort.

There are also potential legislative problems in the way s56 has been worded and placed within the overall structure of the Act. Section 56 of the *Public Sector Act 2009* is similar in wording to the former s51 of the *Public Sector Management Act 1995*, except that the 2009 Act gives the power to require psychiatric examinations to the agency, whereas the preceding Act only gave this power to the Chief Executive. It is possible that the recent problems were exacerbated by actions and decisions taken within agencies by Director-level staff, which in the past could only be made by a Chief Executive.

In addition, the section of the Act considering mental and physical incapacity is situated between other provisions for the termination of employment; disciplinary action and the suspension of employees from duty. This can conflate the investigation and response to disciplinary matters with the investigation and response to illness and disability which should be different both in philosophy and practice.

Commissioner for Public Sector Employment Guidelines

The Commissioner for Public Sector Employment has issued new guidelines on the power to require medical examination (Commissioner for Public Sector Employment, 2012). The guidelines require, wherever possible, Chief Executives to retain the power to personally decide whether to require an employee to undergo a medical examination pursuant to s56 of the *Public Sector Act*. They recognise that being required to undergo an examination can be distressing and such a request requires tact, sensitivity and discretion. The guidelines recommend considering another approach, require procedural fairness, and give extensive practical guidance.

It will be useful for the application of these guidelines to be reviewed, after they have been in operation for a period of time.

The Public Advocate met with the Commissioner and his Director to discuss s56 in the context of mental health awareness in the workplace, and recognition and support of employees with a mental illness. They suggested a forum on this topic that was subsequently convened by the State Division of the Institute of Public Administration Australia (IPAA). Presentations were given at this forum by the Minister, the Commissioner, a Managing Solicitor from the Crown Solicitor's Office, the Public Advocate, a workforce program leader and a Board Director from *beyondblue*.

Limiting the use of s56

The OPA's view is that organisations, wherever possible, should manage performance in the usual way for everyone without reliance on s56 and capacity determinations. Performance management is what organisations should do best, and have the expertise to do. The performance management system should be able to look after the organisation's interests, the employee's interests, and the interests of other employees in the workplace. A performance management system allows for the termination of employment of a non-performing staff member without attaching any other labels.

If a person is unwell, is subject to performance review and then voluntarily raises an illness issue, then information from professionals can be provided to an employer with employee consent so that appropriate consideration can be given. If a person is unwell and needs to be supported, then this can be part of a caring employer response.

There is debate about whether or not we need coercive powers. One view is that statutory provisions such as s56 codify what otherwise would be a common law right of employers to require employees to be assessed when there is a question of fitness for duty. If such powers are to be used, then they should be principally invoked in the interests of an employee — for example, to support an employee to keep a job who might otherwise lose it if assessed only on performance grounds. A person should not lose their job based on a mental health assessment, which they would not have otherwise lost through performance assessment, as this is discriminatory. Job performance criteria should apply equally to all.

While the excessive use of s56 caused unnecessary distress for many, it is also a positive that a problem has led to a greater focus on supporting people who experience mental illness in the workplace. People need to feel safe in coming forward to seek assistance and support. The risk with the aberration that occurred with the excessive use of s56 is that the very people who should be seeking help and support may be discouraged from doing so if being identified as experiencing a mental illness could have an adverse consequence, rather than a helpful one.

Summary

- The excessive use of psychiatric examination provisions in the *Public Sector Act 2009*, impinged on the rights of employees.
- The intervention of the Public Sector Employment Commissioner and the Minister for Employment following advocacy from employees, the Public Sector Association, Rob Brokenshire MLC, the Employee Ombudsman and the Public Advocate, has helped ensure that rights are restored.
- While it can be argued that no employee should undergo a required psychiatric examination, it is also the case that legislation and policies have codified what is already a common law right of employers to seek such examinations to ensure that employees have the capacity to undertake their work.
- Ideally, such powers should be used as a last resort, and in the interests of an employee, as performance management systems should protect the interest of the employer and fellow employees.
- A person should not lose their job based on a mental health assessment which they would not have otherwise lost through performance assessment, as this is discriminatory. Job performance criteria should apply equally to all.
- The implementation of the new guidelines will need to be reviewed after a period of application.

Promoting Rights and Interests

Deprivation of Liberty in Aged Care

Rights and Safety in Aged Care

This year there has been a national focus on the safety of residents living in the Residential Aged Care sector, in particular, the avoidable use of psychotropic medication leading to injury and death (Hilmer & Gnjidic, 2013; O'Neill, 2012). The focus of this discussion has been on avoidable chemical restraint — the use of antipsychotic and sedative medication to control the behaviour of people with dementia, that might otherwise be managed by non-drug means entirely, or through the judicious prescribing of medication. Factors such as the availability of skilled staff, access to personalised care and meaningful activities, and the physical design of facilities can contribute to both physical and mental wellbeing (Looi et al., 2013). This in turn should reduce the need for medication.

Commonwealth Legislation and Planning

The problem is a safety and quality challenge for our nation's aged care system that relates to the standards and outcomes expected in aged care and the funding provided to deliver those outcomes. It is also a human rights issue, with respect to the rights of older people to have accommodation, support and healthcare that adequately meet their needs, while at the same time not being exposed to unnecessary restrictive practices, including the use of avoidable chemical restraint. The topic of human rights protections against unnecessary deprivation of liberty in aged care was discussed in our Annual Report (OPA, 2011).

In that report, this Office considered the need to have better human rights protection for people detained to secure aged care facilities. We suggested amendments to the *Aged Care Act 1997*, and the User Rights Principles under the Act, to recognise the specific rights of residents who may be subject to restrictive practices. We also saw value in a proposal by the Productivity Commission to enhance the status and role of Community Visitors who enter aged care facilities checking on individuals rights, by making it a statutory role (OPA, 2011).

With respect to legislating to control restrictive practices, there are already analogous examples in state-based disability legislation (in Victoria and Queensland) where legislation has sought to reduce and where possible, eliminate the use of restrictive practices for people with disabilities. The same could occur for aged care. Defining what restrictive practices are, and outlining the need to undertake alternative strategies such as positive behaviour support before considering a restrictive measure, could be codified in the Act and the User Rights Principles.

Interface with the state health and mental health systems

These issues sit at the intersection between Commonwealth-funded aged care, and the State health and mental health system, because the specialist expertise to provide for the needs of people who have significant behavioural and psychological symptoms associated with dementia frequently exists in state geriatric and psychogeriatric services. Our 2010 Annual Report charted the future older persons' mental health services for the state as planned at that time including documenting the planned transfer of resources from long-term inpatient units, which were being closed, to community psychogeriatric services.

Many of the people who have been traditionally admitted to long-term psychogeriatric beds experience significant behavioural and personality changes associated with dementia. Based on the 2010 plans, as long-term psychogeriatric beds are closed, five intensive care behavioural units have been planned to be established (each with a capacity of eight residents), along with three step-down units (also with a capacity of eight residents each).

In addition, 50 full-time equivalent clinical positions that were previously associated with the closed inpatient units would be transferred to boost the number of older persons' mental health workers from the 57 FTE in metropolitan community teams to a total of 107FTE across the state. While there has been some activity in this reform, this Office is yet to see the significant expansion of community psychogeriatric capacity as old funds from Glenside and Oakden traditionally allocated to aged mental health are reinvested in community services. We understand that there had been some expansion, but this will now need to be charted against the reinvestment plans. This is very relevant to the discussion of the use of restrictive practices in aged care, as psychogeriatric support may limit the need for all forms of restraint, including chemical restraint.

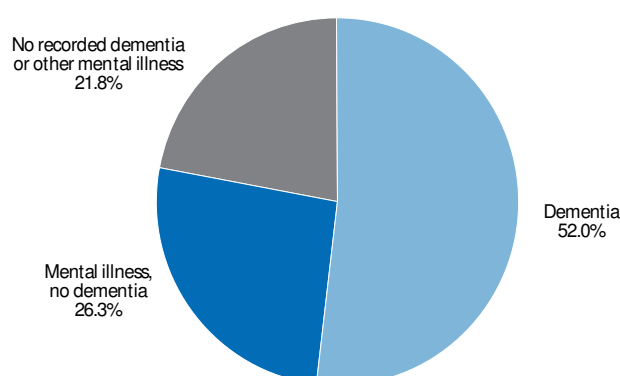
Human Rights Protections for Secure Aged Care

While the numbers can only be estimated, it is likely that only a fraction of older people currently detained in residential aged care are lawfully detained, and therefore have some form of rights protection in place. The majority of people held in locked aged care units are probably there without orders — which is a problem for the individual as rights are not protected, but also for aged care providers who are vulnerable to allegations of unlawful imprisonment.

A relevant context is the number of people receiving care in the sector. The Department of Health and Ageing reporting on the operation of the *Aged Care Act*, identified 17,621 operational places in residential settings in South Australia as at 30 June 2012 (DOHA, 2012). Residents can be admitted for either permanent or respite care. In South Australia, there were 13,181 permanent high care residents and 2,415 permanent low care residents.

People are usually in aged care because of cognitive, behavioural and emotional problems. Nationally, over half of permanent aged care residents experience dementia and a further quarter have a mental illness. This is illustrated in 2011 data from the Australian Institute of Health and Welfare.

Figure 5.2: Diagnosed dementia and mental illness for permanent aged care residents with an ACFI appraisal, 30 June 2011



Source: Online Table A4.10.

Figure A10: Frequency of diagnoses of dementia and mental illness (164,116 aged care residents Australia-wide appraised by the Aged Care Funding Instrument (2010–2011) Data from AIHW (2012)

This is a population that may be subject to a form of restrictive practice such as detention or restraint, including chemical restraint. In a 2009 survey of 2465 residents living in 44 Inner Sydney nursing homes, 47.5% were prescribed some form of psychotropic medication; 28% were on a regular antipsychotic drug (Snowdon et al., 2011). It is reasonable to assume a similar level of prescribing to aged care residents in South Australia for the purposes of determining the need for measures to protect rights.

It is possible that any of the 13,181 high care residents may be potentially detained. With respect to the definition of detention, any person who lives behind a locked door is potentially detained unless the person is allowed to come and go as they choose (for example, some residents are given the code to key pads that allows the doors to the unit to be unlocked, so these residents although living in a locked unit are not detained). While many high care facilities have a designated secure dementia unit, it is also common for high care units that are not designated as 'secure' to have locked doors and for residents unable to operate key pads to those doors to be effectively detained as well. Low care facilities which lock their front door for security purposes, might also stop individual residents leaving at will, effectively detaining them.

Given the need to analyse each resident's situation, it is not possible to know exactly the frequency of detention and restraint. It would be an excellent question to survey. It is reasonable to conclude though, that the number is likely to be in the thousands, given what we know about residents' diagnoses and care needs.

In South Australia, detention in a residential aged care facility can only be authorised under s32 of the *Guardianship and Administration Act*. There is likely to be a significant disparity in the potentially large number of people in residential care, and the comparatively small number of orders granted to authorise such lawful detention.

In 2011–2012, the Guardianship Board reported for all age groups, not just the elderly, 389 new applications for s32 powers, and 282 routine (“s57”) reviews of existing orders (reviews occur after six months, then at 12 months) (Guardianship Board, 2012). This is a total of 671 orders. Not all of these orders are to authorise detention — some are for placement, or to allow the use of force, and do not include detention. Also, this number includes applications for younger people who experience mental illness or disability, so the actual number of orders for people in aged care would be less than 671.

With respect to the Office of the Public Advocate, there are 217 clients living in residential aged care (this is a spot check as at 30 August 2013), and of these, 43 are subject to s32 orders.

So, while numbers are approximate, there is a difference in number between the possible thousands of people in residential aged care who are likely to be detained, and the hundreds of applications to the Guardianship Board for s32 powers to authorise detention.

This is consistent with the anecdotal observations made by our staff. For each person who is lawfully detained in a locked facility, there are likely to be many other residents in the same facility who are not. Legal actions available to those people include *habeas corpus* and an action for false imprisonment.

Solutions in State Legislation

State law is not protecting the rights of elderly people. Many other states do not have a statute to allow for detention in aged care. In South Australia we have one, but as argued in our 2011 Annual Report, the requirement to seek guardianship and s32 orders can be onerous on families and providers, and can be seen to be excessive in situations where people are not attempting to leave a closed facility, but are unable to consent to admission.

A solution put forward by the Victorian Law Reform Commission (VLRC) is a collaborative authorisation process (VLRC, 2012). They suggest that a reformed Guardianship Act allows for such a process to be used only in facilities that are effectively regulated by either the Commonwealth or State. This would include aged care facilities, which would be required to identify when a person is experiencing restrictive practices that need to be authorised. The collaborative authorisation process would require the approval of three people: the person in charge of the residential facility, a medical practitioner or other health practitioner approved by regulation, and the person’s health decision-maker (VLRC, 2012). The VLRC report identifies the requirements for each of the three parties.

The VLRC suggests that when a person consistently resists and opposes restrictions on their liberty, an application to a tribunal to appoint a guardian should be made. Parties, including a person restricted through the collaborative authorisation process, would be able to inform the Public Advocate of their concerns and request an investigation (VLRC, 2012).

It is the view of our Office that our own state legislation should be amended to permit the use of a collaborative authorisation process, for people who are detained in aged care facilities and are a wandering risk. Just as with the Victorian recommendation, if a person is consistently attempting to leave, then this should be the subject of an application for s32 orders.

We think that a measure like this is likely to offer protection to people detained in nursing homes whose situations are mostly not being brought to the attention of the Guardianship Board, leading to a lack of statutory protection to individuals or to the accommodation providers who are detaining these individuals. A collaborative authorisation process offers a new and commensurate protection for this group, and does not place significant extra demands on families, aged care providers and health professionals.

A state could proceed alone to offer restrictive-practice consent protections without requiring any changes from the Commonwealth. However, ultimately changes to the *Aged Care Act 2009* and the user rights principles will have more leverage in preventing restrictive practices through practice requirements of providers.

Summary

Key elements of a reformed authorisation and consent system to better protect against avoidable and potentially harmful restrictive practices in aged care include:

Guardianship and Administration Act amendment to permit a ‘collaborative authorisation’ process involving the aged care provider, medical practitioner and health decision maker. When any concerns are raised about this process, the matter could be investigated by the Public Advocate.

In addition, *Aged Care Act* amendment could require actions from providers that minimise and lead to the elimination of the use of restrictive practices. This would include clear definitions of each restrictive practice, a requirement for assessment and consideration of non-coercive measures, and then a clear requirement for authority for restrictive practices to be used.

Promoting Rights and Interests

Supported Decision Making

Guardianship and Administration Act 1993

Section 21 (1) The functions of the Public Advocate are—

- (c) to speak for and promote the rights and interests of any class of mentally incapacitated persons or of mentally incapacitated persons generally;
- (d) to speak for and negotiate on behalf of any mentally incapacitated person in the resolution of any problem faced by that person arising out of his or her mental incapacity;
- (e) to give support to and promote the interests of carers of mentally incapacitated persons;

Introduction

The OPA 2012 Annual Report (page 52 onwards) described the outcomes of the South Australian Supported Decision Making trial. This project was based in the Office of the Public Advocate and was funded by the Julia Farr MS McLeod Benevolent Fund. Twenty-six people who experienced disabilities including brain injury, intellectual disability and autism spectrum disorders made agreements with family members or friends who agreed to act as decision supporters. The independent evaluation of the project demonstrated increased confidence by participants in themselves and in their decision making, a growth in personal networks, a feeling of greater control in their lives, and increased community engagement (Wallace, 2012).

The work was overseen by the South Australian Supported Decision Making Committee. The group continued to meet, to consider how supported decision-making practice might be furthered with respect to future projects and also law reform.

During 2012–2013, empirical research has continued in other locations with trials under way in NSW and the ACT, and a planned trial in Victoria. During 2013, Cher Nicholson, a committee member and former facilitator presented the South Australian work in Dublin as a guest of Amnesty International and the National University of Ireland, Galway, at a conference considering the theory and practice of supported decision making as Ireland develops its Mental Capacity Bill.

In South Australia, the Office of the Health and Community Services Complaints Commissioner has also advocated for access to supported decision making. They consider that many of the complaints they deal with involving the care of people with disability could be avoided, if the person with a disability had been given a greater voice.

The following discussion considers how supported decision making can be further developed in Australia: by considering a population-based model for supported decision making, current and future supported decision making projects, and specific options for law reform.

A population-based model of supported decision making

Supported decision making is a response to Article 12 of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). This Article reaffirms that persons with disabilities have the right to recognition everywhere as persons before the law, the right to enjoy capacity on an equal basis with others in all aspects of life, and requires State Parties to take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their capacity.

The South Australian project illustrated the significant barriers that still need to be overcome in allowing people with disability to have greater personal control in their lives. The UNCRPD requires State Parties to recognise that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others. The barriers that might stop a person making decisions in their lives can be due to the lack of assistance in making decisions, or the beliefs of others that they are unable to do so.

The South Australian project provided for a particular model of supported decision making: but how can the results of this trial be applied to upholding the rights of a much larger group of people? Using a model borrowed from population health that describes primary, secondary and tertiary interventions, it is possible to consider where interventions might occur — in particular, implementing the ‘stepped model’.

Stepped Model of Supported and Substitute Decision Making

This is a quick overview of the Stepped Model, initially put forward in our 2009 Annual Report, the latest iteration of which is illustrated in full in our 2012 Annual Report. Below is a simplified version.

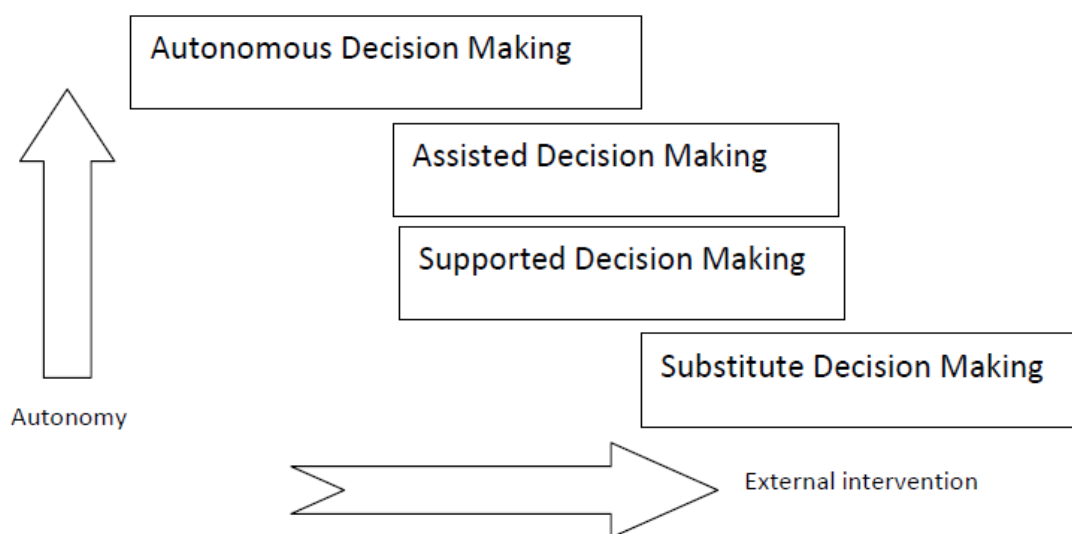


Figure A11: A simplified diagram illustrating the Stepped Model of Supported and Substitute Decision Making. Y-axis: increasing autonomy in a person's life; X-axis, increasing intervention in the life of a person by others.

In stepped models, if a necessary step is missing, the response of a system is more likely to 'fall to the right' so that it is excessive and disproportionate to need. Currently, what Article 12 describes as State Parties' obligation to provide appropriate measures to support a person to exercise their own capacity may not be available. In particular, if assisted and supported decision making is not available, people will then turn to others to make decisions, either on an informal basis or through formal guardianship. Therefore, personal decision making rights can be lost; and the more intensive external interventions delivered instead, by making an individual more dependent, may ultimately be a greater financial cost to the State.

This model distinguishes assisted decision making from supported decision making. Assistance can be delivered by anyone involved in a transaction with a person who has a disability; it may be a disability worker, health workers, bank worker, retail employee — whoever. In contrast to assisted decision making (applying this description), supported decision making occurs when a third person is invited by the person who has a disability to support their decision making, attend meetings, communicate decisions and perform other tasks associated with decision making.

We suggest that there should be a broad expectation in our community that assistance be provided wherever possible. This might mean offering time for a longer discussion, a second meeting, having plain English material, video explanations or arranging communication assistance. The UNCRPD Article 5 Equality and Non-Discrimination would consider such assistance "reasonable accommodation."

A population model of Assisted and Supported Decision Making

In this context a population model is proposed:

INTERVENTION LEVEL	DESCRIPTION OF INTERVENTION	TARGET POPULATION
Primary Universal Interventions	Education Stigma Reduction	Entire Community
Secondary Interventions	Provision of assistance Engaging of a supporter on an ad hoc basis when required	Disability sector — individualised funding facilitators Health sector Justice sector Education and training Financial sector
Tertiary Interventions	Facilitation of Supported Decision Making Agreements. Education & training of those involved in secondary-level interventions.	Specialist non-government providers. Some specialist individualised funding facilitators may develop these skills.

Figure A12: A Population-based Model of Assisted and Supported Decision Making.

Primary interventions: At this time we have done little work in this area. To uphold rights all citizens must know that everyone, including people with a disability, are entitled to equal recognition before the law and if necessary, receive helpful assistance from others as they work, study, shop, engage in recreation — assistance that is useful, that is free of condescension and delivered in a rights affirming rather than a begrudging way. This could be part of disability awareness education for school students, but also be a component of the training of people in different fields, whether it be education, the financial sector, law enforcement, the taxi industry and so on. For some groups, communication aids can help in this task. Article 12 could also be a specific focus of future community-wide disability awareness campaigns.

Secondary interventions: People working in particular industries will need greater skills in either providing assistance or working with a potential supporter. If required, supporters might be invited on an ad hoc basis, to support a person make a particular decision or provide support for a group of decisions. This is not as formalised as the intervention that was used in the South Australian project where an agreement is signed, but the principles still apply, including an understanding of the role of the person receiving support and that of their supporter (described

on pages 54 and 55 of the OPA 2012 Annual Report). A person offering support on an ad hoc basis must be able to fulfil their duty to the supported person and not use this as a way of advancing their own interests.

Anyone working in a range of industries, such as disability services, health services, justice and finance might potentially need more training in assisting people to exercise their capacity and in the use of their supporters.

Tertiary interventions: This reflects the work of what in the future might be the specialist supported decision-making sector, a sector that is yet to exist but would be similar in practice, to the work of the facilitator in the South Australian trial. . This sector could be small, as its primary purpose would be to guide and train others and to facilitate formal supported decision making agreements, particularly in complex situations. In a state the size of South Australia, it might comprise less than a handful of practitioners. Some staff employed to assist people to develop individualised funding plans could also develop their specialist skills in this area. Because these staff are involved in planning rather than provision of services, there is less likelihood of a conflict of interest in facilitating supported decision making agreements.

We consider that this population-based approach helps define a future role for supported decision making facilitators, given that while supported decision making principles might be broadly applied, only a smaller sub-group will need the specialist tertiary intervention.

However, with respect to the appointment of a guardian, we suggest that supported decision making can only be considered to have failed, or not be suitable, if the highest level tertiary intervention has been tried.

Because of the breadth of supported decision making, applicants for guardianship can say that they have considered it, or tried it; in reality, what may have been considered or tried is only the secondary ad hoc intervention, which may or may not have been applied with vigour, if the applicants believe that only a substitute decision maker will do. This is why we consider that a formal, supported decision-making agreement needs to be considered in such circumstances.

Legislative reform

The Committee has developed recommendations for legislative reform which have been presented by the Public Advocate to the Attorney-General, under the provision of s 21 (1) (g) of the *GAA*. This section gives power to the Public Advocate to monitor the administration of the *GAA* and, if he or she thinks fit, make recommendations to the Minister for legislative changes.

Separate to the need to recognise supported decision making, there are other practical reasons for the *GAA* after 20 years to be opened up to Disability reform. Aligning principles in the *GAA* with those in the *Advance Care Directives Act 2013*, and ensuring that the approach in the guardianship and administration sector is consistent with developments in reform in disability, aged care, and mental health are all reasons to consider reform of the *GAA*. For example, this section has already referred to the expectations of decision support included in the legislation and rules underpinning DisabilityCare Australia. We have also suggested practical changes to

the sections on restrictive practices (see the section on Detention in Aged Care in this Annual Report).

With respect to supported decision making, there are two components to the recommended legislative changes. First, by modifying the principles of the *GAA*, so that key principles in the Act, which are identical to the *Advance Care Directives Act 2013*, would require supported decision making. The second would be to add new sections to the Act to recognise supported decision making arrangements.

The first component of legislative change: The addition of a supported decision making principle.

This could be achieved in the *GAA* by adding a key principle of the *Advance Care Directives Act 2013* Section 10 (d) which requires:

- (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;

This Office has in previous years made recommendations that the Act be amended to include a principle to underpin support instead of substituted decision making where possible. We think that the arguments to do so are now more compelling since the South Australian Parliament's support of the *Advance Care Directives Act 2013*, as well as the outcome of the evaluation of the Supported Decision Making trial. As mentioned in our 2009 Annual Report, the United Kingdom Mental Capacity Act 2005 contains a requirement to consider supporting decision making first, and this provision has been a significant driver of supported decision making practice in Britain. The only further work required is to consider how the principle can be applied to financial decisions, as the *Advance Care Directives Act 2013*, on which the suggested principle is based, does not consider financial decisions, whereas the *GAA* does.

The second component of legislative change: Specific recognition of supported decision making arrangements

This Office supports the recommendations of the Victorian Law Reform Commission (VLRC) for supported decision making agreements to be recognised, and the roles of supporters codified.

The legal recognition that a decision made with a supported decision making agreement can be considered to be the decision of the person, would give supported decision making a legal standing equivalent to guardianship. For example, when an organisation asks a client to choose between two options that might involve risk, if there is any doubt about a person's capacity, currently guardianship can be the only option for risk managers in an organisation to remove any ambiguity. Legal recognition of decisions made with supported decision making would provide this clarity. At the same time, legal provisions can codify the duty of supporters towards the person that they support, and protect against abuse.

The details of a potential South Australian proposal, based on the VLRC recommendations, are detailed in the following table.

Proposals to Recognise Supported Decision Making Agreements and the Roles of Supporters (based on VLRC (2012) recommendations modified for SA)

- This would necessitate the addition of a small number of new sections to the *GAA* to recognise support arrangements. These could be grouped into a new part of the Act.
- **Recognition of the appointment of supporter**
 - A new appointment known as a ‘supporter’ should be introduced into the *GAA*.
 - A person supported under the arrangements should be known as the ‘supported person.’
 - The arrangements would support personal decisions — in the areas of health, accommodation and lifestyle.
 - A person should be able to appoint a supporter by agreement if they have the capacity to do so.
 - Where a person is unable to appoint a supporter, the Guardianship Board can appoint someone who will be able to support a person to make decisions.
- **Recognition of decisions with support**
 - Any decision made with the assistance of a supporter or communicated by or with the assistance of a supporter within the authority of the appointment or order should be recognised as the decision of the supported person for all purposes.
- **Selection of supporter**

If appointing a supporter, the Guardianship Board must take into account:

 - The wishes of the person; the desirability of preserving family and other relationships of importance to the person; the nature of the relationship between the person and the proposed supporter, and in particular whether the relationship is characterised by trust; the ability and availability of the proposed supporter to assist the person to make the decisions about the matters to be referred to in the order; whether the proposed supporter will act honestly diligently and in good faith in the performance of their role and whether the proposed supporter has a potential conflict of interest in relation to any of the decisions referred to in the role, and will be aware of and respond appropriately to any potential conflicts.
 - People in a professional relationship with the person should not be appointed.
- **Authority given to supporters**
 - To access, collect or obtain or assist the supported person in accessing, collecting or obtaining information.
 - To discuss the information with a supported person in a way the person can understand.
 - To communicate or assist the supported person to communicate, and to advocate for implementation of the decision.
 - The appointment or order should specify which of these powers the supporter can exercise.
- **To avoid doubt the law should specify that**
 - The supporter is not authorised to make decisions on behalf of the supported person.
- **Responsibility of supporters**
 - Assist the person to make the decisions specified in the order.
 - Act honestly, diligently and in good faith.
 - Act within the limits of the appointment.
 - Identify and respond to conflict of interest, ensure that the supported person’s interests are given paramount consideration, and seek external advice where necessary.
 - Respect the confidentiality and privacy of the supported person by only collecting relevant and necessary information, and only disclosing information with the supported person’s consent.

Are we ready for law reform now or is more empirical research required?

In June 2013, Carney and Beaupert published in the University of New South Wales Law Journal, a considered analysis of what is required to progress Supported Decision Making, considering a phenomenon which “...uncomfortably straddles the macro-level of governance and the micro-level of individual citizen relation”. (Carney & Beaupert, 2013)

These authors observe, as our Office did, that most articles and reviews on supported decision making adopt “standard, normative, doctrinal or policy analysis methodologies” rather than having an evidence-based focus. Their conclusion, on reviewing available literature including the evaluation of the South Australian trial, is that to date there has only been minimal research on practical implementation of supported decision making. They observe that the “issues at stake for people with cognitive and psychosocial disabilities and the public interest are too significant and potentially grave” to be solved by muddling through and normative arguments (i.e. those made without empirical data). They argue for more empirical research and pilot programs. (Carney & Beaupert, 2013)

In a foreword to this journal, former Chief Justice of the High Court, Sir Anthony Mason, said, “I also agree with the authors’ conclusions that proposals for supported decision-making must be based on empirical evidence-based research and pilot programs which are presently lacking. As things currently stand, the proposals seem to reflect little more than ideals that have not been carefully thought through, with the risk that they will result in experimental law making”. (Mason, 2013)

How does this sit with the recommendations to the Attorney-General for law reform made by our Supported Decision Making Committee through the Public Advocate?

We would suggest that the first part of our recommendation, to have an additional principle requiring support, is not controversial and having such a principle consistent with international rights obligations and other existing legislation both here and elsewhere, would not be experimental law making. If only this was achieved for the time being while more research was conducted, we would still be satisfied, given the United Kingdom experience of implementing such a principle

The measures that we see that may still be subject to debate, given the analysis of Carney and Beaupert, and commentary by Mason, are reforms that implement specific provisions for supported decision making agreements and the appointment of supporters as is the case in Canadian legislation and in the VLRC recommendations for statutory supported decision making provisions.

The Public Advocate agrees with Carney and Beaupert’s conclusions about the need for more empirical research, and that this so far has been limited.

However, should more substantive law reform, in particular the legislation of provisions to recognise support arrangements be delayed while such research is undertaken? Our answer would be “No”. An alternative solution would be to formally evaluate new laws as they are put in place. This could be done through prospective research, based on partnerships between academic institutions and providers. The driver and benefits of such research would be so powerful, that it would be likely to obtain competitive research funds. Too often, we know that a

review of a new Act is needed but information is collected retrospectively after a review starts some years after an Act has been operating, whereas the research to evaluate an Act could begin prospectively from day one of operation. A prospective research approach, as an alternative strategy, would ensure that people who are affected by new laws can be interviewed at the time that they engage with the law and the supported decision making process.

Another reason to proceed in this way is that supported decision making is a collection of different interventions in its non-statutory and statutory forms. While findings from empirical research on a non-statutory form can be extrapolated onto how a potential law reform might operate, they still will only ever be an approximation.

Another reason is that we risk a double standard in evidence-based law making if we apply an evidence test to rights-affirming measures that has not been applied to historical rights-removing laws. As a society we have been content to see parliaments legislate for coercive measures applied against people with disabilities that have little empirical evidence to support their use. An example of this is the widespread use in Australia of community treatment orders for people with mental illness, although there is a lack of empirical evidence to support such use (Burns et al., 2013). It would be unfortunate that a measure such as supported decision making, designed to give back rights to individuals, is expected to rigorously justify itself through empirical research, while traditional measures that take away rights do not.

So, Mason's (2013) reference to "experimental law making" could be seen as a positive, if innovative measures that are widely supported and based on the expectations of international agreements are then in their practical application subject to research evaluation that feeds into a legal review of their operation. The work of the South Australian trial could be replicated with larger numbers and applied to statutory agreements, if laws were changed. This could herald a new approach of evidence-based law making that is empirically evaluated.

At the same time, there are other opportunities for empirical research associated with DisabilityCare Australia. Given that the underpinning legislation and the Nominee Rules expect supported decision making, its use and implementation as people develop care plans could be evaluated. Because South Australia's trial involves children and not adults, any evaluation work of this type will need to be undertaken in the other states.

Summary

Further actions that could occur to further the implementation of Article 12 in South Australia would include:

- Applying a population approach that provides for education about rights and decision making for the broader community, skills in assistance and support for people who work in relevant sectors, and a small tertiary supported decision making service.
- The addition to the GAA of a new principle requiring support where possible prior to considering the use of substitute decision making.
- The addition of a new section to the GAA that provides for supported decision making agreements, recognises decisions made with such agreements, and describes obligations of supporters.

Supported Decision Making Committee

A Supported Decision Making Committee was established in February 2010.

It was formed under the provisions of s21(3) of the *Guardianship and Administration Act 1993*, which allows the Public Advocate to establish committees for the purpose of providing him or her with advice in relation to the performance of any of his or her functions. The terms of reference for the committee were published on page 104 of the 2009–2010 Annual Report.

The contribution of the members of the committee listed below is acknowledged.

With the cessation of the Supported Decision Making trial, the committee considered how to further advance the practice and uptake of Supported Decision Making, including considering the role of legislative change, the development of further resources to aid practice, and assisting other projects and practitioners applying supported decision making.

The committee membership is starting to change. Thank you to those members who have served during the trial.

The membership of the Committee is as follows:

<i>John Brayley</i>	<i>Chair</i>
<i>Robbi Williams</i>	
<i>Graham Mylett</i>	
<i>Tiffany Bartlett</i>	
<i>Margi Charlesworth</i>	<i>Until December 2012</i>
<i>Ian Cummins</i>	
<i>Dell Stagg</i>	
<i>Margaret Brown</i>	
<i>Ian Bidmeade</i>	
<i>Helen Mares</i>	
<i>Julie-Anne Harris</i>	<i>Until March 2012</i>
<i>Andrew Sarre</i>	<i>From March 2013</i>
<i>Elly Nitschke</i>	
<i>Di Chartres</i>	
<i>In attendance</i>	
<i>Cher Nicholson</i>	<i>Attended as Senior Practitioner and Project Coordinator, Supported Decision Making Project</i>
	<i>(until November 2012)</i>
	<i>Now a member of the committee in her own right, December 2012 onwards</i>

Heather Linton

Attended as Peer Worker

(until November 2012)

*Now a member of the committee in her own
right December 2012 onwards*

Margaret Wallace

Attended as Independent Evaluator

(until October 2012)

*External reviewer
and commentator*

John Chesterman,

Manager Policy and Education

Victorian Office of the Public Advocate



The Public Advocate was an invited speaker at a forum on Supported Decision Making in Brisbane, in June 2013, organised by Queensland Advocacy Incorporated and the Queensland University of Technology Health Law Centre.

Promoting Rights and Interests

Advance Care Directives Act 2013

Following its passage through the South Australian Parliament, the *Advance Care Directives Act (ACDA) 2013* was passed and will come into effect during 2014, we understand, most likely in June. The ACDA creates a single Advance Care Directive replacing the existing Enduring Power of Guardianship, Medical Power of Attorney and Anticipatory Direction. The Act also makes amendments to *the Guardianship and Administration Act, 1993* and the *Consent to Medical Treatment and Palliative Care Act, (Consent Act) 1995*.

The ACDA is a most welcome piece of legislation. This is because it will take much of the current confusion out of making an advance care directive and it is underpinned by a set of overarching principles that support the rights of people to make their own decisions for as long as possible and to be supported in their decision making if they have difficulty. The Act also promotes a person-centred approach to substitute decision making.

By making an advance care directive, a person is able to write down their values, what quality of life means to them, how they wish to live and how they want decisions made for them if, at some time in the future, they experience impaired decision making capacity and are unable to make their own decisions. As well as providing this information, a person can also appoint one or more substitute decision makers. The information written in the advance care directive will assist substitute decision makers (if any are appointed), family members, health professionals and others to make decisions based on knowledge of the person's preferences. If a circumstance occurs where a person is not able to make decisions even with support, substitute decision makers must 'stand in the shoes' of the person and make decisions as the person would have done prior to their decision making capacity becoming impaired. In this way, a person is able to have their rights upheld with respect to important decisions affecting their lives if they lose decision making capacity.

New Mediation Service at the Office of the Public Advocate

At times, there are disagreements between substitute decision makers, family members, health professionals, service providers and relevant others about decisions that need to be made for someone who has impaired decision making capacity. The conflict can cause relationships to break down and leave the person who has the cognitive impairment without the support and interaction that they want when they most need it. In addition, sometimes the conflict causes the matter to be taken to the Guardianship Board, often resulting in the substitute decision making role being given to an independent body, such as the Public Advocate via a Guardianship Order.

Both ACDA and the Consent Act confer a dispute resolution role on the Public Advocate, so that people are assisted to resolve disagreements that may arise about an advance care directive or a consent issue. The OPA has employed a Senior Project Officer to develop its dispute resolution

service in time for the ACDA and subsequent amendments that come into effect. The dispute resolution service will include the provision of information and advice, providing a declaration in relation to an advance care directive and a mediation service. This service will operate within the principles of the ACDA, which will ensure that the rights of the person at the centre of the dispute are upheld. By participating in mediation, everyone involved is able to come together, share their views and discuss the issues with the aim of coming up with a solution that respects the person's wishes and views without the need to proceed to the more formal process of the Guardianship Board.

The mediation model developed during the project is person-centred, ensuring that the person who made the advance care directive is at the centre of the decision making process, and providing support to enable the person to participate to the fullest extent that they are able. This does not mean that the person has to be directly involved in the mediation, as this may not be possible or appropriate due to the level of conflict and the person's impaired decision making capacity. However, the mediation model is designed to ensure that the voice of the person, their thoughts, views and wishes are brought into the mediation and fully considered in the decision making process. The model includes safeguards to ensure that mediation is appropriate for the participants and is a safe process.

The Senior Project Officer is a member of the Advance Care Directives Implementation Steering Committee. During the coming months she will work with the committee, OPA staff, working parties, consumers and other key stakeholders to further develop the OPA dispute resolution service to ensure that it is ready to deliver an excellent service to South Australians when the ACDA comes into effect in 2014.

Promoting Rights and Interests

Support and Protection of Vulnerable Older Adults

The Office of the Public Advocate has continued to pursue changes to South Australian systems to improve the prevention of, and response to, the abuse of our vulnerable older citizens. Coinciding with the launch of our Vulnerable Older Adults Project Report, *Closing the Gaps*, on World Awareness Day in June 2012, the (then) Minister for Health and Ageing announced a review of the State Plan, *Our Actions to Prevent the Abuse of Older people, 2007*. This review, conducted by the Office for the Ageing (OFTA) commenced in November, 2012 and the OPA was pleased to be invited to sit on the Review Steering Committee along with other key stakeholders.

In June, the OFTA released the draft *South Australian Strategy for Safeguarding Older People, 2014–2021*, for comment. The draft is an aspirational document, offering a broad, overarching framework to guide the further development of adult safeguarding over the next seven years.

As recommended in *Closing the Gaps*, the draft strategy includes a South Australian Charter of Rights and Freedoms of Older People which has the potential to influence rights-based policy and much needed legislative change in the area of abuse prevention and response. The Charter, along with the key principles contained in the draft document, align with the OPA's commitment to a rights-based approach to working with older people who are vulnerable and at risk of harm and abuse.

On the one hand, we are pleased with the draft strategy because it is underpinned by a rights-based approach that aims to provide a right to safety from abuse. On the other hand, we wish to see the strategy go further than what has been put forward in the first draft to translate the rights into the practical results that the many stakeholders in *Closing the Gaps* wanted to see.

To close the gaps in our current system and to ensure the adequate and appropriate safeguarding of vulnerable older people, the draft strategy should at some point translate into legislative reform. In the interim, it is vital that a whole-of-government policy framework be put in place (as recommended in *Closing the Gaps*) to guide services as they work with older people and interface with each other, and provide a modest allocation of resources for coordination, training and specialist assistance to frontline services.

The OPA looks forward to assisting this process by joining with the OFTA, Review Steering Committee, key stakeholders and consumers as OFTA leads the process in taking the draft strategy forward.

Promoting Rights and Interests

Reporting of Abuse of Children and Adults in Mental Health Settings

Our Annual Report 2012 (pages 36–41) described reports of abuse in South Australian mental hospitals of children and adults with mental illness and disability, mostly covering the period from 1960 to the 1980s, but one instance more recently.

People telephoned our Office following a newspaper article by journalist Andrew Dowdell in the *Sunday Mail* on the topic of the abuse of children in mental institutions. Our Office became a contact point to receive reports.

Fourteen people made contact, which we considered to be a significant response from one press article. Reports included sexual assault, physical assault, emotional abuse, abusive use of medications, and neglect. Alleged abusers were staff and other patients. The people who made contact with us belong to a group that has generally not been able to speak up.

Our 2012 Annual Report documented these reports, and the need for a response. Callers wanted the government to respond in many different ways, but recognition, an acknowledgement and an apology were common themes along with accountability of the staff who worked in these facilities.

This matter was reported again by Andrew Dowdell, in an article in the *Advertiser* in March 2013.

As a result of this second press report, nine more people came forward describing further instances of rape, assault and abuse. A particular issue from these reports were the experiences of young teenagers in hospital, put in contact with paedophiles.

This issue is still with the South Australian Government for consideration. Since the matter was first raised, the Australian Government's Royal Commission into Institutional Responses to Child Sexual Abuse is now under way. This might be an avenue for a number of the instances of abuse to be followed up. This however would not cover the full breadth of the problem, given that the abuse reported includes significant physical and emotional abuse as well as sexual abuse, and the victims of abuse were children and vulnerable adults, the latter group not being covered by the Royal Commission.

Raising Matters with the Minister

Guardianship and Administration Act 1993

22—Public Advocate may raise matters with the Minister and the Attorney-General

- (1) The Public Advocate may, at any time, raise with the Minister and the Attorney-General any concerns he or she may have over any matter arising out of or relating to the performance of his or her functions under this Act or any other Act.
- (2) If the Public Advocate so requests, the Attorney-General must cause a report of any matter raised by the Public Advocate under subsection (1) to be laid as soon as practicable before both Houses of Parliament.
- (3) The annual report furnished by the Public Advocate under this Act must include a summary of any matters raised by the Public Advocate under subsection (1).

During 2012–13, the Public Advocate met with relevant ministers and one Member of Parliament in an advocacy role.

The Public Advocate sought appointments with ministers to discuss a range of legislative, policy and funding issues across the law, disability, ageing and mental health.

Meetings with Ministers:

Hon. John Rau MP, Deputy Premier
Attorney-General

Hon. Ian Hunter MLC, former Minister for Disabilities

Hon. John Hill MP, former Minister for Health and Ageing
Minister for Mental Health and Substance Abuse

Hon. Michael O'Brien MP, Minister for Corrections

Hon. Jack Snelling MP, Minister for Health and Ageing
Minister for Mental Health and Substance Abuse

Hon. Tony Piccolo MP, Minister for Communities and Social Inclusion
Minister for Social Housing
Minister for Disabilities

Meetings with Members of Parliament:

Hon. Kelly Vincent, MLC

Meetings with Federal Minister

The Hon. Mark Butler MP, former Minister for Mental Health and Ageing
Minister for Social Inclusion
Minister Assisting the Prime Minister on Mental Health Reform
Minister for Housing and Homelessness

Section 22 Report

No matters were raised under the formal provision of Section 22 during 2012–13.

Presentation to select committees:

The Public Advocate and Margi Keville, Advocate Guardian, presented to the Legislative Council Select Committee into *Access to and Interaction with the Justice System for People with Disabilities*.

Give advice on legislative powers

Guardianship and Administration Act 1993

Section 21 (1) The functions of the Public Advocate are—

- (f) to give advice on the powers that may be exercised under this Act in relation to mentally incapacitated persons, on the operation of this Act generally and on appropriate alternatives to taking action under this Act;

Advice about the Act was provided through:

- The enquiry service
- Education sessions

This work is reported in Part B of this Report.



Senior Advocate Guardian Julie-Anne Harris meets with Assistant Public Advocate Margaret Farr

Part B:

Direct Services

Provided to the Community by the Office of the Public Advocate

Public Guardian

Guardianship and Administration Act 1993

Section 29 —Guardianship orders

- (1) If the Board is satisfied, on an application made under this Division—
 - (a) that the person the subject of the application has a mental incapacity; and
 - (b) that the person the subject of the application does not have an enduring guardian; and
 - (c) that an order under this section should be made in respect of the person, the Board may, by order, place the person under—
 - (d) the limited guardianship; or
 - (e) if satisfied that an order under paragraph (d) would not be appropriate, the full guardianship,of such person or persons as the Board considers, in all the circumstances of the case, to be the most suitable for the purpose.
- (4) The Public Advocate may be appointed as the guardian, or one of the guardians, of the person, but only if the Board considers that no other order under this section would be appropriate.

The role of guardian

Guardians are appointed by the Guardianship Board (under Section 29 of the *Guardianship and Administration Act 1993 (GAA)*) to make decisions on behalf of individuals who are unable to do so for themselves due to mental incapacity. Decisions that a guardian can make cover health care, accommodation or lifestyle, depending on the nature of the order. If decisions about finances or legal matters are required, then an Administrator needs to be appointed. The person under an order is called a protected person.

The GAA requires the Board to make the order which is the least restrictive intrusion in the life of an individual affected by its order. This also will lead to the least intrusion in the lives of families. In accordance with the Act, the Board must first consider whether a limited order is sufficient to address the decision making issues, and then only make a full order if it is satisfied that a limited order would not be appropriate.

In keeping with a least restrictive and rights-based approach to guardianship, the OPA guardians enquire as to the ability of protected people to make their own decisions, notwithstanding the existence of a guardianship order. Where the protected person is able to understand the information pertinent to the decision and can be appropriately supported to decide, OPA guardians will respect their wishes and decision.



Advocate Guardian members of the “Long Term” team: David Cripps, Katrina Burgess, Belinda Lake, and Elicia White. Foreground, facing away from camera, Popi Amanatidis.

Guardianship and Medical Consent

During 2012–13, OPA policy on consenting to medical and dental treatments was changed to explicitly reflect the intent of Sections 58 and 59 the *Guardianship and Administration Act 1993*. The provisions of the Act are such that third parties only have a responsibility for and right to make substitute medical consent decisions when it is determined that, by reason of mental incapacity, an individual is not capable of giving effective consent on that occasion. This extends to people who are subject to guardianship orders which include health care decision making.

This section of the GAA infers that mental incapacity is in fact decision-specific and that the decision to make a person a “protected person” does not detract from their right to be properly informed and to have the opportunity to have their ability to make informed decisions explored and respected.

Proposal for Additional Principles in Section 5 of the Act

In previous annual reports, this Office has advocated for the inclusion of additional principles in the Act to clarify the concept of mental incapacity in order to foster a more rights-based view. To view mental incapacity as decision-specific is in effect what is required in order to faithfully apply the current provisions of sections 58 and 59 of the Act.

The OPA notes that the new *Advance Care Directives Act 2013*, in s10, incorporates principles which further define what is referred to in that Act as “impaired decision making capacity”. These principles incorporate the following key notions:

- in the absence of evidence to the contrary, the right to have capacity presumed
- the fluctuating nature of capacity
- the right to be supported to make own decisions for as long as possible
- the ways in which autonomy can be expressed
- notion of substituted judgement.

The OPA will continue to advocate for changes to the *Guardianship and Administration Act 1993* to promote a more rights-based approach as appears in the *Advance Care Directives Act 2013*. Achieving legislative congruence in approach to the application of these pieces of legislation will be important to South Australians who come within their remit and to those administering the legislation.

Such reform would also improve access to supported decision making, so that a person does not have decisions made for them by a substitute, when with support, they could make their own decision. This is explored further in Part A of the report in the section on Promoting Rights and Interests — Supported Decision Making.

Guardianship Activity 2012–13

Overview

Key activity level changes noted in public guardianship since the last reporting period include-

- 25% increase in the number of people in receipt of public guardianship services at some stage during this reporting period compared with 2011–12.
- 28% increase in the number of people under public guardianship at the end of 2012–13 compared with the end of 2011–12
- 26% increase in the number of new statutory guardian appointments during this reporting period compared with 2011–12
- 10% increase in guardianship case closures during this reporting period compared with 2011–12
- 11.6% drop in closure rate (i.e., proportion of active guardianships closed during reporting period) between 2011–12 and 2012–13 reporting periods. (While the total number of closures is up, this reflects the increase in the total numbers of people under guardianship, whereas the actual rate of closure is down.)
- 14% increase in limited orders for new statutory guardianship appointments compared with the previous reporting period and parallel reduction in full orders

Changes in Total Guardianship rates (both public and private appointments) since the last reporting period include -

- 28% increase in the rate of statutory guardianship per 100,000 as at June end
- 26% increase in the rate of new statutory guardianship appointments per 100,000
- 11% increase in the rate of new private guardian appointments per 100,000
- 17% increase in the rate of all new guardianship appointments per 100,000

The South Australian population increase for this period was 2%.

Overall, in a two-year period, there has been a 50% increase in the number of public guardianship appointments in South Australia. As was discussed in the 2011 Annual Report (page 122 onwards), our Office considers that this is not an outcome that Parliament intended when the GAA was passed and is contrary to the requirements of the UN Convention on the Rights of Persons with Disabilities. It can also be contrary to good practice if the need for an order is in fact due to the limitations of the mental health and disability systems to provide adequate accommodation and support, rather than an intrinsic need of an individual to have in place substitute decision making (see page 131, 2011 Annual Report).

This is discussed further in Part A, in the section Monitoring Legislation.

Data

During 2012–13, the Office of the Public Advocate provided guardianship services under the *Guardianship and Administration Act 1993* on behalf of 1162 people (928 in 2011–12). This represents a 25% increase over the previous year. In the previous four reporting periods, the increases were 17%, 6.7%, 9.6%, and 17%. The 25% increase during 2012–13 represents the biggest expansion in the past five years.

Figure B1 illustrates the upward trend in active guardianship numbers over the past five years as well as end-of-year active caseloads.

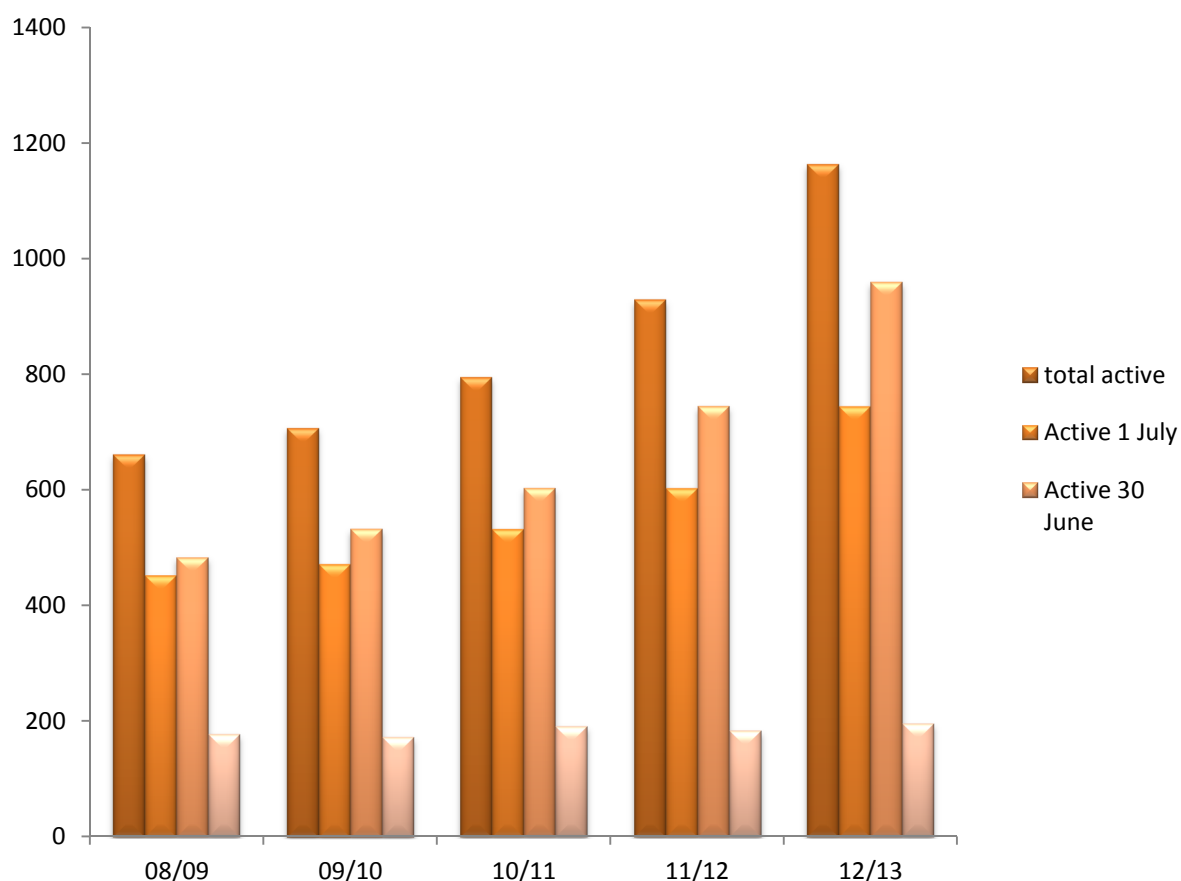


Figure B1: Guardianship Activity 2008–09 to 2012–13 (Total active, Active 1 July 2012, Active 30 June 2013, Revoked)

As at 30 June 2013, there were 959 active guardianship cases compared with 750 at the beginning of the financial year. This is a 28% increase in end-of-year active cases compared with 23.6% increase for the previous reporting period.

The OPA has experienced a 100% increase in active cases since the end of June 2009 (four years).

During 2012–13, additional Treasury funding and internal restructuring allowed conversion of temporary positions to permanent and recruitment of additional advocate/guardian staff. However, the significant increase in active guardianship cases has continued to be challenging, thus requiring allocation waiting lists to remain in place for the entire year.

The growth in active guardianship over the past five years is depicted in the next chart (Figure B2).

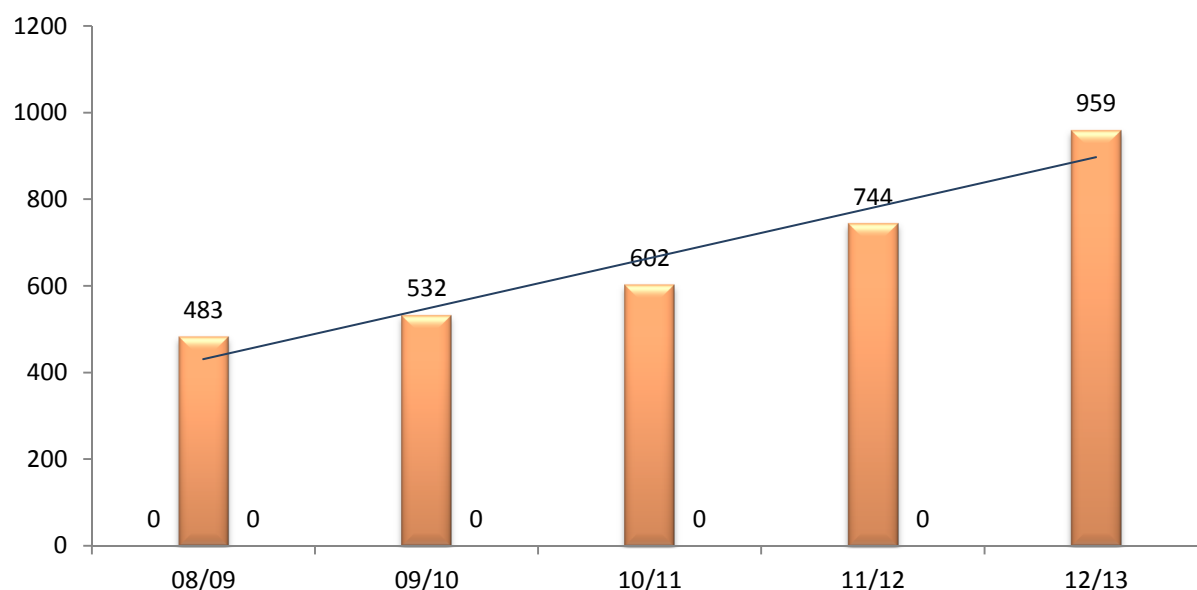


Figure B2: Comparison of Active cases as at year-end 2008-09 to 2012-13

This year, 412 new Public Advocate guardianship appointments were made, a 26.4% increase on last year's figures (326). Figure B3 illustrates the general upward trend in number of appointments with numbers of new appointments near doubling over the past four years. Of the 412 new appointments, 201 were limited orders (49%) and 211 (51%) were full orders. In 2011-12, 35% of new Public Advocate appointments were limited orders and 65% were full orders. There has been a 14% shift away from full orders to limited orders over the past year which can be interpreted as a shift to a less restrictive intervention approach on the part of the Guardianship Board.

Of these new appointments, 43 orders (10%) involved joint appointments with private guardians.

Appointments were for 182 (44%) females and 230 (56%) males.

Of the 412 appointments, 69 (16.7%) involved an emergency order appointing the Public Advocate as interim guardian compared with 89 of 326 cases (27%) and 71 of 258 cases (28%) in the previous two reporting periods.

Of the 412 new appointments during 2012-13, 114 cases (28%) had S32 powers granted at the initial hearing or at some stage during this reporting period. This is a similar figure to 2011-12.

New guardianship cases are managed within a two-team structure and stable matters are later transferred to a monitoring category. This year, the numbers of new guardianship cases allocated to the short-term team were affected by the large number of new cases resulting from policy changes in the disability sector. The waiting list for these cases was held by the short-term team; hence, approximately 64% of new cases were identified as short-term clients during 2012-13. In the previous reporting period, the short- and long-term teams had similar numbers

of new cases allocated and this year's picture would have been similar, were it not for the disability clients.

It has now been decided to manage this client group as a separate category outside of the short-term team structure, with cases only being allocated to an advocate/guardian when significant issues arise. Duty workers respond to one-off consent matters and general enquiries within this client group.

The short-term team has fewer staff but has the objective of more rapid throughput due to its clientele and the nature of substitute decisions required. Many of their cases transfer to the monitoring list once major decisions are made.

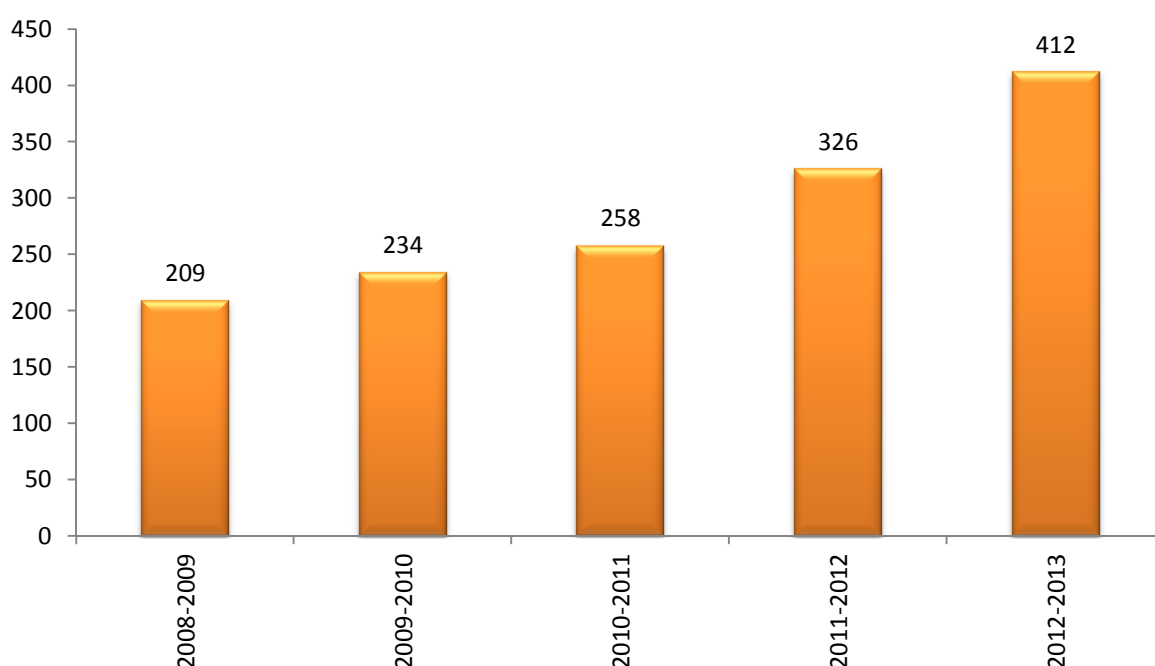


Figure B3: Comparison of new Guardianships over the past five years

Policy changes within Disability Services began to impact this Office in August 2012. Formal guardianship arrangements were to be sought for all clients who lacked family members willing to make substitute decisions where this was necessary. With respect to medical and dental decisions, the policy reversed the standard South Australian practice that the person in charge of day-to-day care would provide health consent if needed.

134 individuals with an intellectual disability were received into guardianship during 2012-13, accounting for 1/3 of all new appointments. This is substantially more appointments for this client group than would have occurred in previous years. The Office of the Public Advocate has worked with Disability Services who have agreed to reverse the policy change with respect to medical and dental consent matters which will result in fewer appointments in the future.

During 2012–13, 203 cases were closed — a 10% increase (19) when compared to 184 closures in 2011–12. Of the 203 closures, 91 were due to revocation of orders, 81 due to death, and 31 due to private guardians being appointed. Reasons for closure are illustrated below (Figure B4). This is analysed in more detail in the following pages.

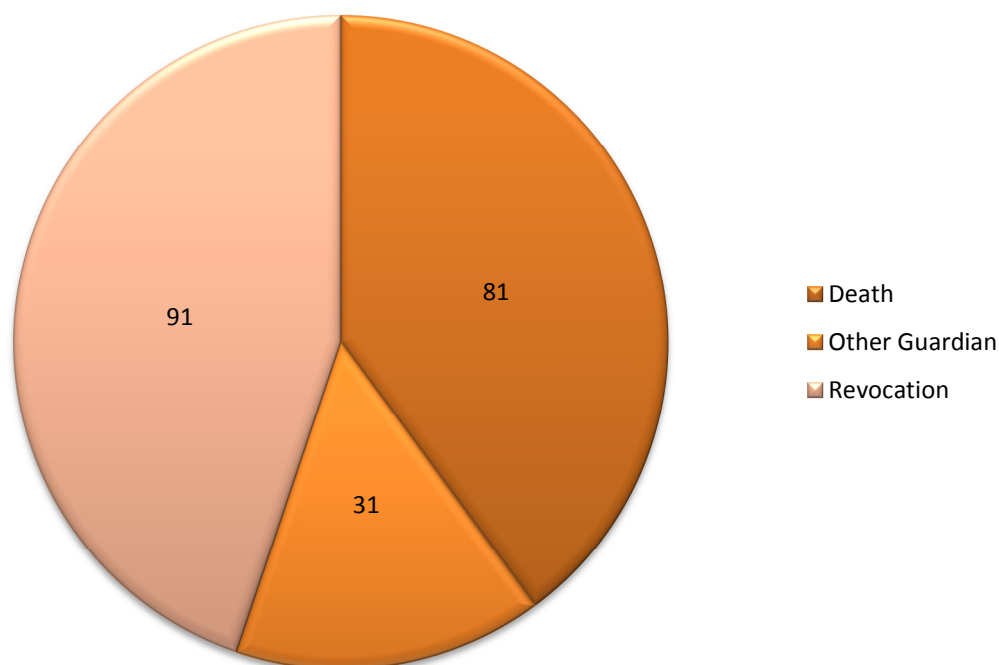


Figure B4: Reasons for closure of guardianship cases 2012–13

The rate of closure in 2012–13 as a percentage of all orders was 17.5%. This compares to 19.8% in 2011–12, 24.1% in 2010–11 and 24.5% in 2009–10. Rates of closure for the past eight years are illustrated in Figure B5. This reporting period has the lowest rate of closure.

In the 2011–12 Annual Report, we offered several possible explanations for a decline in closure rate. These included less attention to throughput at times where staff resources are under most pressure, the policy position of the Guardianship Board about the role of guardianship and current interpretation of the law which sees otherwise stable cases being kept under guardianship to authorise detention in secure facilities and the lack of coverage of the monitoring caseload.

This downward trend in closure rate raises both practical resourcing concerns and philosophical concerns in terms of guardianship practice. An increase in new guardianships coupled with a significant decline in closure rate will see statutory guardianship numbers accelerate at a time when international focus is on promotion of alternatives to guardianship and practical rights-based approaches to adults at risk.

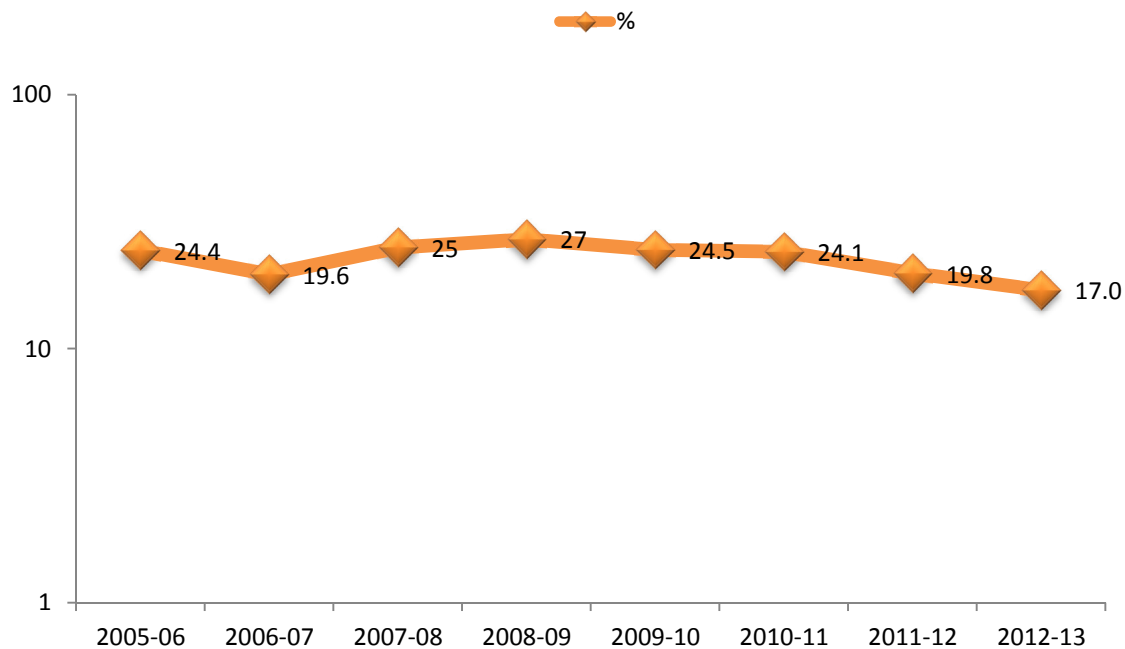


Figure B5: Rate of Guardianship closure 2005-06 to 2012-13

Figure B6 compares numbers of guardianship cases and closures over a six-year period. This reporting period represents the lowest rate of closure during this time.

Closures as Percentage of Guardianship Services Provided						
	2007/2008	2008/2009	2009/2010	2010/2011	2011/2012	2012/2013
Closures	152	178	173	191	184	203
Services	603	661	705	793	928	1162
%	25.2%	26.9%	24.5%	24.1%	19.8%	17.5%

Figure B6: Closures 2007-08 to 2012-13 as percentage of all guardianships

The next table (Figure B7) compares reasons for closure for a five-year period. Note that revocation as reason for closure remains at the lower end when compared with other years, and death remains at the higher end.

Reasons for closure of Guardianship Cases										
Year	Death		Revocation		Private G		Other		Total	
	No	%	No	%	No	%	No	%	No	%
2008-09	53	30%	118	66%	7	4%	0	0%	178	100%
2009-10	40	23%	110	64%	19	11%	4	2%	173	100%
2010-11	67	35%	84	44%	40	21%	0	0%	191	100%
2011-12	61	33%	84	46%	38	21%	0	0%	184	100%
2012-13	81	40%	91	45%	31	15%	0	0%	203	100%

Figure B7: Reasons for closure 2008-09 to 2012-13 — client death, revocation of an order, the appointment of a private guardian to take over guardianship responsibility, and other.

Figure B8 reflects the nature of closures as a proportion of the total closures over the past five reporting periods.

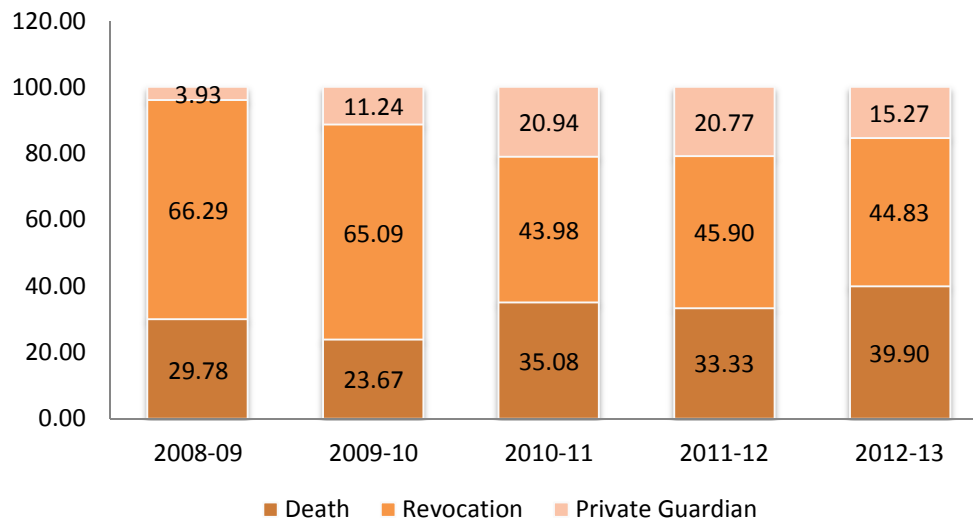


Figure B8: Reasons for closure expressed as a proportion of total closures 2008-09 to 2012-13

Of those clients whose guardianship orders were revoked during the year, 47% were under guardianship for less than 12 months, 64% for less than two years and 78% for less than three years. 22% were under guardianship for more than three years before closure. Closures for the past three reporting periods are compared below (Figure B9).

Comparison of Length of Guardianship for Closed Cases				
Length	< 12 months	< 2 years	<3 years	3 years +
2010-11	39%	71%	77%	23%
2011-12	36%	78%	82%	18%
2012-13	47%	64%	78%	22%
Average of three years	41%	71%	79%	21%

Figure B9: Closed cases length of guardianship comparison of 2010-11 to 2012-13

Figure B10 below compares the number of closures in each category over the past nine reporting periods.

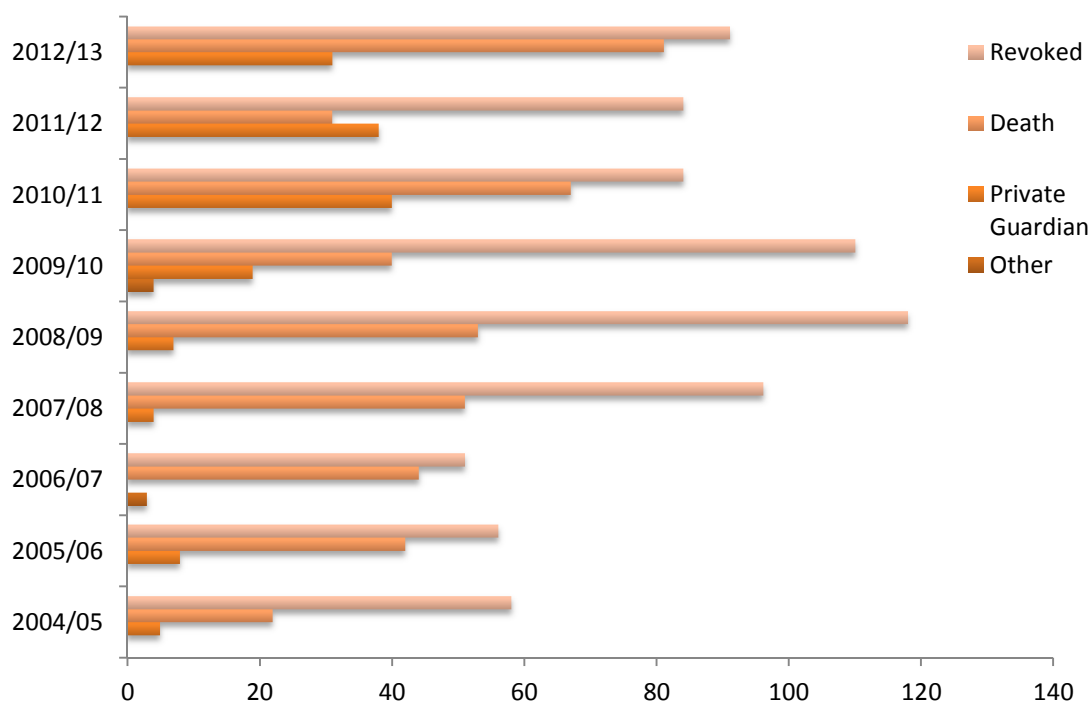


Figure B10: Guardianship Numbers by Closure type for past nine reporting periods

The average length of guardianship for closed cases in 2012-13 was 1.9 years (median 1.1 yrs). This compares with an average length of 1.8 and 1.7 years in the previous two reporting periods (median 1.1 and 1.2yrs).

Average and median lengths of guardianship have remained relatively steady despite the fall in the overall rate of closures. This might be explained by the increase in number of cases closed within the first 12 months of guardianship.

Figure B11 compares diagnostic groupings with length of guardianship for those cases closed in 2011–12 and 2012–13. Average length of guardianship for closed cases has risen in most diagnostic categories over the past two reporting periods. This is not the case with clients with dementia and other related degenerative diseases.

In the previous year, we speculated that an increased average length of guardianship for people with dementia may relate to the policy shift around detention and section 32 powers. However, this year the average length of guardianship for people with dementia reduced. This may be due to the number of deaths.

Guardianship Cases Closed in 2011–12 and 2012–2013								
Diagnosis and Length (years) of Guardianship								
Diagnosis		Brain Damage	Dementia and degenerative Conditions	Mental Illness	Intellectual Disability	Dual diagnosis	Other	Total
Numbers	2011-12	21	83	29	26	19	9	184
	2012-13	15	84	42	28	20	14	203
Average	2011-12	2.2	1.8	1.7	1.6	1.8	0.7	1.7
	2012-13	2.4	1.5	2.2	2.0	3.1	0.6	1.9
Median	2011-12	1.2	1.1	1.5	1.0	1.2	0.7	1.1
	2012-13	0.3	1.0	1.7	1.0	3.0	0.3	1.1

Figure B11: Closed guardianships diagnostic profile and length of guardianship

Average and Median length of guardianship for closed cases in different age groups in the past three reporting periods is represented in figure B12 below. Note that median length of guardianship at closure for all the age groups has not varied greatly over the past three years.

Closed Guardianships and Age Profile by Length of Guardianship						
Age groups	2010-11		2011-12		2012-13	
	Average	Median	Average	Median	Average	Median
< 41 years	1.2	1.0	2.2	1.0	2.8	1.2
41 to 70 years	2.2	1.0	1.7	1.2	1.8	1.4
71 years plus	1.7	1.2	1.7	1.1	1.4	1.0

Figure B12: Closed guardianships age profile and median length of guardianship

Figure B13 maps length of guardianship for closed guardianship cases over the last three reporting periods.

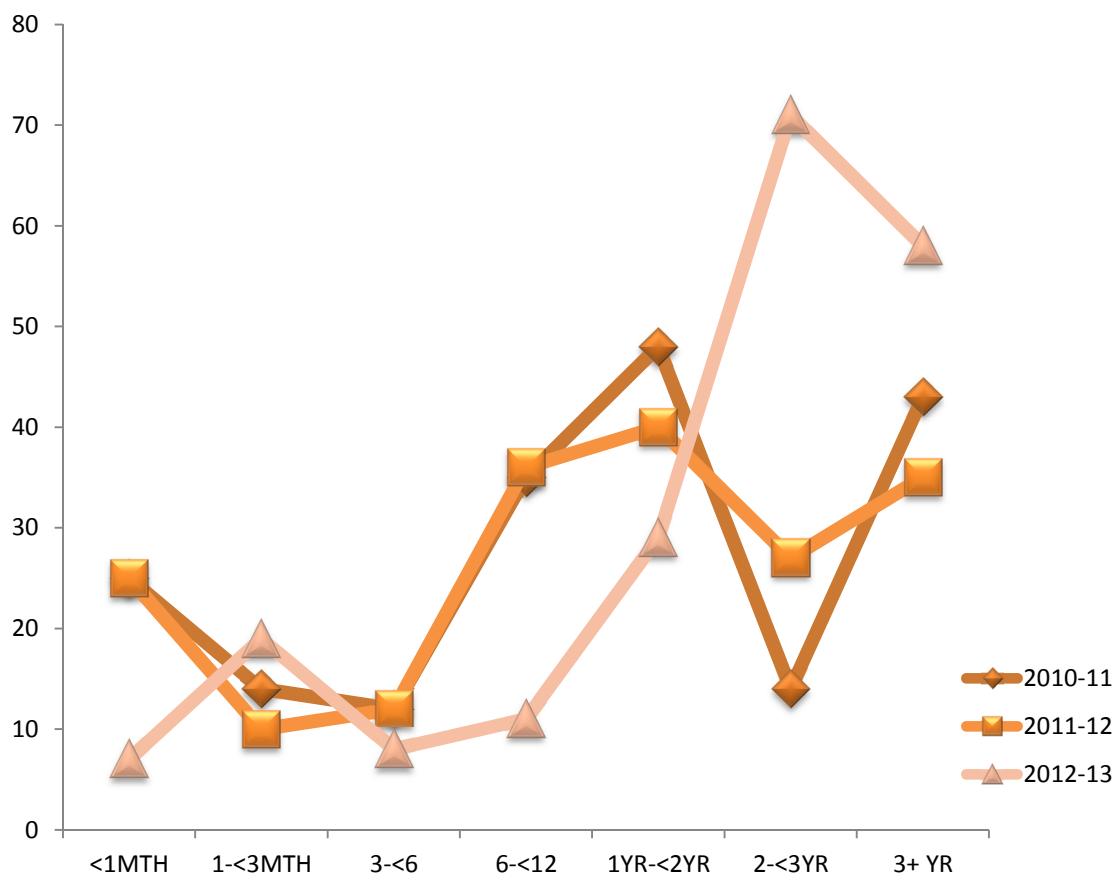


Figure B13: Number of closed cases by length of guardianship (2010-11 to 2012-13)

For the 959 guardianship cases still active as at 30 June 2013, the average length of time open to that date was 2.4 years as in the previous reporting period (in 2010–11 it was 2.3 years) and a median length 1.6 years (the same as in 2010–11 and 2011–12).

The tables below (Figures B14 and B15) compare length of guardianship for those cases open at the end of the past four reporting periods and those closed during these reporting periods.

Comparison of length of guardianship Active Cases June 30								
Length of Guardianship by Reporting Period	Open cases 30/6/ 10	Open Cases 30/6/11	Open Cases 30/6/12	Open cases 30/6/13	Closed cases 09-10	Closed Cases 10-11	Closed Cases 11-12	Closed Cases 12-13
Average length (yrs)	2.3	2.4	2.4	2.4	1.7	1.8	1.7	1.9
Median length (yrs)	1.6	1.7	1.6	1.6	1.3	1.1	1.1	1.1

Figure B14: Comparing average and median length of guardianship over four years

Proportion of guardianship cases in each time period over 4 reporting periods								
Time Periods	Open cases 30/6/ 10	Open Cases 30 /6/11	Open Cases 30/6/12	Open cases 30/6/13	Closed cases 2009-10	Closed Cases 2010-11	Closed Cases 2011-12	Closed Cases 2012-13
<12mths	36%	34%	37%	37%	38%	45%	45%	47%
12mths < 2yrs	24%	22%	20%	22%	31%	25%	22%	17%
2yrs to < 3yrs	14%	16%	14%	13%	14%	7%	15%	14%
3 years plus	26%	28%	29%	28%	17%	23%	19%	22%

Figure B15: Proportion of cases by length of guardianship over four reporting periods

The graph below (Figure B16) compares numbers of active cases as at 30 June, from June 2009 to June 2013 and the length of the orders as at those dates.

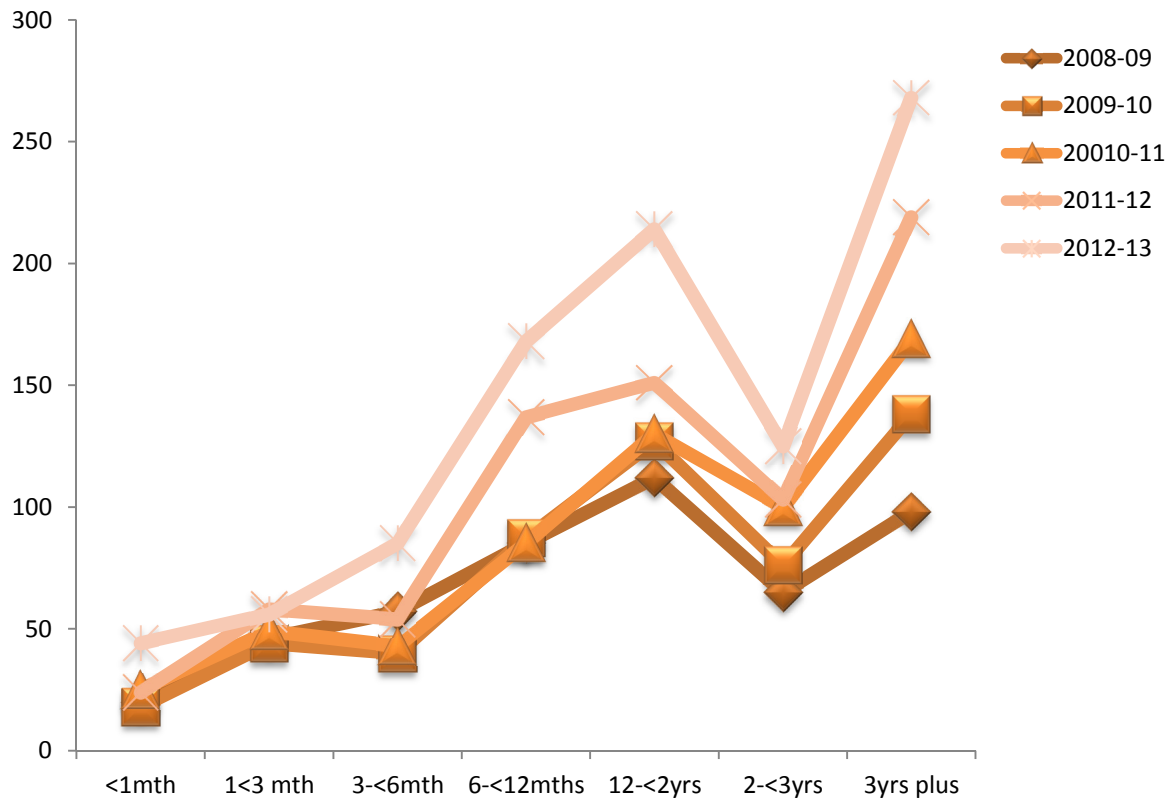


Figure B16: 5-year comparison of length of guardianship for open cases as at 30 June each year.

The age profile of active, new and closed guardianship cases as at 30 June is compared in the table below (Figure B17).

Age Profile of Closed, Active and New Cases 2009–10 to 2012–13												
Age	Closed Cases (age at closure)				Active Cases (as at June end)				New Cases (age at opening)			
	09-10	10-11	11-12	12-13	09-10	10-11	11-12	12-13	09-10	10-11	11-12	12-13
Age < 41 years	21%	13%	19%	25%	29%	28%	30%	27%	21%	24%	29%	24%
41 to 70 years	33%	30%	37%	29%	36%	40%	38%	42%	35%	18%	34%	41%
> 70 years	46%	57%	45%	46%	35%	32%	32%	31%	44%	58%	37%	35%

Figure B17: Age profile of guardianship clients 2009–2013

Diagnostic profiles of guardianship clients active at 30 June 2013 and all active guardianships during this reporting period are illustrated in the following tables (Figures B18 and 19). Figure B18 compares the past two reporting periods.

Diagnostic Profile of Guardianship Clients				
Diagnosis	30/6/2013		2012–2013	
	Number	Percentage	Number	Percentage
Dementia	261	27%	351	30%
Mental Illness	201	21%	243	21%
Intellectual Disability	296	31%	325	28%
Brain Injury	73	8%	93	8%
Dual Diagnosis	103	11%	125	11%
Other	21	2%	25	2%
Total	955*	100%	1162	100%

Figure B18: Diagnostic profile of all active guardianship cases this reporting period

*data missing

Diagnostic Profile Guardianship Clients				
	End of Year Active		All Active Cases during Year	
Diagnosis	30/06/2012	30/6/2013	2011-2012	2012-13
Dementia	31%	27%	30%	30%
Mental Illness	21%	21%	21%	21%
Intellectual Disability	22%	31%	22%	28%
Brain Injury	9%	8%	8%	8%
Dual Diagnosis	16%	11%	12%	11%
Other	0%	2%	6%	2%
Total	100%	100%	100%	100%

Figure B19: Diagnostic groupings as a proportion of guardianship cases 2011-12 to 2012-13

There has been a significant increase in the proportion of clients with an intellectual disability over the two reporting periods. This group constituted 22 % of the active guardianship cases on 30/6/2012 and rose to 31% as at 30/6/2013. This is because of the significant number of appointments (over 100 matters) since August 2012 when Disability Services policy changes took effect.

Clients under guardianship at some time during 2012-13 were 630 men (52%) and 532 women (48%).

Use of Special Powers

32 - Special powers to place and detain etc. protected person

- (1) The Board, on application made by the guardian of a protected person -
 - (a) may, by order, direct that the protected person reside -
 - (i) with a specified person or in a specified place; or
 - (ii) with such person or in such place as the guardian from time to time thinks fit
 - according to the terms of the Board's order; and
 - (b) may, by order, authorise the detention of the protected person in the place in which he or she will so reside; and
 - (c) may, by order, authorise the persons from time to time involved in the care of the protected person to use such force as may be reasonably necessary for the purpose of ensuring the proper medical or dental treatment, day-to-day care and well being of the person

A guardian may apply for and be granted special powers under Section 32 (1) (a) of the *Guardianship and Administration Act 1993* to give enforceable directions regarding where a person under guardianship will live.

In addition, application can be made by a guardian for the Guardianship Board to authorise the detention of a protected person in that place (s32 (1) (b)) and to authorise the use of reasonable force (s32 (1) (c)) for the purposes outlined above.

The existence of these powers does not automatically lead to their application in practice. The issuing of a formal direction by a guardian to exercise their powers is considered a last resort or emergency strategy when other options are exhausted and there is a need to ensure the health and wellbeing of a protected person or others.

In 2012–13, there were 395 clients who had a history of s32 orders at some time during the lifetime of guardianship (i.e. 34% of clients). This reflects the same proportion of active clients under s32 orders as reported in 2011–12. Of the 412 new guardianship appointments during 2012–13, 114 clients (28%) had s32 orders in place at some stage during the reporting period. A more detailed analysis of the use of s32 powers was prepared in the 2010–2011 Annual Report.

Rates of Guardianship and Service Demand

The OPA has been tracking trends in appointments of statutory and private guardians over seven years. The information below illustrates the substantial increase in the use of guardianship intervention in the lives of South Australians over this period.

Rate of Appointment of Public and Private Guardians South Australia

Of the estimated 1235 applications for consideration of the appointment of a guardian received by the Guardianship Board of South Australia during the 2012–13 financial year, 412 (33%) resulted in the appointment of the Public Advocate, an increase over the previous two years (2011–12 29% and 2010–11 = 26.5%) .

553 (45% of all applications) led to private guardian appointments in 2012–13 compared with 510 (46%) in 2011–12, 465 (47%) in 2010–11 and 256 (26%) in 2009–10.

965 of 1235 applications (78%) resulted in guardianship appointments compared with 836 of the 1115 applications (75%) in 2011–12 and 723 of 975 (74%) in 2010–11. These figures are presented for the previous seven reporting periods in the table below (Figure B20).

YEAR	06/07	07/08	08/09	09/10	10/11	11/12	12/13
Guardianship Applications	709	734	694	978	975	1115	1235
Guardianship appointments	318	402	406	490	723	836	965
% resulting in appointments of guardians	44.9	54.8	58.5	50.1	74.2	75%	78%
% resulting in appointments of the Public Advocate	26.1	27.5	30.1	23.9	26.5	29%	33.4%
Number of Public Guardianship appointments	185	202	209	234	258	326	412
Number of Private Guardianship appointments	133	200	197	256	465	510	553
% of Guardianship Orders which are Public Guardianship	58%	50.2%	51.5%	47.7%	32.5%	39.0%	42.75%

Figure B20: Comparison of applications and guardian appointments July 06 to June 2013

Note that there is some discrepancy between Guardianship Board figures and OPA figures, as the Board counts matters heard rather than individual people. Clients who have an interim order and then a full hearing may be counted twice in these figures above. The OPA figures count people only once. This means that the percentage of people actually placed under guardianship resulting from an application is likely to be a higher figure.

The graph below (Figure B21) illustrates the trends in appointment of guardians in the past six years. Both OPA numbers and private guardianship numbers are increasing.

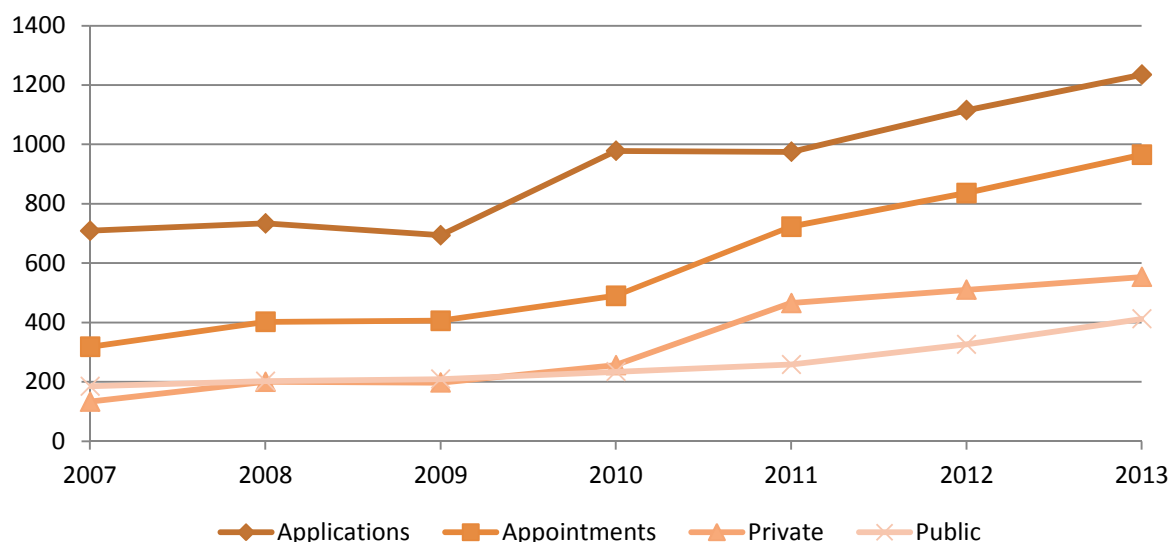


Figure B21: Numbers guardianship appointments July 2006 to June 2013

Prevalence of Guardianship

Figure B22 below represents the rate of South Australian public guardianship per 100,000 at the end of each financial year and the rate of change. It is notable that South Australia's end-of-year rate of public guardianship has nearly doubled in the past five years, whilst the population growth has been only 2% for the same period. Comparative figures from other jurisdictions were not available.

Active Guardianship cases AS AT 30 June	ABS Data SA Population (100,000)	Number under public guardianship 30 June	Rate per 100,000	Change per 100,000
2009	1632	483	29.6	-
2010	1633	532	32.6	+3
2011	1635	602	36.8	+4.2
2012	1650	744	45.1	+8.3
2013	1662	959	57.7	+12.6

Figure B22: Rate of public guardianship June 2009 to June 2013

Figure B23 compares the rates of public and private guardianship appointments per 100,000 for the past five reporting periods. Note the steady increase in both public and private rates of appointment over the 4 year period.

New Guardianships in Financial Year	ABS Data SA Population	Number of new appointments	Public Guardian Appointment rate per 100,000	Change in Rate of Public Appointments	Private Guardian appointment rate per 100,000	Guardianship Appointments per 100,000
2008-09	1632000	209	12.8	-	12.1	24.9
2009-10	1633000	234	14.3	+1.5	15.7	30.0
2010-11	1635000	258	15.8	+1.5	28.4	44.2
2011-12	1650000	326	19.7	+3.9	30.1	49.8
2012-13	1662000	412	24.8	+9.7	33.3	58.1

Figure B23: Rates of new public and private guardianships 2008-09 to 2012-13

As demonstrated in Figure B23 above, the rate of new public guardian appointments per 100,000 has also doubled over the past four years. The rate of private guardian appointments has nearly trebled in the same period. We do not have information on the number of private guardianships which are active at the end of each financial year but would presume that the rate per 100,000 is expanding each year, probably at a rate greater than public guardianship.

Responding to demand

This year the OPA continued to be challenged by the increasing demand for guardianship services. In May 2012, the Government announced additional funding of \$500,000 to the Office, indexed annually. This allowed the conversion of temporary advocate guardian positions to ongoing status and the creation of new positions. Restructuring of the Information and Advisory Service also released additional resources for guardianship work.

Stable guardianship cases placed in our “monitoring” caseload and which had a duty response only were allocated to a part-time advocate/guardian part way through the year. This has enabled a more coordinated response to reviews, visits and consent requirements. This change has improved our response to these clients.

We have nevertheless experienced significant delays in being able to allocate new guardianship matters.

The impact of additional staff on waiting lists was weakened because of a large number of applications for appointment of guardians for disability clients who had no suitable family in their lives to make substitute decisions. Approximately 100 appointments were made during 2012–13 as a result of these policy changes within the disability sector. The majority of these clients have not yet been allocated an individual guardian and matters requiring attention are dealt with through the duty system.

The work of responding to the needs of clients on the waiting list, both regular clients awaiting allocation, and those clients associated with the policy change in disability services, still falls on the shoulders of the team leaders, who receive calls about significant matters, and on the members of the teams when rostered on as duty worker. Visits to clients on the waiting list are undertaken when needed..

The overall average caseload at year end (excluding team leaders) was 65.1 per FTE Advocate Guardian. The short-term team average caseload had reduced from 45.8 FTE as at June 2012 to 41 as at 30 June 2013 and the long-term team caseload remained at 49.5 per FTE. The monitoring caseload had increased to 230, the equivalent to 284 clients per FTE worker. In addition, the 70 disability clients awaiting allocation are not counted in the team FTE calculations. This demonstrates that, despite the increase in resources, overall demands on staff for services in the guardianship area are greater than this time last year. In June 2012, there were thirty-six guardianship clients on the waiting list for allocation to an individual guardian. By June 2013 this had climbed to 112. Part way through the reporting period, disability clients awaiting allocation were separated from the short-term team on-hold list for statistical purposes. The end-of-year result demonstrates that were it not for the disability clients, there would have been only a minor increase in the numbers awaiting allocation (i.e., 45 as at end June 2012 compared with 36 as at July 2012). This position was possible due to the staffing increase during the year.

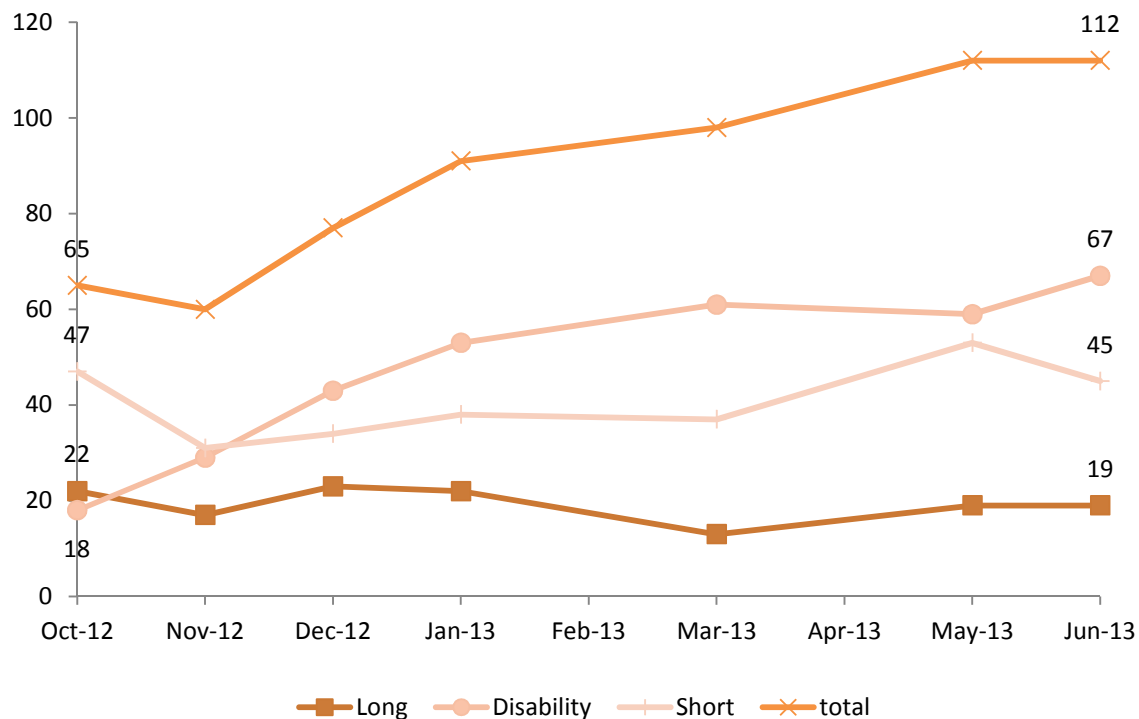


Figure: B24 Waiting list for allocation of new cases October 2012 to June 2013

Figure B24 (above) illustrates the recent waiting list at the Office of the Public Advocate. Full-year figures are not shown, as disability clients were not separated from the short-term team waiting list until part-way through the period.

The OPA continues to contemplate how best to respond to the workload demands including determining which clients actually require allocation to an individual advocate/guardian, which require proactive responses and which can be appropriately dealt with through the monitoring or duty systems. The latter are most likely to be clients who are in stable accommodation, have robust service systems in place or where a guardian has been appointed for policy reasons, rather than because there are significant decisions to be made.

Throughput of cases per FTE staff is illustrated for the short-term and long-term teams in B25 below. Transfer of cases to the Monitoring caseload does not appear in the team throughput figures. Note the decline in throughput of closed cases per FTE for both teams and the service as a whole. In contrast, the new cases per FTE have risen over the three reporting periods. New disability clients are shown against the short-term team for this table as practices with waiting lists did not change until part-way through the year.

Guardianship Cases per FTE					Total Cases
Team Data (Excludes seniors)	Number Opened per FTE worker	Number of Cases opened for team	Number Closed per FTE worker*	Number of cases closed for team	Total Cases managed per FTE guardian worker in year
Short Term Team					
10-11 (3.7FTE)	35.9	133 cases	22.2	82 cases	
11-12 (4.8FTE)	34.6	166 cases	14.0	67 cases	
12-13 (5.4FTE)	45.4	245 cases incl disability cases	13.5	73 cases	
Long Term Team					
10-11 (6.7 FTE)	17.4	117 cases	11.8	79 cases	
11-12 (7.7FTE)	21.3	164 cases	10.9	84 cases	
12-13 (8.6FTE)	16.2	139 cases	9.8	84 cases	
Combined Teams					
10-11 (10.2 FTE)	25	255 cases**	18.7	191 cases	77.6 per FTE (793 cases)
11-12 (12.5FTE)	26.1	326 cases**	14.7	184 cases	74.3 per FTE (928 cases)
12-13 (14.8FTE)	27.8	412 cases	13.2	196 cases	78.5 per FTE (1162 cases)
Notes	Senior Advocate Guardians and Management not counted in guardian FTE numbers Transfers from teams to monitoring caseload not counted in closure calculations Short-term Team in particular transfers significant numbers to monitoring Combined Team figures include management cases and monitoring cases Disability clients opened this year have been included in the Short-term Team figures for the purposes of calculation of new cases per FTE. When these cases have required allocation they have been spread across management and team leaders				

Figure: B25 Comparison of short- and long-term team throughput 2010-11 to 2012-13

Optimal caseloads per FTE have been previously benchmarked at 35 active cases per FTE and 75 cases per FTE for monitoring. However, it has not been possible to sustain this optimal position for some time. The OPA has spent time exploring its business practices using a consultancy process employed within the Attorney-General's Department.

Business Improvement and Guardianship

Analysis of practice processes, particularly around guardianship, led to a number of recommendations at the beginning of this reporting period.

Business process improvement changes have been undertaken internally in the Office, through monitoring data, redefining some roles, and moving staff. During the year, we were also assisted through a short consultancy from *Think 180* funded by the Attorney-General's Department. This work validated the process reforms and flow strategies our team has been putting in place.

During 2012–13 the following activities occurred:

a/ the allocation of resources to manage the previously unallocated monitoring caseload.

In November 2012, a 0.8FTE advocate guardian resource was transferred from the short-term team to manage the monitoring caseload. As a result, a large number of clients were shifted from active to monitoring status hence monitoring numbers increased by 100 (or 79%) over the reporting period. This meant that the proportion of guardianship cases held in monitoring increased from 17.3% to 23.7% by June 2013.

Since allocating guardian resources, a detailed analysis and tracking process for clients in monitoring has been implemented. It is anticipated that the proportion of guardianship cases held in monitoring will increase in 2013–14, as new approaches to stable guardianships are adopted. Additional part-time guardian resources will be allocated to manage the increased demand.

b/ new ways of managing throughput at the "front end"

The volume of new work presenting in 2012–13 hampered the organisation's ability to experiment with new strategies for managing cases at the time of new appointments. However, the existence of a monitoring worker enabled speedy transfer of some cases from active to monitoring status. This was particularly true for the short-term team. Had it not been for the Disability policy change leading to an influx of new guardianship matters, it is likely that the waiting list for allocation would not have expanded during this reporting period.

The expanded waiting list has been a cause for internal concern because of the difficulty in providing timely allocation of new non-urgent matters and delivering the standard of response which has been given to other new clients previously. Whilst urgent matters are dealt with through immediate allocation or the duty system, these approaches have been less than ideal. Continuity of knowledge and coordination of responses rests heavily on the shoulders of the two team leaders who also carry their own caseloads. The Senior Advocate Guardians maintain essential information regarding the waiting lists including appointment date, priority for allocation (a rating scheme to identify urgency) and brief details about the risks for the client. Ratings are adjusted where circumstances change and senior staff coordinate a team response to these clients.

c/ Continuation of the two team model

The BPI process concluded that the two-team model was still a valid approach to the workload and should remain for the time being. However, strengthening regional allocation within the two teams was recommended.

In effect, by the end of 2012–13, the OPA had adopted four workload groupings, the short- and long-term teams, the monitoring team and the disability clients (managed through the duty system in the main).

It is likely that discussions in 2013–14 will lead to further refinement of the guardianship priorities for intervention, which may result in a change in team structure in the longer term. Whilst the practice of allocating an individual guardian to all clients is preferable, the service will need to refine its understanding of which clients are most in need of this approach and which clients may be managed through alternative approaches. This has already been the focus of new planning work within our service in August 2013.



Advocate/Guardian members of the “Short term” team meet: Passant Ibrahim, Karen Bowden, Susan Goldeband, Jeannie Thompson, Stephen Burns, and Acting Senior Advocate/Guardian Bethany Jordan

d/ BPI recommendations to improve effectiveness and efficiency around record keeping and statistics

These changes are yet to be implemented. However, discussions have commenced regarding the reduction in paper record duplication, by increasing reliance on electronic records rather than hard copy records.

c/ Mobile workforce, satellite office and technology to support this

OPA clients are spread over metropolitan and non-metropolitan South Australia and most direct contact with protected people and their family and service providers occurs in community settings rather than at the OPA. The OPA has concluded that it would be practical and efficient to establish a local base in the southern metropolitan area to increase efficiency and effectiveness. This would require additional funding to support a second office and improved technology to allow the use of the OPA database from remote locations.

During 2013–14, the OPA will explore additional technology initiatives to enable more staff to work remotely, including working from home for some parts of the week.

Predicting Future Demand

OPA uses past demand for services to predict likely future trends. Whilst there are many factors which will affect this trajectory, it remains a useful strategy for contemplating resource needs. Potential end-of-year active guardianship caseloads are modelled for the next four years based on various past increases and shown in figure B26. This, combined with a declining rate of closure, presents serious workload considerations.

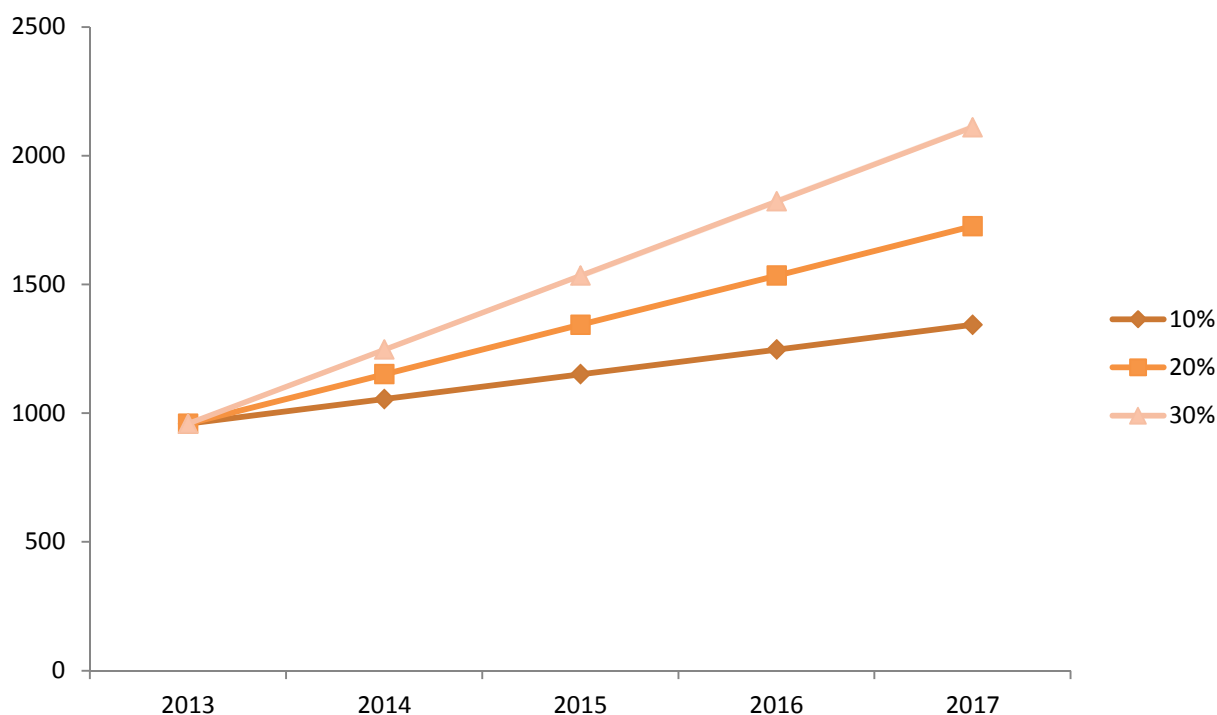


Figure B26: Projecting future demand for guardianship

Court-related matters — Litigation Guardianship

In civil legal matters, when a person is unable to instruct a lawyer because of a mental incapacity, the Court may appoint the Public Advocate to ‘stand in the shoes’ of the person — to be their ‘litigation guardian’. The Public Advocate or delegate then instructs the lawyer, on behalf of that person.

The OPA commenced the reporting period with six active litigation guardianship matters. A further 18 were opened during 2012–13. Matters included actions in the Youth Court, the Federal Magistrates Court and the Supreme Court and were about a range of issues, mostly the care of or contact with children.

Investigations

Guardianship and Administration Act 1993

Section 28—Investigations by Public Advocate

- (1) The Public Advocate must, if the Board so directs after an application has been lodged with the Board for an order under this Part, investigate the affairs of the person the subject of the application.
- (2) On completing an investigation carried out at the direction of the Board, the Public Advocate must furnish the Board with a copy of the report of the investigation.
- (3) The Board may receive the copy of the report in evidence and may have regard to the matters contained in the report.

Section 28 of the *Guardianship and Administration Act 1993* provides that the Public Advocate can be directed by the Guardianship Board to conduct an investigation relevant to an application the Board has received.

The aim is to provide a balanced, concise report on the circumstances of the person, relevant to the application before the Board.

Investigation reports may be presented as evidence at Guardianship Board hearings, and considered along with other evidence.

Number of investigations 2012–2013

The Office of the Public Advocate responded to 20 directions from the Guardianship Board to investigate matters before the Board.

- 8 were open at the beginning of the reporting period
- 28 were opened during the year and
- 17 remained open as at 30 June 2013

Attendance at initial hearings of applications for Guardianship Orders

Whenever an applicant to the Guardianship Board nominates the Public Advocate as a potential guardian for an individual, the OPA will consider the application. A staff member from this Office will attend the hearing whenever possible.

During 2012–2013, the OPA staff reviewed 506 applications which nominated the Public Advocate for appointment as guardian. This compares with 436 and 321 such screening matters in the previous two reporting periods.

In addition, the Public Advocate is sometimes appointed as guardian without OPA's prior knowledge or the screening process. This is usually when the Board changes the guardian during the review of a private guardianship order or when an emergency order is made.

It is therefore not possible to make an accurate direct comparison between the number of matters screened by the OPA staff and the number of the Public Advocate's appointments made.

Combining the number of investigative activities (attendance at initial hearings as a 'screening matter' and formal investigations), the following picture emerges (Figure B27).

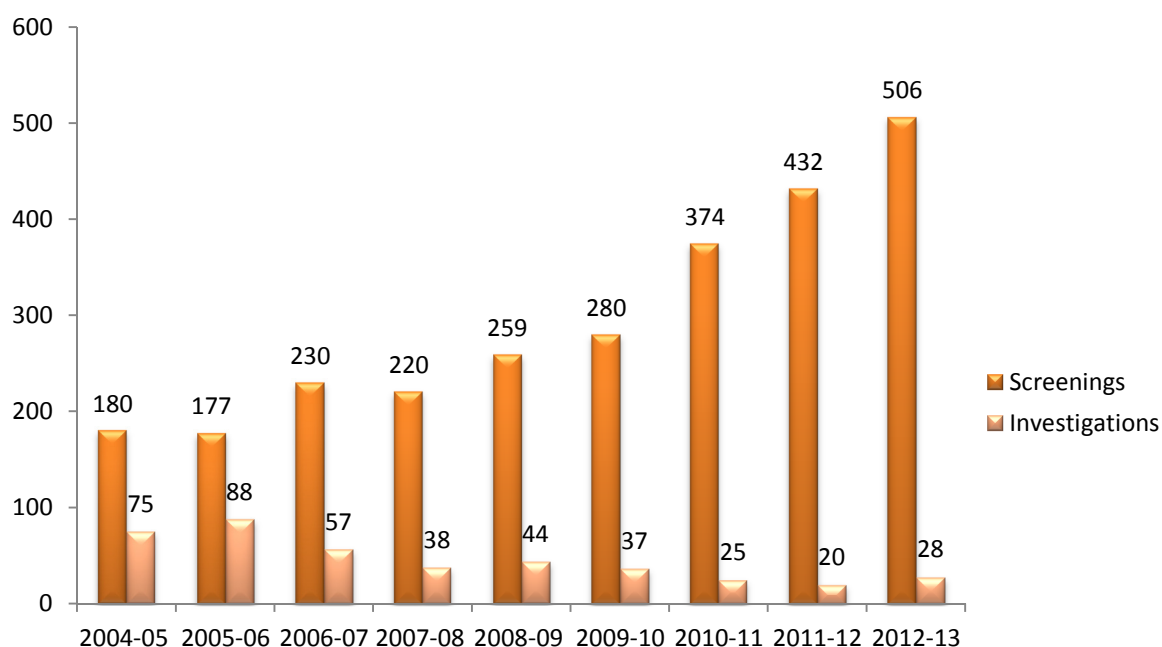


Figure B27: Number of guardianship applications screened & investigations undertaken 2004–05 to 2012–13

Applications for Warrants by the Public Advocate

Guardianship and Administration Regulations 1995

7—Annual report (Public Advocate)—prescribed particulars of warrant applications (section 24)

For the purposes of section 24(2) of the Act, the particulars relating to applications for warrants made during the year that must be included in the Public Advocate's annual report are as follows:

- (a) the number of applications for warrants made during the year;
- (b) the age, sex and details of the alleged mental incapacity of the persons to whom the applications related;
- (c) the grounds on which the applications were based;
- (d) the number of applications withdrawn during the year;
- (e) the number of warrants issued during the year;
- (f) the number of warrants refused during the year;
- (g) in relation to warrants issued—
 - (i) the age, sex and details of the mental incapacity of the persons to whom the warrants related;
 - (ii) the grounds on which the warrants were issued;
 - (iii) the action taken under the warrants.

During 2012–2013, there were no applications for warrants made by the Public Advocate. However, the OPA has been approached by the Guardianship Board to assist in several matters where the potential protected person has required specialist medical assessment and were resistant to this or lacked the mechanism to attend for assessment appointments.

Individual Advocacy

Guardianship and Administration Act 1993

Section 21 (1) The functions of the Public Advocate are—.

- (d) to speak for and negotiate on behalf of any mentally incapacitated person in the resolution of any problem faced by that person arising out of his or her mental incapacity;

The Office of the Public Advocate undertakes advocacy for people under guardianship, as part of our information and advisory service and through taking on a small number of advocacy clients. The OPA officers will intervene on behalf of individuals who have a mental incapacity or on behalf of their carers, in an attempt to ensure that they receive assistance or have their rights respected. Private guardians may also be assisted to resolve complex issues through OPA advocacy.

There were 34 new specific advocacy cases opened in 2012–2013. Comparison of the past seven years is featured below (Figure B28).

	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013
New Cases	28	23	27	43	48	46	34

Figure B28: New advocacy clients in each reporting period

Community Visitor Schemes

The introduction of the Community Visitor Scheme under the provisions of the *Mental Health Act 2009* and the plans to establish a similar scheme for disability clients is considered a very positive development for vulnerable adults. The Public Advocate and the Principal Community Visitor have taken a number of opportunities to work together on shared concerns about systemic and individual client issues.

Strathmont Residents

OPA representatives again participated in individual planning processes for residents preparing to leave Strathmont for community accommodation. The availability of government funding has allowed innovative planning around the individual requirements for clients with complex needs.

Office of the Public Advocate Community Visitor Program

At the request of the Department for Communities and Social Inclusion, in 2011–12 the Public Advocate and his staff commenced a visiting program to a non-government residential service which provides accommodation and support for young men with high and complex needs, most of whom were under the guardianship of the Public Advocate. These clients have mental health,

disability and forensic backgrounds and many have limited family involvement. This visiting program was described in our last annual report.

Visits continued during this reporting period but it is now planned to hand responsibility over to the Community Visitor Scheme in 2013–14, now that the scheme has been funded and will operate in the disability sector.

Advocacy in matters before the Guardianship Board

Lack of routine access to advocacy services for clients appearing before the Board for both GAA and *Mental Health Act 2009* matters has been raised over the past three reporting periods.

Whilst Section 14(9) of the GAA provides that a person can be represented by the Public Advocate or a recognised advocate, this Office is seldom in a position to provide representation and matters are referred out.

Our view is that the current legal representation scheme for appeals should be extended either to cover all Guardianship Board matters, or there should be a system which ensures that all people have access to a lay advocate from this Office or elsewhere for mental health, guardianship and administration matters.

Dispute Resolution Service and Advance Care Directives

In Part A of this year's report, there is a detailed description of the Advance Directives reform process and the new *Advance Care Directives Act 2013*. An important initiative under this legislation is the establishment of a mediation service to assist in resolving disputed matters where individuals have in place advance care directives, have mental incapacity and there is disagreement amongst interested parties about decisions to be made. During 2012–13, a Senior Project Officer developed a model of mediation for this service which places the vulnerable adult at the centre of consideration in the dispute resolution process. This model is being trialled within the OPA. As at June 2013, six matters in dispute were being managed by the Senior Project Officer. A number of other matters have been reviewed and either considered inappropriate for mediation or the parties have not been willing to enter a voluntary process of dispute resolution.

Education

The Office of the Public Advocate responds to requests from organisations and individuals to participate in a range of educational activities. These include providing written information for displays, acting as panel members or presenters for conferences and workshops, and attending meetings and education sessions for service providers and members of the public.

The OPA staff have presented to a number of service providers and community groups during 2012–13 regarding Advance Care Directives, the GAA and the role of the Office of the Public Advocate and the Guardianship Board. The Public Advocate and OPA staff have also presented at a number of conferences, workshops and training programs during this period. Some presentation material is made available on the OPA website.

The Public Advocate comments publicly on advocacy matters and guardianship issues through radio, print and TV media when opportunities arise.

The OPA was pleased to have the company of senior representatives from the National Office for the Empowerment of Persons with Disabilities, Thailand, in August 2012. Their visit to South Australia was organised by the non-government sector agency Community Accommodation Respite Agency. They were particularly interested in the work OPA has undertaken around supported decision making.



Standing from left to right - Cher Nicholson, Ms Yingluk Sriboonruang, Margaret Farr, Elly Nitschke, Ms Putharee Srisara, Mr Pichaya Yaikaensai, Mrs Jitra Sirisomboonlarp, Mrs Benjawan Thienthong.
Sitting from left to right - Ms Unchalee Pattarapongsin, Mr Chaiya Mulsan, Mr Siripong Sriarkha.

The Alliance for the Prevention of Elder Abuse

The Alliance for the Prevention of Elder Abuse (APEA) consists of representatives from the Aged Rights Advocacy Service, the Office of the Public Advocate, the Legal Services Commission, the Public Trustee and the South Australia Police. It is committed to improving the system's ability to prevent and respond to the abuse and neglect of older people. The Alliance has a website that provides brochures designed to assist in abuse prevention and information on protective mechanisms (www.a pea.org.au).

Enquiry Service

During 2012–13, the OPA restructured the Enquiry System. All professional staff employed within the OPA now have a primary responsibility for advocacy guardianship matters.

The Information and Advisory Service is now coordinated by an Information Officer on a part-time basis. The Information Officer is able to provide practical and factual advice on the legislation and redirect queries to other, more appropriate services. Duty Advocate Guardians provide back-up advice and follow up on more complex matters.

The incumbent Information Officer is employed full-time in the OPA with other administrative duties being performed when not acting as Information Officer. This allows maximum responsiveness to the public.

Service providers are encouraged to seek consultancy and supervisory support from within their own organisations in the first instance. However, OPA staff remain available to discuss complex and urgent matters including through our after-hours on-call system.

This year, there were 2894 discrete episodes of enquiry. A comparison with previous years is graphed below (Figure B29). The substantial drop in 2006–07 coincides with a new database recording system which has improved our ability to link callers with their previous enquiries.

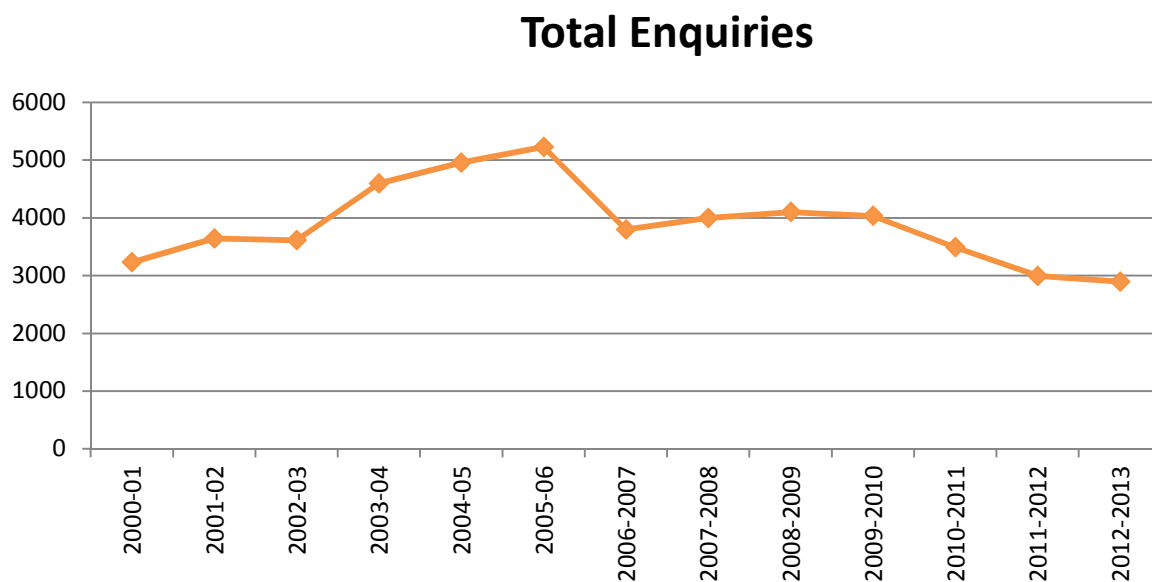


Figure B29: Number of enquiry episodes July 1999 to June 2013

Common reasons for seeking advice include requesting information about advance directives, guardianship and administration orders, Guardianship Board hearings and mental health appeals.

Figure B30 below identifies the main issues raised in enquiries during the last reporting period; advance directives and guardianship and administration matters are the most common issues raised.

Main Enquiries Issues	2010-11	2011-12	2012-13
Mental health issues	370	264	246
Guardianship issues	1008	1035	811
Administration issues	866	873	604
Advance Directives	856	737	656
Total issues raised	5012	4181	3811
Discrete Episodes	3490	2995	2984

Figure B30: Issues Raised in Enquiries

After-hours emergency response

OPA senior staff and experienced advocate guardians who put themselves forward to do after-hours work participate in an after-hours roster on behalf of the OPA and the Guardianship Board. The roster covers 5:00p.m. to 9:00a.m. on weekdays and 24 hours a day on weekends and public holidays. This service acts as the emergency response for existing OPA clients and an advisory service on the legislation and on matters which may require an approach to the Guardianship Board for emergency orders. The President and Deputy Presidents of the Guardianship Board make themselves available to hear urgent matters outside of working hours.

Each year the after-hours workload increases as more people come under guardianship. During this reporting period, 906 calls were logged with the paging, an average of 76 per calendar month.

Complaints and Decision Reviews

The OPA complaint and decision review processes are described in some detail in our 2011 Annual Report (p.171 onwards).

Complaints may relate to decisions made in our role as guardian, or other matters.

Complex guardianship decisions are ratified by senior staff before they are implemented to ensure that the process has been comprehensive and the decision is supportable. Reviews of decisions can be undertaken at several levels in the Office; by a Senior Advocate Guardian, Assistant Public Advocate and ultimately by the Public Advocate.

There is no provision within the GAA for dissatisfied parties to lodge external appeals against decisions made by this Office. However, if a person is dissatisfied with a decision of the Public Advocate, the Public Advocate may apply to the Guardianship Board to seek advice and direction under Section 74 of the GAA. This can provide an external forum for discussion of the issues. Directions then made by the Board are legally binding on all parties. In addition, because this now becomes a decision of the Guardianship Board, interested parties can appeal the decision to the Administrative and Disciplinary Division of the District Court.

Activity

During 2012–13, the OPA acted on 26 separate matters consisting of:

- 19 formal complaints/requests for decision reviews
- 1 Freedom of Information (FOI) application
- 7 Ministerial and Ombudsman's requests

All matters related to 23 current or past clients of the OPA.

Some matters were requests for information briefings or explanation only (e.g. ministerial requests) others generally related to decisions made by the OPA in the role of advocate/guardian. One matter related to a service provider complaint about the OPA.

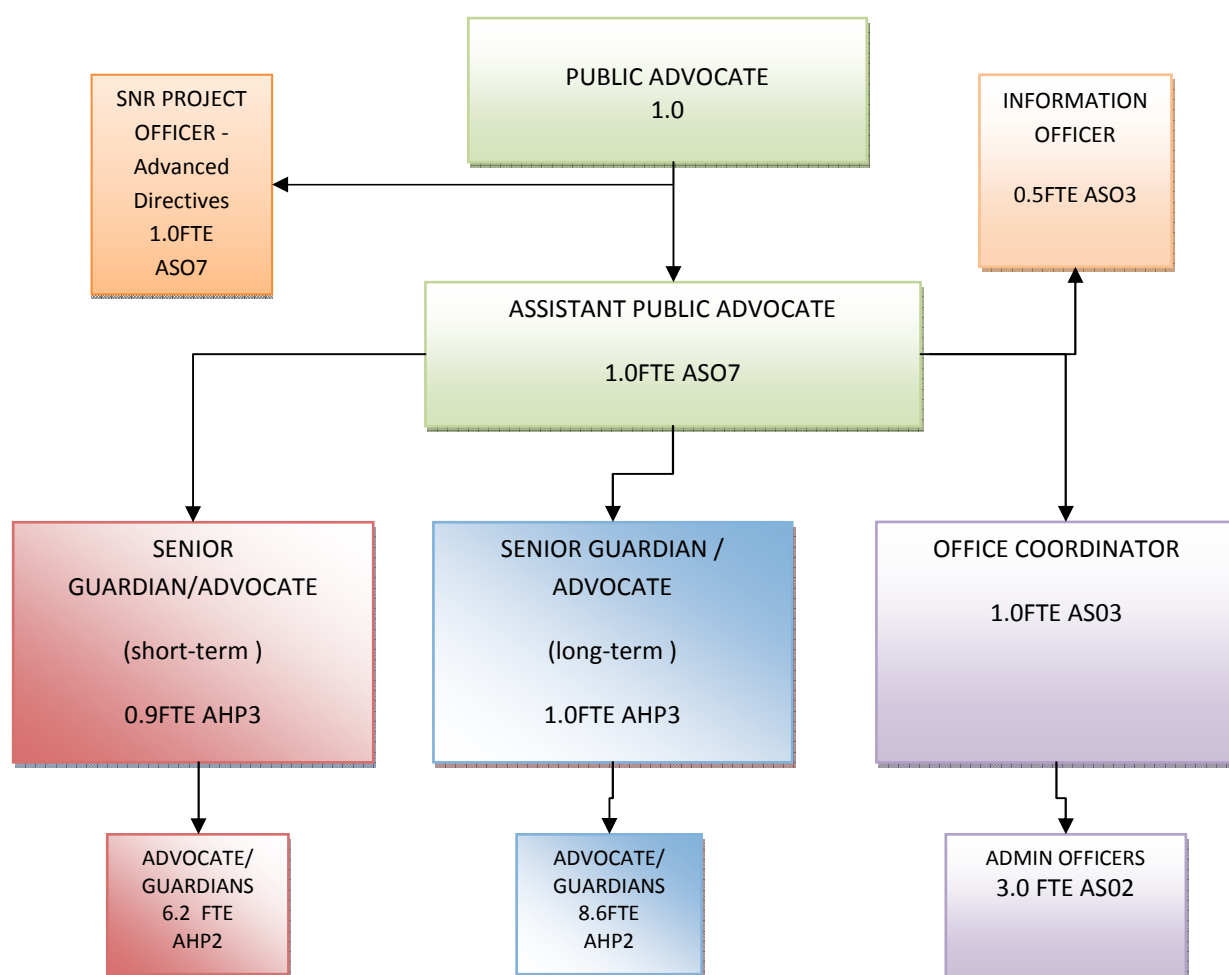
Six matters pertaining to four clients were taken to the Guardianship Board under S74 of the Act for a Board direction, either following a series of complaints about the OPA's decisions or because of the particular nature of the decision required.

Employment and Human Resources

The OPA ongoing funded staffing establishment at the beginning of 2012–2013 was 19.3 FTE. By year end, this figure had increased to 24.2FTE. The new staffing model replaced the AHP1 Community Enquiry Public Advocate Officer position with a part-time ASO3 Information Officer, with the expectation that members of the public who required the additional expertise of an advocate guardian would be referred by the Information Officer to the duty worker. The Advocate Guardian teams were expanded to cope with the additional workload

A Senior Practitioner and part-time Peer Worker were also employed as part of the Supported Decision Making Trial funded by the Julia Farr MS McLeod Benevolent Foundation. These positions finished in late 2012. A Senior Project Officer was appointed to commence the implementation work related to advance care directives. This position continues into 2013–14.

Deployment of funded positions as at 30 June 2013



Operational: 24.2 FTE as at 30/6/2013

Staff of the OPA 2012–2013

The following is a list of staff members who worked either full-time or part-time at the Office of the Public Advocate for some time during 2012–2013.

John Brayley	Public Advocate
Margaret Farr	Assistant Public Advocate (Part-time)
Helen Mares	Assistant Public Advocate (Part-time)

Administration

Cheryl Thomas	Office Coordinator
Michelle Howse	Administration Officer (Part-time)
	Information Officer (Part-time)
Mardi Mushan	Information Officer (Part-time)
Aileen Vincent	Administration Officer
Jerusha Nicholls	Administration Officer (Part-time)
Erin Lerner	Administration Officer

Advocacy, Guardianship, Investigation and Enquiries

Julie-Anne Harris	Senior Advocate /Guardian Long-term Team
Elly Nitschke	Senior Advocate/Guardian Short-term Team
	Senior Project Officer — Advanced Directives
Bethany Jordan	Advocate / Guardian
	A/ Senior Advocate/Guardian Short-term Team
David Cripps	Advocate / Guardian
Karen Bowden	Advocate / Guardian
Maria Atkins	Advocate / Guardian
Margi Keville	Advocate / Guardian
Elicia White	Advocate / Guardian
Barbara Robertson	Advocate / Guardian
Rebecca Norman	Advocate / Guardian
Popi Amanatidis	Advocate / Guardian
Tarnia White	Advocate / Guardian
Ella Nalepa	Advocate / Guardian
Andrew Sarre	Advocate / Guardian
Belinda Lake	Advocate / Guardian
Amy Martin	Advocate / Guardian
Katrina Burgess	Advocate / Guardian
Margaret Thompson	Advocate / Guardian
Jeannie Thompson	Advocate / Guardian
Stephen Burns	Advocate / Guardian

Passant Ibrahim	Community Enquiry Officer A/Advocate/Guardian
Susan Goldeband	Advocate/ Guardian

Supported Decision Making Project

Cher Nicholson	Senior Practitioner/Senior Project Officer
Heather Linton	Volunteer Peer Consultant
Neil Nicholson	Volunteer

Workplace safety

OPA is guided by the policies and best practice principles of the Attorney-General's Department (AGD) in relation to Workplace Health, Safety and Injury management. Practical assistance was provided by the AGD on request. OPA has an elected, trained WHS representative and First Aid Officer. WHS matters are routinely discussed in OPA staff meetings. Regular meetings of senior administrative staff and the workplace representative this year have assisted in promoting WHS awareness and review of OPA policies and procedures (duress alarm testing and staff response to duress incidents).

Risk and Incident Monitoring

The OPA work regularly involves emotionally charged and conflictual situations which can result in behaviour which is difficult to manage. OPA staff have increased their vigilance about threats and behaviours which constitute risk using the AGD's incident reporting system and the AGD security incident report. Staff have received training in incident reporting and personal safety this year. Some staff have also attended workshops on managing aggression and found these very valuable.

Risk Review Group

The OPA established a Risk Review Group during the previous reporting period in response to concerns about how the service monitored risk. This group meets monthly and involves senior staff, WHS representative and staff involved in particular incidents. The organisation maintains a register of incidents or situations where it has been assessed that there is a risk to staff or others. The Risk Review Group meets on a regular basis to monitor these individual matters.

Since commencing the process in February 2012, staff have brought 22 matters to the Group's attention with 12 matters under active monitoring as at June 30 2013. Incidents this year have included threats to harm staff members, abusive communications from some interested parties and significant risks to the safety and wellbeing of some clients. Risks for staff are generally not from clients and are more likely to come from family members or associates who are involved in their lives.

Given the number of clients and interested parties who relate to OPA staff, it would appear that the vast majority of relationships are positive and respectful even where differences may exist around the issues which the OPA is seeking to resolve.

Responses to the issues raised include the development of protocols for safely managing an individual matter, use of the OPA database alert systems, tandem working between senior staff and the staff member involved and seeking external advice and assistance from others including the SAPOL and the AGD Security Advisor.

Equally concerning for staff is the emotional impact of dealing with protracted conflict in families when parties seek to make the OPA part of the conflict. The support of peers and senior staff, including co-working situations and case transfers is critical to staff wellbeing.

The Risk Review Group provides input on organisational issues that arise from individual cases and general administration of WHS.

Risk Screening

As part of the process of promoting staff safety, OPA developed and implemented a risk screening tool during 2012–13, applicable to all new clients. The objective was to identify risks early and plan for preventative and management strategies which not only promoted staff safety but also sensitised the service to risks for the clients, their service providers and families.

The screening tool has undergone several changes to make it more practical and to promote consistent use. The tool will be reviewed during next year. It is also planned to audit existing clients using the risk screening tool.

Security Review

During 2011–12, the Public Advocate requested that the Attorney-General's Department conduct a Security Review on behalf of the OPA following several incidents of threats and abuse towards staff. The OPA has responded to a number of issues raised in the report. In particular, the Attorney-General's Department assisted the OPA to develop better security surveillance systems and processes at the office. All public areas are now monitored, duress systems connect to Police Security Services and additional training has been provided. There are some matters still under consideration.

Accommodation

The OPA accommodation envelope was expanded in the second-half of 2012 in order to provide accommodation for additional staff and to prepare public spaces suitable for new mediation functions. This was managed within the recurrent funding of the OPA with additional funding made available from the AGD corporate security budget and careful use of recycled furniture and fittings. We are grateful for the assistance received from the staff of the Attorney-General's Department who assisted us in achieving a smooth transition to our new arrangements.

Financial Information

The OPA's budget is allocated, managed, audited and reported through the Attorney-General's Department.

During 2012–2013, the core program expenditure of **the OPA** was as follows:

Income	
Grants	\$51,204*
Recoveries:	\$1,694
Total Revenue:	\$52,898
Expenditure:	
Employee entitlements	\$2,306,582
Supplies and Services	\$578,884
Depreciation	\$17,090
Total Expenditure	\$ 2,902,556

*Included funding from the Supported Decision Making Project.

The Supported Decision Making Project was funded until late 2012 by the Julia Farr MS McLeod Foundation. The OPA was required to report to the funding body on a regular basis.

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