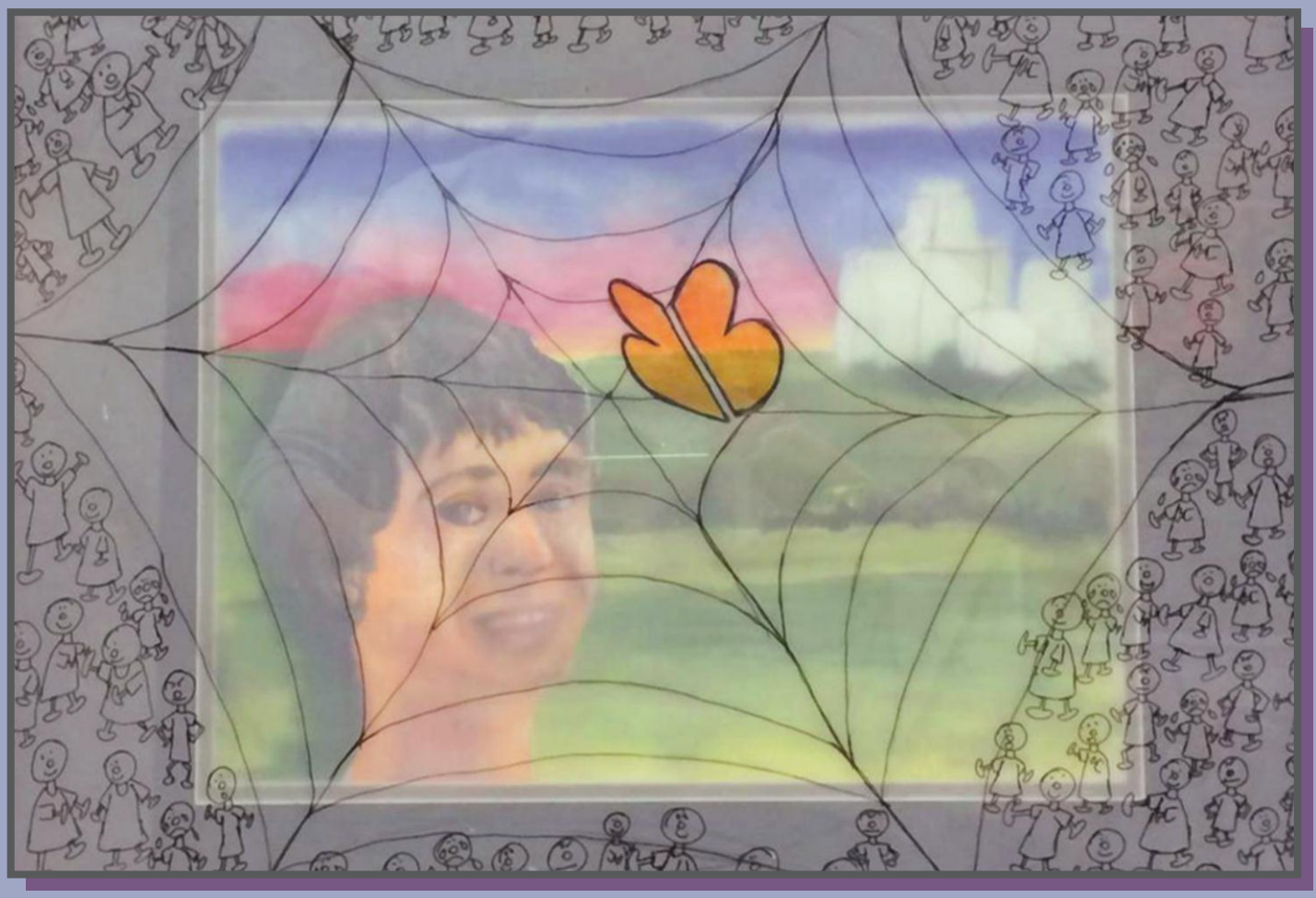
OFFICE OF THE PUBLIC ADVOCATE



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South Australian Office of the Public Advocate

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Front Cover: "A Working Life" by Dana Nance

Human society is all about working together. Each one of us has a role. My artwork is about working at Bedford for eight years where I have enjoyed companionship, friendship and trust. In the picture I have used the spider's web as a symbol of a working community, showing exceptional strength and flexibility. The little men represent people working together and the girl is me, looking into the future to the opportunities work can provide for friendships and security.

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6 November, 2015

The Hon. John Rau MP
Attorney-General
45 Pirie Street
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Dear Mr Attorney

I have the honour to present to you the twenty first 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 2014 to 30 June 2015. Part A includes a review of programs, consideration of unmet need, and advocacy positions taken by the Office. This year this part of the report summarises issues raised in past Annual Reports since 2009 and reviews progress. Part B provides statistical data on direct client services provided by our Office.

Dr John Brayley has held the position of Public Advocate for the last 7 years, including throughout the reporting period. I acknowledge his outstanding contribution and commitment to human rights in this State and beyond.

Yours sincerely

Anne Burgess

ACTING PUBLIC ADVOCATE

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INTRODUCTION

Reflections on the role of Public Advocate

Dr John Brayley resigned his position as South Australian Public Advocate on 3 October 2015. This is the last Annual Report for the period that he has been in that position. Below are comments made in a farewell speech by him on Tuesday 29th September, that also provide a suitable introduction to this year's Annual Report.

In our community holding the role of Public Advocate is a unique privilege. The Public Advocate is expected to tell it as it is; to reflect, to comment, and at times the Office is the last hope for people who have been abandoned and ignored, people who may be at risk.

I do not want to talk about myself, but I do want to reflect on the institution of Public Advocate, an institution that was set up as it is through the wisdom of the Parliament of this state 23 years ago.

There are many reasons why this institution of the Public Advocate is important, and why the institution of the Public Advocate succeeds.

The first reason is everyone here. Whatever your role and whatever your interaction with the Office of the Public Advocate is, people in general want us to be effective. We have been given the licence to say what you all think, and to fight the good fight for the people we all serve. Departments, Ministers, will welcome our advocacy even if it might put them on the spot. The institution is something that we have to have and is wanted.

A second reason for success is the dedicated professional and administrative staff of the Office of the Public Advocate. Complimenting staff at farewells can almost be a cliché, but this is truly different. Our staff are self-selected. There are powerful personal reasons why people choose to seek a job in our Office and then stay for year after year. This group delivers passion, dedication and competence in their roles. This is important for the services we deliver such as information services, dispute resolution and guardianship but also to our overall mission. We are at once both an advocate and a service provider. In delivering commentary and advocacy about systems, we need to walk the talk, by delivering our own services well and upholding the rights of our own clients while doing so.

This is where our Office, brought together by its Senior team, deliver. This is not without challenges, for example, with increasing demand we have had a waiting list for many years, but through our duty systems and senior staff, people on this list still get a service.

There are risks for our service in the future; we already have the highest number of clients per staff members of comparable services in the country. This is a risk. The Office, with its considerable statutory power can potentially go in one of two directions.

On one hand there is the direction of defending rights, empowering people to live rewarding lives, and upholding a right for people to be free of abuse and neglect. This is what we want, but it takes skill and time spent with clients to do this.

The second direction, the direction that we do not want, is the one of control, knowing best, making decisions for others with limited information, in essence acting as an agent of social control. This is the inevitable direction that services head when under resourced, and when services are not anchored in the vision of Parliament for our Office and the vision of the United Nations in its UN Convention on the Rights of Persons with Disabilities.

This is why the institution of the Public Advocate, its Office and its staff must itself be protected. It can speak up for others, but it needs you all to speak up for it.

I would like to make some specific acknowledgements. I have mentioned our team. I will not cite individuals, except, for Aileen Vincent. We are a team of two within the larger team. Thank you Aileen Vincent.

I also wish to thank the Attorney General's Department and in particular Deputy Chief Executive Caroline Mealor. We have been well supported and have grown to meet increasing demand over the years.

Thank you also to those in Disability Services, Health, Aged Care and Corrections who have worked with us, or accepted our Advocacy over the last 7 years; also to fellow statutory office holders, with whom we have coordinated responses over critical issues.

I think we also need to acknowledge our clients, our fellow citizens. Although we don't give up, right now, as we share this pleasant occasion, a number of those clients are still in terrible circumstances: in SRFs without a room of their own, homeless, in prison, and in solitary confinement.

There is still so much work to be done. The situation for us all is different now than when the Public Advocate was first established. We have greater acknowledgement in our community and in our political systems of issues related to the needs of people with disability or mental illness. We have a Community Visitors Scheme, an NDIS on the way, and soon a State Mental Health Commissioner. However, while the institution of Public Advocate will need to evolve, it will itself still be essential for years to come, and with pride I can be pleased to say that I have belonged to this group, this team, and been given the opportunity to contribute to the institution. Thankyou all for your collegiality, friendship and support over the years.

PROMOTING RIGHTS AND INTERESTS

Overview

Upholding rights in service delivery is a global and national issue but is also very much a local issue, because of the problems South Australia has had in effectively delivering human services and the consequent rights impact on individuals. There are two broad solutions. First there is a challenge of planning and operating human services well. Well planned, well led services with a positive staff culture, services that are effective, will uphold the rights of their clients in a way that services that are poorly planned and ineffective cannot - services with bureaucratic cultures will always have quality problems. The second solution is the broad recognition of human rights. Every decision made by Government that affects either a person or a community should conform to a charter or statement of Human Rights. It is no coincidence that the places that recognise human rights such as the United Kingdom, New Zealand and Victoria are also the places that have good reputations for effective management of key human services at least in comparison to other jurisdictions.

Any organisation that detains, and/or restrains people should be subject to independent inspection. A restraint that is poorly applied or a restraint that is used when it could be avoided can become a punishment. Australia has signed the Optional Protocol on the Convention Against Torture, but is yet to ratify it. When it is ratified there will be additional protections for people in custody – whether it be in prison, police cells, hospitals or locked disability accommodation.

South Australia does not have enough forensic mental health beds and the beds that we do have are limited in what problems they can manage. Instead we routinely use prison instead of hospital. Prisoners with mental illness who should be in hospital can stay in prison. Not guilty forensic patients are managed in prison because our hospitals are full or unable to cope. This problem is likely to continue even when our bed number increases from 40 to 50 beds in future months.

In December 2014 there were 18 forensic patients in SA prisons. A small number of these patients are placed in solitary confinement, 22 hours per day in a cell, in places such as G Division, D wing or Unit 7. Solitary confinement is harmful and causes pain and suffering. Juan Mendez, the UN Special Rapporteur on the Convention Against Torture has recommended that solitary confinement for vulnerable people be explicitly banned(Mendez 2013). Yet in South Australia we use solitary confinement instead of hospital. People with mental illness or disabilities can stay days, weeks, months or longer in solitary confinement in South Australia.

Ultimately we need to anchor our practices in basic principles. Courts should decide who goes to prison, not Government Departments or Ministers. Prison regimes should not be used for patients, and a solitary confinement bed is not a substitute for a psychiatric intensive care bed. We need to plan to provide sufficient forensic mental health care and disability capacity, aiming at least to match the improvements seen in Victoria and the UK.

The restraint of people in disability services, also leads to mental suffering. We know from what has been achieved elsewhere that South Australia has not done enough in this area. Without ready access to positive behaviour support planning, a misguided use of restraint can be implicit punishment particularly when it is repeatedly applied and reapplied. In South Australia there

are no legislated definitions of restrictive practices, or statutory powers for our Senior Practitioner to prevent its use. While there is now good work underway to put in place a reporting system of such practices, at this moment we do not know the extent to which such practices are used in this state. In contrast in Victoria and Queensland there is restrictive practices legislation and government policies that have increased access to skilled resources, as well as providing significant education and research in this area.

Another example is our use of restraint when patients have a prolonged stay in an emergency department. If a person is in a properly designed ward the use of such restraint is unheard of. It is avoidable.

The solutions to these problems rest in delivering quality services. There is a strong link between upholding rights, and maintaining service quality. It is also more economical to act in the right way. The link between quality and rights is effectively made by Lorna Hallahan in a paper she wrote for the HCSCC entitled, Towards quality and safety; Confronting the 'corruption of care' (Hallahan 2012).

In her paper she labels abuse, maltreatment, neglect, physical and sexual assault and undue use of restraints as violence. Aggressive environments are harmful to consumers, but also harm staff physically and mentally.

Torture is an extreme act of aggression but any act of dominance intended to bring about submission of another is inherently aggressive, no matter how apparently minor the act is.

Harvard Professor Chester Pierce wrote some key papers in the 1970s about racism, work that has been rediscovered in recent years and applied more broadly to all forms of discrimination (Pierce 1995).

Chet Pierce defined micro-aggressions. Micro-aggressions are subtle, seemingly innocuous degradations and putdowns. The person who administers the slight may be oblivious to what has happened. The comment or the action may seem harmless though Pierce says the cumulative burden of a lifetime of these micro-aggressions flattens confidence and causes stress and diminishes health. An oppressed person seeks to dilute, postpone or deflect the stress of micro-aggressions, similar to the response of a torture victim, and the dynamic to control the victim, to create an advantage over the other is also the same.

Pierce links these micro-aggressions to violence, analogous to Hallahan's conclusions about disability service failures as violence

Pierce was talking about society in general, but if we apply it to services, it shows we need to be exquisitely careful about the exercise of power by one human being over another because it can go very wrong – subtly and imperceptibly over time, or dramatically and disastrously in a significant event.

Pierce also saw discrimination as a public health problem, to be solved across communities. Mental illness related stigma, and ill-informed beliefs about disability, create discrimination either overt, or covert and the covert form, micro-aggression can oppress people deflating confidence and strength.

Program Review, Unmet Need & Protecting Rights

The sections of the report on reviewing programs, identifying unmet need and promoting rights, this year are presented in table format.

Rather than identify new topics and issues to analyse, the 2015 report updates matters identified in the last six Annual Reports of the Office of the Public Advocate.

The topics and the issues listed in the table, while being included in these tables because they were discussed in earlier editions of the Annual Report, vary in nature and who first raised them. Some are matters first identified by this Office or matters we have responded to. Others are matters that have been collectively identified in the sectors we work in by service users, advocates and providers during the year, and then noted by us in our report.

Many of the topics and issues listed in the tables are a statement of Government policy. In commenting on gaps and unmet need it has been helpful to compare our Office's observations and experience of services that people can receive with the intended policy.

During this period the work of the Social Inclusion Board was significant in setting State strategic directions in mental health and disability sectors, first with the Stepping Up plan for mental health services, and then later the Strong Voices report for disability service reform. These are useful reference points when reviewing programs.

While there remain many gaps, there have also been many improvements in the last 7 years.

While the institution of the Public Advocate has and will continue to have a significant role raising issues, many of the positive developments listed have been realised because multiple parties including service users, community groups, service providers and organisations, Departmental officers, and Members of Parliament have expressed them.

Ultimately elected Government and Members of Parliament make the difficult decisions to fund initiatives and change services. We are pleased though from the feedback received that the Annual Report of this Office has been a tool and reference for policy makers and those who contribute to policy.

Program Review, Unmet Need & Protecting Rights

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;

Topic	Previous Annual Report Discussions	Explanation of issue	Progress to date	Further work that could be done to address the issue
Disability Services: Unmet need for people in critical need because of homelessness or at immediate and high risk to self or others.	2010: pages 16-17 2010: pages 15-17 2011: pages 18-20 2012: pages 13-15 2013: pages 12-14 2014: pages 11-12	In November 2008, 525 people were on the unmet need category 1 waiting list waiting for 643 services.	In June 2015, 1415 people were on the unmet need category 1 waiting list, waiting for 1619 services. This is a reduction from 2014.	While the NDIS should, in theory, address this critical problem, urgent action is still needed to assist people in this group prior to the commencement of the NDIS.
Disability Services: Unmet need for people with intellectual disability.	2009: pages 20-21.	In our advocacy, people's unmet needs include those who are (i) not receiving a service, eg not presenting themselves to Disability SA, (ii) receiving a limited service but with unmet	Increases in the State disability budget, and roll out of individual funding to a number of clients. Plan for the NDIS to be established.	Key elements of the NDIS plans, yet to be completed, should address the needs of people who may not self-present for a service and need outreach. The yet to be

Topic	Previous Annual Report Discussions	Explanation of issue	Progress to date	Further work that could be done to address the issue
		needs, eg. accommodation support or specialist services and (iii) receiving a service from Disability SA but not other Government services, eg. mental health services for co-mordity.		completed safeguarding and quality strategy should address access to services. With respect to access to other services such as health, education, housing, justice, and employment, States will need legislation and policy to ensure effective service provision to this group.
Disability Services: Gaps in services for people with mild intellectual disability or borderline intellectual impairment who have emotional or behavioural symptoms	2009: pages 20-21.	People with borderline intellectual impairment who do not meet strict eligibility criteria may not receive a service. (in particular those who also experience a mental health problem with emotional or behavioural concerns.) People with mild intellectual disability may have limited resources allocated for their cognitive impairment.	Specialist programs for women with a diagnosis of both an intellectual impairment and borderline personality disorder are operating effectively providing group accommodation.	Attention will be needed to ensure that people in these groups are eligible for a service based on their overall functional impairment (rather than diagnosis or psychometric measures such as IQ considered in isolation.) People in these groups will need to be considered so that gaps are not created in the NDIS.

Topic	Previous Annual Report Discussions	Explanation of issue	Progress to date	Further work that could be done to address the issue
Disability Services: Unmet need for people with brain injury	2009: page 21	Services need to respond quickly to provide rehabilitation on release from hospital, rather than focusing on supporting permanent impairment.	The NDIS will fund services for people with head injuries. The Lifetime Support Scheme for people who have sustained serious or lifelong disabilities as a result of a motor vehicle accident is operating.	The rehabilitation and support response for people with head injury will need significant coordination between the NDIS and health services in the first instance and then the NDIS and a range of services to address dual disability (brain injury and substance use, or brain injury and mental illness) and triple diagnosis (brain injury, mental illness and substance use.)
Disability Services: Unmet need for people with autism spectrum disorders	2009: pages 21-22 2011: pages 24-28 2012: pages 16-19	A planned service response is needed for adults with high needs, instead of relying on individual solutions developed on a client by client basis by the Exceptional Needs Unit or Disability Services.	Disability Services have increasing expertise in assisting adults with autism spectrum disorders, assisted by the Positive Behavioural Support Team, and the Centre for Disability Health. The Exceptional Needs Unit remains available when a person experiences significant co-morbidity.	An Autism Plan could chart the coordination of NDIS funded services with State Government services for people with autism spectrum disorder

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Disability Services: Development of individualised funding.	2009: pages 23-25 2011: pages 21-23 2013: pages 16-18	Increasing evidence from Julia Farr Association, Western Australia, and the UK of the benefits of individualised funding which previously was not available in South Australia.	South Australia has operated an individualised funding trial, that has assisted service users and providers prepare for the NDIS and has been positively received. OPA made submissions to the NDIS when planning the "nominee rules" seeking to bolster supported decision making in selecting services and providers in the context of the NDIS model of individualised funding.	To maximise the number of people who can exercise choice, supported decision making should be an expected part of individualised funding models – in particular the NDIS. This could be achieved by incorporating the Australian Law Reform Commission's decision making principles into the *National Disability Insurance Scheme Act 2013*, as per the recommendations in their final report.
Disability Services: A new Disability Act.	2010: pages 17-20 2014: pages 14-15	Content of a new rights based Disability Act suggested. In 2011 The Strong Voices report suggested a new Act to align with the UNCRPD.	Significant amendments were made in 2013 to the *Disability Services Act 1993* in response to the Strong Voices recommendations. The *NDIS Act 2013* regulates services from that scheme.	While the NDIS Act regulates specialist disability services, a new state Disability Act in South Australia could regulate effective service provision of State based services to people with disabilities.

Topic	Previous Annual Report Discussions	Explanation of issue	Progress to date	Further work that could be done to address the issue
Disability Services: Client Trust Fund	2011: pages 29-35	Disability Services were, at the time, proposing to discontinue a free trust fund service to many clients that was highly regarded. It was our view that this service should continue and that as a general principle involuntary substitute decision making services involving money, including those offered by the Public Trustee for clients on administration should also be free to the client (although there may be scope to charge for accountancy, investment and legal services.)	The Trust fund was continued for clients using it.	These clients should not be disadvantaged when they move to the NDIS, and arrangements made to continue this service on existing terms.
Disability Services: Quality of food served to residents of disability accommodation.	2011: pages 36-37	Strathmont: food transported warm from Highgate to Strathmont leading to poor appearance and taste of the food for Strathmont residents.	A new cook-chill system was installed with improved palatability of food at Strathmont with apparent success. More generally, variability of food palatability remains an issue for many people across disability housing as food quality depends	Attention to palatability and enjoyment of food served to clients will need ongoing attention. Providing enjoyable meals could address concerns that people can turn excessively to take away food to get meals they enjoy, which

Topic	Previous Annual Report Discussions	Explanation of issue	Progress to date	Further work that could be done to address the issue
			on the cooking skills and training of workers in each location. (This matter is not as extreme as the previous Strathmont concerns.)	then affects their health.
Disability Services: Need to prevent the use of restrictive practices	2009: pages 60-65 2010: pages 68-89 2011: pages 65-75	Strategies to reduce restrictive practices in disability services required. The use of these often preventable practices in Government and non-Government services need to be counted so as to set reduction targets. Improvement needed in plans, which are often crisis response plans rather than positive behaviour support plans, and therefore do not provide sufficient attention to prevention. A Senior Practitioner to be appointed.	The OPA implemented its own Restrictive Practice Policy in 2011. Disability organisations are required by the *Disability Services Act 1993* to have a Restrictive Practices Policy. A Senior Practitioner has been appointed. Work to establish a reporting system is underway. Positive behaviour support expertise has been developed in a team providing this service which has significantly improved access to positive behaviour support, but this still remains an issue for many services. However, South Australia is significantly behind practice	Restrictive practices prevention strategies should be required in legislation. The Senior Practitioner should have statutory powers. The model for restrictive practices reduction and elimination in the NDIS is still to be determined.

Topic	Previous Annual Report Discussions	Explanation of issue	Progress to date	Further work that could be done to address the issue
			leaders Victoria and Queensland in preventing the avoidable use of restrictive practices.	
Disability Justice Strategy	2011: Pages 52-62	A comprehensive strategy is needed to address justice for people with disability who are victims, accused of committing a crime or are witnesses, rather than by seeking to address the problem through individual solutions. The work of Murray and Powell provides an overview of existing recommendations from past enquiries.	As recommended by the Social Inclusion Board and led by the Attorney General, the Disability Justice Strategy, with a broad scope of legislative changes and actions, is seen as the most advanced in Australia and a model for implementing equality of access to health services that could be considered by other jurisdictions – for example, the *Statute Amendment (Vulnerable Witnesses Act) Act 2015*.	Further assessment and continuous improvement of the strategy as it is implemented.
Disability Justice Strategy: New sexual offences law.	2011: Pages 55-56	*NSW Crimes Act 1900 s66F* has two specific offences related to cognitive impairment: The first makes it an offence to have sexual intercourse with a person where the accused is responsible for that person's care. The second makes it an an offence to have sexual intercourse with a person who	Review of past case law indicated an effective use of the NSW provisions, making the case for a new law in SA. In SA the *Criminal Law Consolidation (Sexual Offences-Cognitive Impairment) Amendment Act 2014* is now in operation.	The effectiveness of the new legislation will need review after a period of time in operation, in particular the introduction of "undue influence" to the offence, not present in the simpler NSW law, and whether SA defendants then seek to prove that undue influence did not

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		has a cognitive impairment, with the intention of taking advantage of that person's cognitive impairment that applies to all people (not just providers). In South Australia CLCA s49 (6), which refers to the inability to understand the nature or consequences of sexual intercourse, is of limited assistance to people with cognitive impairment.	This law creates offences if a person who provides a service to a person with cognitive impairment has sexual intercourse, has indecent contact or behaves in an indecent manner with the consent of the person with cognitive impairment where that consent has been obtained by undue influence.	occur. Further action is still needed to replace the current CLCA s49 (6) with a new offence that would apply to anyone "taking advantage" of a person's cognitive impairment similar to the *NSW Crimes Act s66F (3)*.
Disability Justice Strategy: Communications Assistants Scheme	2011: Page 62.	Implement measures to address the needs of people with cognitive impairment in legislation and/or police orders. The Victorian OPA volunteer Independent Third Persons' Scheme is an example.	The *Statute Amendment (Vulnerable Witnesses Act) Act 2015* provides a general entitlement to have a communication assistant present. $1.362M over 4 years has been allocated to fund a NGO to establish a pool of independent volunteers for a Communications Partner Scheme. The OPA view is that efficiencies would be obtained if this scheme	The effectiveness of the new volunteer communication partner scheme will need evaluation – particularly with respect to the objectives related to expert assistance in Court and whether this is achievable within the current budget. The efficiency of the scheme should be compared to combining the infrastructure

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			was co-located with the Community Visitors Scheme in South Australia using the existing infrastructure that recruits and trains volunteers. Also the laudable SA scheme objective of providing independent "experts" for the Court appears to be more in line with the objective of the UK intermediary scheme (which uses paid speech, language and communications professionals) than a volunteer scheme, which usually offer skilled and highly valued services but not communication experts for Court.	of a volunteer community visitor/communication assistant scheme.
Mental Health and Disability Services: Historical abuse of children and adults in former mental hospitals	2012: pages 38-43 2013: page 65	Reports of historical abuse: 14 people contacted the Office with reports of sexual, and other forms of abuse of child and adult patients (who experienced either a mental illness or disability): seven reports involving the former Hillcrest Hospital (from the	Information from this call-in has been provided to SA Health, the Mental Health Commission and the Royal Commission into Institutional Responses to Childhood Sexual Abuse. Following further press reporting in 2013 a further 9 people	Further documentation of past abuse to people who may have difficulty coming forwards themselves. Lessons learned can be incorporated into sexual safety and abuse prevention policies which seek to keep

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		1960s and 70s) and six Glenside Hospital (1960s to 80s).	contacted this Office.	people safe in the present day.
Mental Health and Disability Services: Need to establish a separate forensic disability unit	2014: pages 17-19	A separate 10 bed forensic disability facility should be operated under the Minister for Disability.	$1.7M over 4 years allocated to fund forensic disability care, but this is within the already planned mental health bed envelope, and remains a service delivered by Health and under the Minister for Mental Health.	Amend the CLCA to give the Minister for Disability responsibility for clients who have a principle disability. Fund the establishment of a separate and additional 10 forensic disability beds operated by a disability provider using disability staff and models.
Mental Health Services: Provision of supported accommodation and 24 hour acute and rehabilitation community beds	2009: pages 27-36 2010: pages 26-28 2010: pages 36-37 2011: pages 50-51 2011: pages 95-111 2012: pages 46-49 2014: pages 24-25	The Stepping Up Plan required: 73, 24 hour supported accommodation places 60 community rehabilitation centre places 90 new intermediate care centre places 30-40 secure rehabilitation places at Glenside. Need to update accommodation policies:	The Community Rehabilitation Beds have been delivered and are working well. Only 20 of the 73 24 hour supported accommodation places were delivered (the rest became "up to" 24 hours support). The intermediate care centres appear to be working well, but a new centre has not been built in the Northern suburbs of Adelaide although funds were allocated for	An investment in quality 24 hour supported accommodation is required. This could allow secure rehabilitation services to refocus on their originally intended function.

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		In particular for the provision of independent units to meet client wishes in this area, but with available support. This can be achieved with a greater use of cluster units with on-site-support. Back pressure due to a lack of accommodation and support to discharge people to contributes to extremely long lengths of stays for clients waiting for a bed in ED departments.	this purpose. Secure rehabilitation wards have been built but are not working according to the intended secure model (many are open wards, housing people who might be provided intensive 24 hour supported accommodation if available.)	
Mental Health Services: Aboriginal and Torres Strait Islander Mental Health	2010: pages 29-31 2011: pages 47-49 2012: pages 44-49	Social Inclusion Board had reported concern from aboriginal advocates that aboriginal people may miss out on the benefits of reform. Specific recommendations to audit progress and have a senior leadership group, not implemented. Elements of a culturally safe model of community empowerment, wellbeing	"Stepping Up" recommendations not implemented. Still many positive initiatives have operated reflecting the work of different services but without the central Chief Executive led response and associated auditing of activity that was expected.	Priority is needed for services assisting aboriginal people in the next round of planning. This should achieve equivalence in access for aboriginal people (based on need to all the elements of the "Stepped Model" including early intervention programs, community mental health services and 24 hour residential programs (eg ICCs

Topic	Previous Annual Report Discussions	Explanation of issue	Progress to date	Further work that could be done to address the issue
		programs and specialist services were considered.		and CRCs).
Mental Health Services: Early intervention	2010: pages 32-35	Social Inclusion Board recommended the fast tracking of a specialist first episode and early psychosis service. Progress has been modest and slow with limited funding to a small Early Psychosis Intervention Service.	Additional Commonwealth resources have assisted in this area. The State has worked to establish SA Youth Mental Health Services and reform Child and Adolescent Mental Health Services (CAMHS).	A single population based mental health plan, if developed, could coordinate Commonwealth and State investments in early intervention and avoid gaps and duplication.
Mental Health Services: Community Mental Health model	2010: pages 39-43	Concerns re lack of resources to provide sufficient community mental health support for clients, and under treatment. SA Health had proposed a new model with rapid access to case coordinators, and an improved capacity to respond to clients.	A new community mental health model has been implemented across metropolitan Adelaide. Concerns exist that while the model across Adelaide is standardised, Community Mental Health still does not have the capacity to prevent demand on emergency departments and take up the central role in the stepped system envisaged by the Social Inclusion Board.	Review of the operation of the new community mental health model. Increase Community Mental Health capacity with new resources or the reallocation of existing resources (this is based on the recommendations for system reform across Australia of the National Mental Health Commission in its key 2014 report).

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Mental Health Services: Services for Older People	**2010: pages 37-39**	**SA Health plans to close 72 aged extended care beds and reinvest recurrent funds into part funding 24 Transitional Care Unit beds in aged care facilities, 40 Intensive Care Behavioural Unit beds in aged care facilities and an additional 50 FTE community older persons mental health staff.**	**There has been minimal progress in implementing new services.** **Widespread concern exists within the sector that as mental health beds have closed, funds may have been resorbed into the general health budget and not reallocated to new older persons mental health services.**	**A state older person's mental health service plan could address current and projected population needs. Mental health funds require "ring fencing", and within that, funds for aged care mental health services should also be protected.**
Mental Health Services: Governance and accountability for the delivery of policy objectives	2011: pages 40-43 2014: pages 27-30	A mental health commission would provide greater accountability for delivery objectives and performance.	Establishing a Commission is Government policy.	A Commission could be legislated for (as per the NSW model), and have a commissioning role (as per the WA model.) A new plan, and possibly a 10 year blueprint for community services and beds established.
Mental Health Services: The need for planning targets rather than relying on national averages.	2013: pages 22-29	Mental health accommodation places and bed numbers should be benchmarked on population based targets, and agreed definitions of types of services rather than interstate averages.	National Mental Health Commission has completed a review into Australia's Mental Health Service.	Agreement needed on what targets should be, and then a commitment to work towards the targets (even if targets are set as part of a 10 year plan.)

Topic	Previous Annual Report Discussions	Explanation of issue	Progress to date	Further work that could be done to address the issue
Mental Health Services: Overuse of CTOs.	2009: pages 49-51	No evidence whether CTOs benefit or harm patients. In the OPA's view CTOs have a role, but are likely to be overused in Australia.	No change in practice.	Improved access to services and engagement with clients on a voluntary basis to limit coercion through the use of CTOs.
Mental Health Act 2009: **Broadening of the criteria for involuntary treatment**	2009: pages 52-58	Risk based criteria have been broadened in the new Act, and there is no reference to mental capacity criteria. This may expand the use of coercion.	Chief Psychiatrist's Review of the Mental Health Act in 2014 recommends the incorporation of capacity criteria into the *Mental Health Act 2009*.	Implementation of capacity criteria and a focus on supported decision making along the lines of the Victorian *Mental Health Act 2014*.
Mental Health Act 2009: **Non provision of written reasons for involuntary admission and treatment orders to patients.**	2011: pages 80-84	When placed on an order, the form no longer contains a section for a practitioner to briefly state the grounds for the order. This has been replaced by tick box. The OPA considers that writing grounds would better uphold rights and improve the quality of decision making. A copy of the form should be given to a patient.	This issue was considered in the 2014 Review of the Mental Health Act, with a decision to continue with the current tick box form.	South Australian patients should have written grounds, as do patients in Victoria with their new Act. Written grounds should be provided unless there is a specific reason for not doing so, that itself can be reviewed.

Topic	Previous Annual Report Discussions	Explanation of issue	Progress to date	Further work that could be done to address the issue
Mental Health Services: Need to rebuild James Nash House.	2009: pages 66-70 2010: pages 97-101	The out-dated prison like design of James Nash House requires a total rebuild, using a modern campus design (security in a perimeter fence, not in the buildings which are clinical in design). Capacity needs to be expanded.	Forensic beds transferred from Glenside have been built using the new campus model, along with 10 extra forensic beds. The out-dated buildings are still in use.	Older building needs to be replaced. A further expansion of at least 10 forensic mental health beds and a separate 10 bed disability unit is required.
Mental Health: Mental health services for prisoners.	2012: pages 21-33 2014: pages 25-26	A population based mental health plan is needed for people in prison, to provide "equivalence" of mental health care compared to what general community members would have access to.	Prisoners in need of admission still have limited access to James Nash House (as beds are required for forensic patients.) Mental health forensic service in reach remains limited.	Further investment in forensic mental health in reach, and greater access to admission to meet National Forensic Mental Health Principles for prisoners.
Mental Health: Forensic patients should be in hospital not prison	2013: pages 33-39	The forensic mental health system is relying on prison because beds are unavailable or a person is considered at high risk. Such patients are in prison but are not prisoners. When a Ministerial Direction is made for a forensic patient to be housed in prison, the Direction should ensure that	The Minister and SA Health have implemented an improved system to oversee the welfare of forensic patients in prison. There is agreement as to what a Ministerial Direction should address. The bed number of James Nash House has been increased by 10 beds, which may reduce the need	Increased forensic bed numbers, and a rebuild of James Nash House will address this issue so that it can manage clients numbers and high acuity clients.

Topic	Previous Annual Report Discussions	Explanation of issue	Progress to date	Further work that could be done to address the issue
		care and supervision needs are met.	to use prisons. Redevelopment work at James Nash may better meet the needs of patients who might then not be transferred to prison.	
Mental Health: Forensic mental health services for women.	2012: pages 33-37	Lack of a women's only unit for forensic patients. Lack of access to sufficient beds for women prisoners requiring acute care, sub-acute care, crisis care as well as psychosocial care for women with personality disorders.	Correctional Services developments: Between 2012 and 2015 a therapeutic unit was operated by Corrections at Sandalwood Port Augusta, which had social work leadership, and was staffed by Officers. It is expected a similar service will be provided at the Adelaide Women's Prison (AWP). Access to specialist mental health beds for women is still limited.	Establish a women's wing at James Nash House for both women forensic patients and prisoners. Consider the development of a small unit at AWP for crisis care and psychosocial support for women in crisis.
Mental Health Services: Sexual safety in inpatient settings	2011: pages 90-94	A sexual safety policy amongst other goals, would aim to prevent sexual and physical assaults on women, improve recognition if it occurs and lead to effective response with police and Yarrow Place	Policies to respond to alleged sexual assault have improved. Work has been undertaken in SA Health on a state-wide sexual safety policy which is still to be released.	Mental Health Services may benefit in using some of the Disability Services responses (including the involvement of the Care Concerns Investigation Unit when required.)

Topic	Previous Annual Report Discussions	Explanation of issue	Progress to date	Further work that could be done to address the issue
		attendance. A sexual safety policy could establish a women's only intensive care unit, and in mixed units create pods for women and women only lounges.		There is an urgent need for SA Health to complete and implement a sexual safety policy. Other states have continued work in this area developing policies related to gender sensitive care and trauma informed care.
Mental Health Services: Absconding from facilities	2011: pages 85-89	Routine monitoring of absconding rates is indicated. This topic arose after concerns about involuntary patients absconding from either wards or emergency departments. In wards, literature suggests that the rate is affected by leadership and team work on wards.	The OPA has not undertaken further work in this area.	Routine reporting of absconding rates is still indicated.
Aged Care: Detention and Restraint	2011: pages 76-78 2013: pages 46-50.	Restraint prevention should be a part of the Commonwealth's *Aged Care Act 1997* User Rights Principles. The use of guardianship (*GAA* s32) provisions to authorise	The OPA has a 2015 Restrictive Practices in Aged Care Policy. There is greater awareness of the need to provide protections nationally, while also modifying	Inclusion of restraint prevention and elimination in the User Rights Principles. The *GAA* could permit a 'collaborative authorisation process' for the admission of

Topic	Previous Annual Report Discussions	Explanation of issue	Progress to date	Further work that could be done to address the issue
		detention protects the rights of people wishing to leave aged care, but are an excessive requirement for people who are "wanderers", and is often not complied with.	s32 provisions.	people to locked aged care facilities who wander – based on a model proposed by the Victorian Law Reform Commission. People who wish to leave should still be protected through s32 processes.
Workplace Mental health in the SA Public Sector	Public Sector employees – psychiatric examinations.	Concern re use of coerced medical examinations (in particular psychiatric examinations) of public sector employees (under provisions of *Public Sector Act 2009* s56.)	The Commissioner for Public Sector Employment has issued new guidelines on the use of the power that address concerns.	Monitor to ensure that the guideline is being followed and in particular that coercion is not applied that could be avoided.
Recognition of human rights	2012: pages 69-76	The rights of at risk populations can best be argued when the rights of all people are recognised. The rights argument then becomes one of seeking equality rather than special consideration. Canada, the UK, New Zealand, Victoria and the ACT recognise human rights in either an Act	Progress since 2012 in recognising human rights includes (i) a reference to the UNCRPD added to the *Disability Services Act 1993*, (ii) a statement about the rights of older South Australians in SA's A Strategy to Safeguard the Rights of Older South Australians. There appears to be little appetite for a wider recognition of rights at this time, although this could	Formal recognition of the rights of all South Australians.

Topic	Previous Annual Report Discussions	Explanation of issue	Progress to date	Further work that could be done to address the issue
		or Charter.	greatly benefit the rights of people with a mental incapacity.	
Adult Protection: The need for policy and legislation	2009: pages 38-46 2010: pages 61-65 2011: pages 112-113 2013: page 60.	Improved policies for preventing and responding to the abuse of people with disabilities. Mandatory reporting of abuse of at risk adults, and the development of an adult protection policy were proposed.	There has been effective progress by Disability Services which has included the development of comprehensive "Care Concern" policies. Policies require mandatory reporting of abuse and assaults to the police and the Care Concerns Investigation Unit. Improved screening of people working with at risk adults has been implemented. The OPA led a Vulnerable Adults Project which has influenced the development of the State's Elder Abuse Prevention Policy. Subsequently the focus of our advocacy has been on mandatory "response" by organisations rather than mandatory reporting.	A single adult protection policy response to the needs of at risk adults of all age groups is still required. Ideally this will lead to adult protection legislation modelled on Scotland's *Adult Support and Protection Act 2007* and *England's Care Act 2014.*

Topic	Previous Annual Report Discussions	Explanation of issue	Progress to date	Further work that could be done to address the issue
Adult Protection: A Community Visitors Scheme	**2009: pages 38-46** **2010: page 66.**	**In 2009 the OPA continued its long term advocacy for a Community Visitors Scheme along with many other groups in the sector.**	**Community Visitors Scheme legislation for Mental Health Services is passed and the Scheme is operating and valued.** **It has been subsequently extended by regulation to Disability Services and SRFs.**	**Legislation is required to consolidate the role of the Scheme in Disability accommodation and SRFs, so that it has the same legislated standing it has in mental health services.**
Supported Residential Facilities	2010: pages39-60 2014: pages 47-49	Problems in supported residential facilities (SRFs) include the use of shared bedrooms for many residents, old buildings in many instances that do not support quality care, and at times lack of personal security and privacy. New legislation is required to regulate this sector. Facilities are required for women, including the choice of living in a women's only facility and a requirement to have sexual safety policies in place.	Industry self-development has occurred and a number of operators have shown leadership in improving care and building standards. Nevertheless the basic service and financial parameters of the industry are flawed and most key issues are still to be resolved.	The *Supported Residential Facilities Act 1992*, is in need of urgent review, and should properly reflect the expectations on SRFs as care providers. This could coincide with the advent of the NDIS, which may help fund, many SRF clients' care.

Assistance Dogs and Supported Accommodation

The Commonwealth *Disability Discrimination Act* outlaws both direct and indirect disability discrimination. Provided the circumstances are not materially different, it is unlawful to treat - because of their disability - a person with a disability less favourably than others. Circumstances are not materially different merely because a person with a disability requires adjustments for their assistance animal. To avoid disability discrimination therefore, the *Disability Discrimination Act* requires people and organisations to make reasonable adjustments for a disabled person's assistance animal.

According to the UK Equality and Human Rights Commission, the duty to make reasonable adjustments arises out of the recognition that bringing about equality for people with disabilities might mean changing the way in which services are delivered. in addition, the duty is anticipatory, meaning that an organisation must think in advance and on an ongoing basis about what people with a range of impairments might reasonably need and do what is reasonable to meet those needs.

The *Disability Discrimination Act* defines "assistance animal" to include not only an animal accredited under a law of a State that provides for the accreditation of animals trained to assist persons with a disability to alleviate the effects of the disability; the definition also includes a non-accredited animal that has been trained to assist a person with a disability to alleviate the effects of the disability, and to meet standards of hygiene and behaviour that are appropriate for an animal in a public place.

In South Australia, the Dog and Cat Management Board is responsible for accrediting guide dogs, hearing dogs and disability dogs. Both Guide Dogs SA and Assistance Dogs Australia provide accredited autism assistance dogs to children with an autism spectrum disorder. Other organisations such as AWARE Dogs Australia Inc may also train an animal to assist an adult with a disability and apply for accreditation from the Board. Other organisations may not seek to train animals to an accreditation stage but nevertheless provide trained companion animals to people living with disabilities. If such animals are trained to assist a person with a disability to alleviate the effects of the disability, and to meet appropriate standards of hygiene and behaviour they would fall within the *Disability Discrimination Act's* definition of as assistance animal.

What are the implications for organisations that provide accommodation and services to people with disabilities? While Disability SA explicitly recognises the value of pets in the lives of disability clients, accommodation and service providers might be understandably reluctant to allow the provision of an assistance animal to an existing client. The client's accommodation may not feature appropriate outside space. There may be concerns about the impact of an assistance animal on the welfare of other clientele. The client's disability might mean that care workers would find themselves caring for a dog as well as the person with the disability.

On the other hand, there is increasing recognition of the benefits that accredited assistance animals and trained companion animals can offer in the lives of disabled people. Not only do they assist people with visual or hearing impairments, they can counter anxiety, provide solace, motivate and encourage communication. The challenge for accommodation and service providers is to act to acknowledge these benefits - to make reasonable adjustments - so as to ensure compliance with anti-discrimination legislation.

SUPPORTED DECISION MAKING

Overview

There is nothing more intrinsic to the autonomy of a human being, than to be recognised as a person before the law, and to have personal control and authority over one's actions and life.

Article 12 Equal recognition before the law

Persons with disabilities have the right to recognition as persons before the law

Persons with disabilities enjoy legal capacity on equal basis with others in all aspects of their lives

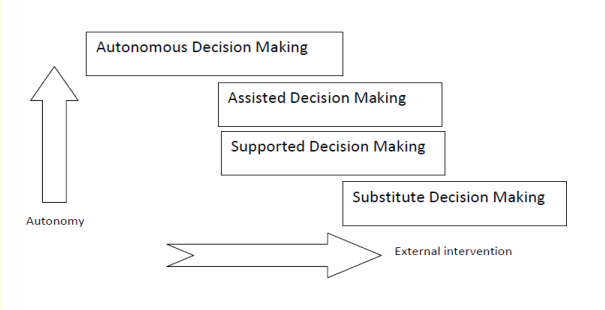
Persons with disabilities access the support they may require in exercising their legal capacity

All measures that relate to the exercise of legal capacity are safeguarded to prevent abuse; they respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest possible time and are subject to regular review by a competent, independent and impartial authority or judicial body.

In the UN Convention on the Rights of Persons with Disabilities, this is described in Article 12.

All people have the right to recognition before the law. At a practical level people may need support to make their decisions. In South Australia we developed a Supported Decision Making model, based on the following stepped approach.

Stepped Model



Substitute decision making has a role, but in between autonomous decision making on one hand and supported decision making on the other, sits assisted and supported decision making. Professionals should assist clients who need it to understand options and make their decision. For some people a family or friend may need to be a support person if a person wants this support.

Historically there have been significant numbers of people who can make their own decisions with support, who have instead had decisions made for them by others because support is not available. This includes people with mild to moderate intellectual disability, brain injuries, autism spectrum disorders, mental illness, and mild to moderate dementia.

When we undertook the Supported Decision Making Project in our Office, some people told us that this was the first time in their life that others had shown confidence in their decision making. We assisted people and their supporters make Supported Decision Making Agreements, the document which was proudly seen by the participants as a certificate of capacity and confidence. This was a change from their former compliant submissive role, a role which was without an opportunity to learn decision making skills and a role which created a habitual expectation that others will make decisions for them.

This powerlessness, this lack of confidence, is discrimination. The problem is not the individual's impairment but the failure of other people to show reasonable accommodation in their actions, and the non-existence of systems to deliver support.

Harm can be caused by unnecessary substitute decision making, just as harm can be caused by unnecessary restraint.

It may be due to a single disastrous decision, or the cumulative effect of many small decisions made by another person when this was not needed and not wanted. An example of a single disastrous decision is the coerced sterilisation of women with disability described by Women with Disability Australia as torture.

Pierce's micro-aggression theory can be applied to avoidable making of everyday decisions, made by one person for another. Even a small decision made for a person who could otherwise make it himself or herself is ultimately oppressive, and diminishes an individual and their confidence needed to make future decisions. While guardianship tends to focus on the big decisions – such as the medical consent to a significant treatment, or a decision to move out of home – the approach to day-to-day decisions sets the scene.

In this context there is no such as thing as a benign paternalistic decision if a person could make the decision themselves, because ultimately unnecessary, unwanted and uninvited decision making reflects an exercise of power of one person over another. This can be experienced as a micro-aggression and repeated invalidation saps skills and confidence.

Pierce describes characteristics of inherent operational prejudices in an academic context. One is that the dominating agent uses the submissive agent as the target to be understood, helped, analysed, categorised, and controlled. Hardly ever is the dominator the subject of study by the dominated.

Supported Decision Making research takes on a systems perspective to address a failure of support rather than attribute failure to an individual with a disability.

Review

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;

Topic	Previous Annual Report Discussions	Explanation of issue	Progress to date	Further work that could be done to address the issue
Supported Decision Making	2009: pages 84-87 2010: pages 90-96 2011: pages 114-118 2012: pages 54-68 2014: pages 31-33	A practical model of supported decision making needs to be developed to be an alternative to substitute decision making wherever possible.	Completion of the SA Supported Decision Making trial at OPA (funded by the Julia Farr MS McLeod Benevolent Fund), work which has led to many other trials nationwide and has generated international interest. Completion of a second Supported Decision Making trial based at the Health and Community Services Complaints Commissioner's office.	*Guardianship & Administration Act* reform to provide a statutory framework to supported decision making. Funding of a small supported decision making service to provide training and assist with complex matters requiring a supported decision making agreement. This could be an alternative to future expansion of guardianship services.

Topic	Previous Annual Report Discussions	Explanation of issue	Progress to date	Further work that could be done to address the issue
Supported Decision Making: Population based model.	2013: pages 54-55	After completion of the Supported Decision Making trial, a model of implementation was needed so that supported decision making is widely available.	The model describes primary (education to the entire community), secondary (skills training in relevant sections on assisting and supporting decision making) and tertiary interventions (the provision of an expert service as an alternative to guardianship).	Further training to disseminate best practice in supported decision making in the relevant sectors. Funding of a small supported decision making service, that could be based in an NGO.

Committee

This year this committee assisted the Public Advocate in developing a response to the Australian Law Reform Commission enquiry into Equality, Capacity and Disability in Commonwealth Laws, and in making draft changes to the National Guardianship Standards. The Committee has also received regular reports on the second Supported Decision Making trial auspiced at the Health and Community Services Complaints Commissioner's Office and provided feedback.

The membership of the Committee is as follows:

Ian Bidmeade

John Brayley (Chair)

Margaret Brown

Di Chartres

Ian Cummins

Tiffany Littler

Helen Mares

Graham Mylett

Cher Nicholson

Elly Nitschke

Steve Tully

Robbi Williams

Guardianship and Administration Act 1993

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

(g) to monitor the administration of this Act and, if he or she thinks fit, make recommendations to the Minister for legislative change;

Topic	Previous Annual Report Discussions	Explanation of issue	Progress to date	Further work that could be done to address the issue
Guardianship and Administration Act 1993 (GAA): **Definition of capacity**	2009: pages 78-80	The legislation should refer to decision specific capacity, a presumption of capacity and that all efforts be made to assist a person exercise their capacity.	These principles were incorporated into the *Advance Care Directives Act 2013*. There has been no change to the *GAA*.	*GAA* law reform to bring decision making capacity criteria up to date and in line with the *Advance Care Directives Act.*
GAA: **Incorporation of the principles of the Stepped Model of Supported and Substitute Decision Making into the Act..**	2009: pages 84-87 2010: pages 105-109 2013: pages 56-59	Legislation should recognise decisions made using support, and the obligations of the decision supporter to act in the interests of the person they are supporting.	While there is increasing use of non-statutory models of supported decision making, statutory recognition in South Australia is limited to references in the *Disability Services Act 1993* and the *Advance Care Directives Act 2013*.	*GAA* law reform to refer to Supported Decision Making. This includes recognition of agreements where a person appoints their supporter, and tribunal appointments where a tribunal appoints a supporter as a less restrictive alternative to a substitute decision making order.

Topic	Previous Annual Report Discussions	Explanation of issue	Progress to date	Further work that could be done to address the issue
***GAA*: The need to limit the number of guardianship appointments and the breadth and duration of appointments.**	2011: 122-132	The common law view is that there is a presumption of capacity and that capacity is decision specific. Guardianship can be sought to deal with issues unrelated to an individual's incapacity – family conflict requiring mediation, service gaps requiring advocacy, and personal safety concerns that might be dealt with by an adult protection response without an order.	The new *Advance Care Directives Act 2013* and amendments to the *Consent to Medical Treatment and Palliative Care Act 1995*, have established a new dispute resolution service in OPA, giving the Tribunal more power to make directions to parties on specific matters without making an order, and clarified who can give health consent as a "prescribed relative." This has reduced the need for an order. The South Australian Civil and Administrative Tribunal's (SACAT) focus on the application of administrative law and its use of detailed specific orders should reduce the need for orders, the length of orders and the scope of orders.	*GAA* reform to recognise supported decision making, and align decision making incapacity definitions across Acts. *GAA* reform to detention powers so that ongoing orders are not required for people who are "wanderers" in aged care facilities.

Topic	Previous Annual Report Discussions	Explanation of issue	Progress to date	Further work that could be done to address the issue
Private Guardians and Enduring Guardians	2012: pages 80-82	Private guardians and enduring guardians wanted more information and support. Only 35% of enduring guardians aware of the legislative principles that should underpin their decision making.	*Advance Care Directives Act* implementation has led to the development of new resources and there has been an education role for SA Health, the Legal Services Commission and the OPA. Resources allocated to OPA for education and information about Advance Care Directives.	Similar work is required to support private guardians. An outdated Private Guardians Manual of the OPA will be updated when resources permit this to occur.
Community Guardianship Planning	2014: pages 35-40	In 1999 the *GAA* was amended to allow the Public Advocate to delegate to non-public sector employees with the approval of the Attorney General. This allows for the use of volunteer community guardians. Recurrent funding has not been available to fund such a scheme based on Victorian or WA models (training, support and insurance require funding.) Community Guardianship should not be used to solve matters that could be dealt with more effectively using	SA Health Completed a report of options for community guardianships (explained in last year's Annual Report.). One-off funding of $100,000 is still to be allocated. Because this is one-off funding that would not in our view be able to sustain a scheme into the future because of a lack of a recurrent resource, there may be other options to achieve similar policy objectives of expanding the capacity of the community generally to undertake guardianship tasks. This could include the	While the OPA supports community guardianship this should be with recurrent funding for training, support, volunteer insurance and oversight, and any scheme should have a rights based focus. There is also a need to fund supported decision making consistent with the current focus in law reform and policy, and to consider other contemporary adult protection initiatives.

Topic	Previous Annual Report Discussions	Explanation of issue	Progress to date	Further work that could be done to address the issue
		other solutions: eg circles of support to overcome isolation, statutory community visitors to aged care, access to advocacy.	development of resources to assist private guardians and substitute decisions makers that may give confidence for people to take on these roles and then remain in them.	

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 2014-15, the Public Advocate met with relevant Ministers and Members of Parliament in an advocacy role.

The Public Advocate regularly met with Ministers, Shadow Ministers and Members of Parliament to discuss a range of legislative, policy and funding issues across the law, disability, ageing and mental health. In addition responses were provided on request when approached regarding particular issues.

Meetings with Ministers, Shadow Ministers and Members of Parliament

Hon. John Rau MP, Deputy Premier and Attorney-General

Hon. Tony Piccolo MP, Minister for Disabilities

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

Hon Stephen Wade MLC, Shadow Minister for Mental Health and Substance Abuse

Hon Duncan McFetridge, MP Shadow Minister for Disabilities

Hon. John Gardner MP, Shadow Minister for Correctional Services, Shadow Minister for Justice

Hon Kelly Vincent MLC

Attendance at Committees

The Public Advocate and Ms Barbara Robertson Advocate/Guardian presented to the Social Development Committee of the South Australian Parliament on the topic of dual disability.

The Public Advocate and Ms Anita Smith, the Chair of the Australian Guardianship and Administration Council, presented to the Senate Standing Committee on Community Affairs of the Australian Parliament on the topic of the Social Services Legislative Amendment Bill 2015.

Submission to Parliamentary and Government Inquiries

South Australian Parliament Social Development Committee: Inquiry into Co-morbidity

Australian Parliament Senate Standing Committee on Community Affairs: Social Services Legislation Amendment Bill 2015.

Department of Social Services, Australian Government: National Disability Insurance Scheme Quality and Safeguarding Framework

Department of Health, South Australian Government: Chief Psychiatrist's Review of the SA Mental Health Act.

Australian Law Reform Commission: Legal Barriers for People with Disability (Issues paper response) Combined response from the Victorian and South Australian OPA.

Submissions from previous years related to the ALRC inquiry and the SA Sentencing Council's review of Part 8A of the *Criminal Law Consolidation Act 1935* (mental impairment provisions)are available on our website.

Section 22 Report

No matters were raised under the formal provision of Section 22 during 2014-15.

Advance Care Directives Act 2013

Section 45 —Resolution disputes by Public Advocate

Consent to Medical Treatment & Palliative Care Act 1995

Section 18C - Resolution disputes by Public Advocate

Introduction

The *Advance Care Directives Act 2013* (ACDA) came into operation on 1 July 2014. The Act amended the *Guardianship and Administration Act 1993* (*GAA*) and the *Consent to Medical Treatment and Palliative Care Act 1993* (*Consent Act*), authorising the Public Advocate to resolve disputes in the following circumstances:

- If the person has made an advance care directive and there is a disagreement about a health, accommodation or personal decision that has to be made for the person. This includes people who have made an Enduring Power of Guardianship, a Medical Power of Attorney or an Anticipatory Directive prior to 1 July 2014.
- If a person does not have an advance care directive but there is a disagreement about health care and/or medical treatment. This includes disputes involving children under 16 years of age.

Aim of the Dispute Resolution Service (DRS)

The Dispute Resolution Service is staffed by qualified mediators who have experience in working with people who have impaired capacity. The aim of the DRS is to enable participants who disagree about an issue regarding an advance care directive, or a health consent issue, to come together in a collaborative way, in a safe environment, to discuss the issues that are in dispute and develop options to resolve the issues.

The dispute resolution model (including a mediation model) that was developed for the OPA service takes a rights based approach and is person - centred. The model ensures that all parties to the dispute are able to relay their views about the current situation and discuss options that will bring a resolution to the conflict. Most importantly, the model ensures that the thoughts, views and wishes of the person who is at the centre of the dispute, is brought into the resolution process, even if they are not able to directly take part in mediation.

The First Year

During the first year of operation, the OPA Dispute Resolution Service received 101 applications. Of those applications, 44 matters were resolved, 3 matters were withdrawn, 3 clients deceased before conclusion of case and 29 matters were referred to the Tribunal. There were 22 active cases at the end of the 30th June 2015.

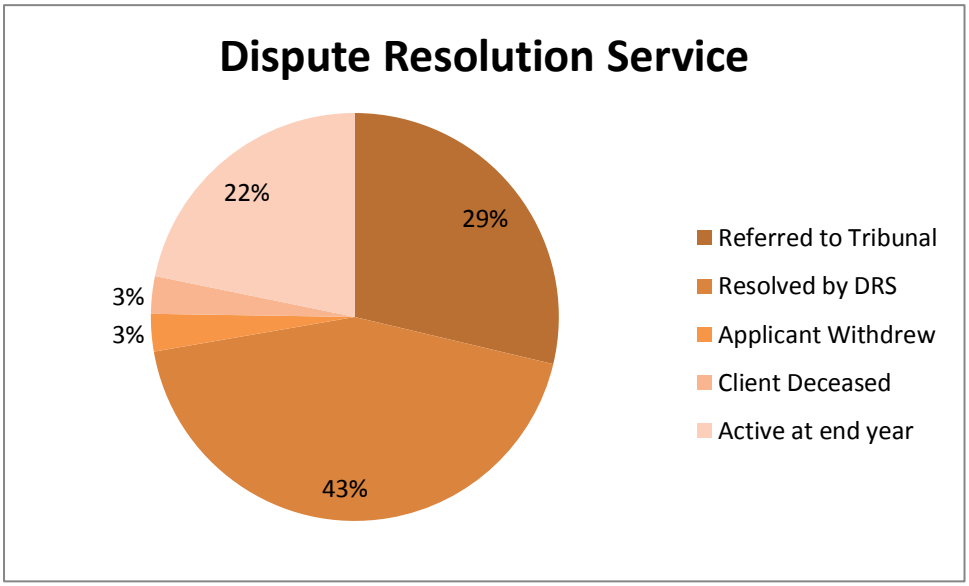


Figure B1 - Reasons for closures

Nature of the disputes

In many cases, disputes that were brought to the OPA were taking place amongst family members and the person who was at the centre of the conflict was not involved in the dispute and did not know that it was occurring. Reasons for dispute resolution included:

- Substitute decision makers wanting to renounce their appointment under an advance care directive
- Person with impaired decision making capacity wanting to revoke or alter their advance care directive
- Challenges to the decisions of substitute decision makes or persons responsible
- Accommodation decisions for the person who made the advance care directive
- Lack of communication or consultation between substitute decision makers
- Family members being denied access to a parent or other relative
- Family members or significant others being denied information about the person's health and well-being or location
- Challenges to the decisions of substitute decision makers or persons responsible
- Accommodation decisions for the person who made the advance care directive
- Dispute over end of life decisions
- Dispute over the person's decision-making capacity
- Challenge to an advance care directive (concern about someone being coerced to appoint a substitute decision maker when capacity was impaired)
- Dispute over medication

Resolution of Disputes

The majority of the disputes (30) were resolved during the pre-mediation stage of the dispute resolution process. Pre-mediation meetings refer to individual meetings between the mediator and the participants. The participants can choose to take part either by telephone or in person, the mode of communication often depending on the time frame for decision making and also the location of the participants. It is most important to involve the person who made the advance

care directive or whom the health dispute is about, to the fullest extent of their abilities. The dispute resolution practitioner will visit the person who has made the advance care directive, or whom the health dispute is about (if the matter is pursuant to the *Consent Act*) to ascertain their views about the situation.

During the pre-mediation process, the dispute resolution practitioner can often find that, in speaking with participants, an agreement can be reached without the need to proceed to mediation.

14 matters did proceed to mediation, 13 of which were resolved and resulted in an agreement being made. Only 3 persons who were at the centre of the dispute were able to, or chose to, directly take part in mediation. In the other 11 cases the mediator ensured that the views of the person were clearly heard during the mediation and that their rights were upheld throughout the process. Two of the cases that were resolved were in relation to health care decisions for minors.

The resolution of disputes about advance care directives has avoided people who made the directives being placed under guardianship orders.

Referrals to the Guardianship Board / South Australian Civil and Administrative Tribunal (SACAT)[1]

It is the intention of the *Advance Care Directives Act 2013* and the *Consent Act* that applications for dispute resolution should be resolved by the OPA Dispute Resolution Service and only proceed to the more formal SACAT process if resolution is not possible.

Following a review of applications to the DRS and some pre-mediation work, 29 matters were referred to the Guardianship Board/SACAT. Reasons for the referrals were as listed below:

- 7 matters where there was a presence, or a high suspicion, of elder abuse
- 1 matter where domestic violence was suspected and SAPOL were involved
- 2 matters where the substitute decision maker had impaired decision making capacity and was unable to make decisions for the person who made the advance care directive
- 2 matters were referred due to the person having multiple advance care directives
- 2 matters were considered unsafe for mediation due to potential for violence during the mediation
- 1 matter where mediation was unsuccessful
- 3 people who made the advance care directive and had impaired decision making capacity wanted the substitute decision maker removed
- 4 matters where participants refused dispute resolution/mediation
- 2 matters referred for the Guardianship Board/SACAT to make directions
- 1 matter where there was continued disagreement about who should be the Person Responsible to make health decisions

[1] The Guardianship Board was in operation until 31 March 2015 with the South Australian Civil and Administrative Tribunal coming into operation on 1 April 2015.

- 1 matter where the person did not have an advance care directive and the dispute was about accommodation
- 2 matters where the sole substitute decision maker wanted to renounce the position
- 1 matter where the advance care directive was made when the person did not have the legal capacity to do so

Matters ongoing

At the close of business on 30th June 2015, there were 22 matters ongoing in the dispute resolution service with work on these cases in various stages of completion. It is significant to note that one reason for matters being ongoing is that participants had agreed to trial an agreement for a period of time, (ie making an interim agreement) before finally settling the matter.

Information Sessions / Workshops

A function of the Dispute Resolution Service is to provide information about the *Advance Care Directives Act 2013* and amendments to the *Consent Act 1995* and *Guardianship & Administration Act 1993* to community and professional groups. The information presented focuses on the legislation and how it should be applied, decision making capacity, substitute decision making and the role of the Dispute Resolution Service. Presentations are given in various formats, depending on the audience and the information required. During the first year of operation, 45 requests for presentations or workshops were undertaken.

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 South Australian Civil & Administrative Tribunal (SACAT) (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. A guardian can make substitute decisions for a person in the areas of health care, accommodation and lifestyle, depending on the scope of the order. If decisions about finances or legal matters are required, an administrator can be appointed by SACAT. The person under an order is called a protected person.

The *GAA* requires SACAT to make the order which is the least restrictive intrusion in the life of the person who is the subject of the order. Accordingly, the SACAT must first consider whether a limited order, perhaps in one specific area of a person's life, is sufficient to address the decision making issues, and only make a full order (covering health accommodation and lifestyle) if it is satisfied that a limited order would not be adequate.

A guardian can use their substitute decision making powers to make a decision if a person does not have capacity to make that specific decision. This 'decision specific' approach was made explicit in the *GAA* prior to its amendment in July 2014. Sections 58 and 59 of the *GAA* as it was until 30 June 2014, gave specified third parties (including guardians) the responsibility and right to provide substitute consent for medical and dental decisions, but only when the person was unable to give effective consent for that decision. This same principle applies now with the

enactment of amendments to the *Consent to Medical Treatment and Palliative Care Act 1995* (the "*Consent Act*") on 1 July 2014. The *Consent Act* now regulates health care decisions formerly regulated in the *GAA*. In the new amendments a guardian with health powers, like other substitute decision makers, can only make a substitute health decision if a person has impaired decision-making capacity for that particular decision. This means that substitute consent should only be provided when a person is not capable of understanding information related to that particular decision, retaining the information, using the information, or communicating his or her decision.

While this decision-specific capacity approach, which limits the decisions a guardian can make, is not explicitly stated for accommodation and lifestyle decisions, it can be inferred from the principles of the *GAA* that this approach should be taken. Where a protected person is able to understand the information pertinent to the decision and can be appropriately supported to make their own decision, OPA guardianship staff respect the person's wishes and decision.

A guardian when appointed is given powers "in law or in equity", and accepts correlative duties to these powers. These duties are informed by common law and include a duty to keep the protected person safe from the actions of others as well as from the consequences of their own decisions.

To do this work the guardian must inform him or herself of the person's needs and circumstances sufficiently to advance the person's interests. Guardians follow the National Guardianship Standards of the Australian Guardianship and Administration Council. These standards require that a protected person be visited at least once a year, however clients with high needs can require significant input with visits to clients, attendance at case conferences, and need extensive contact with family members, friends, service providers and stakeholders. A number of our clients have "fallen through the gaps" between other services, or are at the centre of intensive conflict between people in their lives and this Office offers a line of last resort to ensure that the interests of clients themselves are upheld.

Public Guardianship Activity 2014-15

Overview

After many years of relentless growth in guardianship appointments, this year was a landmark year with a significant reduction in active guardianship cases throughout the year although the number of cases who were active clients at the end of the financial year was the same as at the beginning. (In the past this number has generally increased.) The highlights were :

- A 4.3% decrease in the total number of people receiving active public guardianship services at some stage during this reporting period compared with 2013-14. This compares with a 12% increase in the previous year, and a 25% increase the year before that.
- A 0% change in the number of people under public guardianship at the end of 2014–15 compared with the end of 2013-14. This compares with a 4% increase in the previous year, and a 28% increase in the year before that.
- An 18% decrease in the number of new public guardian appointments during this reporting period compared with 2014–15.

- An 11% decrease in the number of guardianship cases closed during this reporting period compared with 2014-15 however the closure rate as a percentage of all orders remains similar.

As an Office we have sought to reduce the number of appointments made, and increase the number of revocations. This does not mean however that people do not receive a service, as one of our aims in legislation is to give advice on appropriate alternatives to taking action under the *GAA* (s21 (f)) and we wish to ensure that people's rights are upheld in other ways.

Last year in our Annual Report we were anticipating that there could be a change in the pattern of appointments because of the implementation of the *Advance Care Directives Act 2013* (ACDA), and amendments to the *Consent Act*.

This we believe has occurred. There are a number of contributing reasons.

First, is the creation of the OPA Dispute Resolution Service (DRS). Many of the 90 matters dealt with by this service may have otherwise progressed to guardianship appointments, if the new DRS had not been created. While the DRS work is intensive this investment can assist clients, families and in the long run is more efficient than creating an ongoing guardianship role.

Second is the clarity of the new amendments to the *Consent Act* which defines who can give substitute health care consent, expands the range of people who can give consent to adult friends who have a close and continuing relationship with the person, and restates the role of people responsible for day to day care in health care consent.

Third are new powers given to the tribunals in the *ACDA* and the *Consent Act* which can now give directions to parties without needing to make a guardianship order or revoke advance care directives. Prior to the *ACDA* the Guardianship Board may have had no alternative but to revoke an advance directive and appoint a guardian, often the Public Advocate. Now the *ACDA* allows our Office to seek directions from SACAT to different parties. SACAT can also direct the Public Advocate to have a monitoring role to ensure that a person remains safe – this is preferable to taking over decision making as guardian when such an intervention is not necessary. This can solve problems and uphold rights.

This is all in the context of pre-existing high rates of adult guardianship in South Australia compared to other jurisdictions due to increases over the years, an increase in orders that is not in keeping with international and national priorities to uphold the rights of people with disability, including their equal recognition before the law, wherever possible.

Upholding rights also means upholding a right to safety. In the future as work progressively occurs to uphold these rights (based on Article 16 of the UNCRPD) then there should be less need to appoint guardians. We have already seen the development of the Community Visitors Scheme, and the start of the Disability Justice Strategy as initiatives to keep people safe. This could be complemented further with adult protection policy and legislation to keep people safe.

Another influence on appointment rates is the work of our advocate / guardians to suggest alternative solutions for clients in hearings when appointments are first considered, or when revocations of orders are requested.

Data

During 2014-15, the Office of the Public Advocate provided guardianship services under the *Guardianship and Administration Act 1993* on behalf of 1247 people (1303 in 2013–14). This represents a 4.3% decrease. In the previous four reporting periods, the increases were (most recent first) 25%, 17%, 6.7% and 12%.

Figure B2 illustrates the upward trend in active guardianship numbers over the past five years which has been reversed in 2014-15.

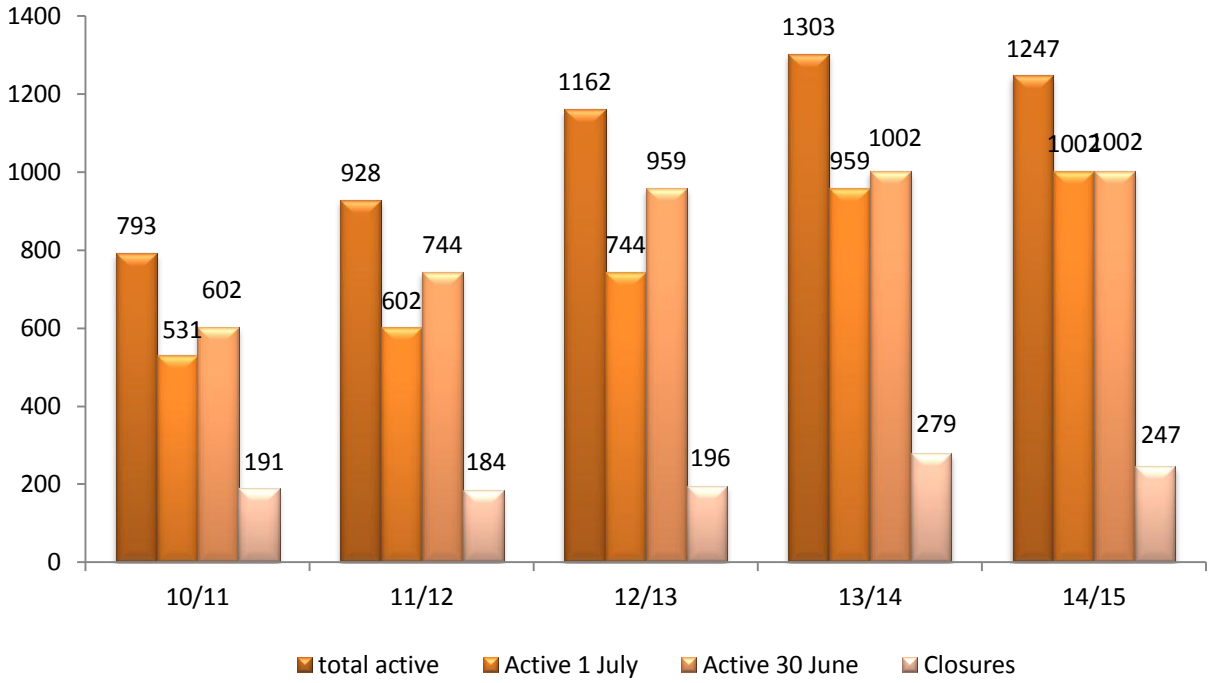


Figure B2: Guardianship Activity 2010–11 to 2014–15 (Total active, active 1 July 2013, active 30 June 2014, Revoked).

As at 30 June 2015, there were 1002 active guardianships, which is the same number as at the beginning of the financial year.

The growth in active guardianship at the end of each financial year over the past five years, and the slowing this year is depicted in Figure B3 (below).

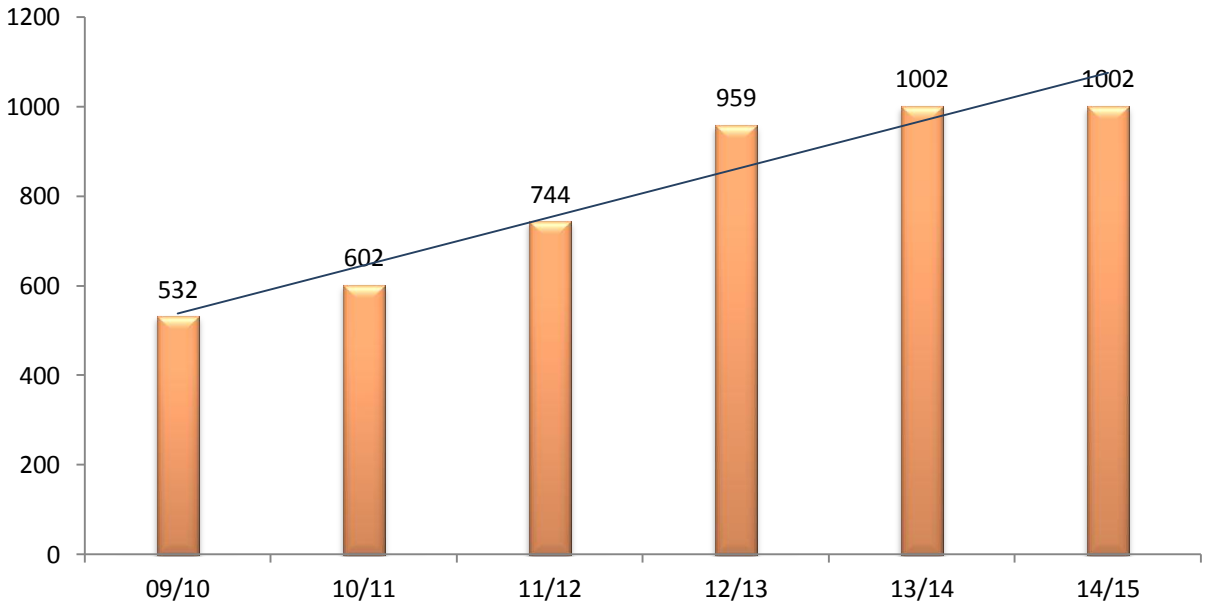


Figure B3: Comparison of Active cases as at year-end 2009–10 to 2014–15

New appointments

This year 275 new Public Advocate guardianship appointments were made, an 18% decrease on last year's figure for new appointments (334).

112 (41%) were females and 163 (59%) males.

Figure B4 illustrates the general upward trend in number of appointments and the reduction in the last year.

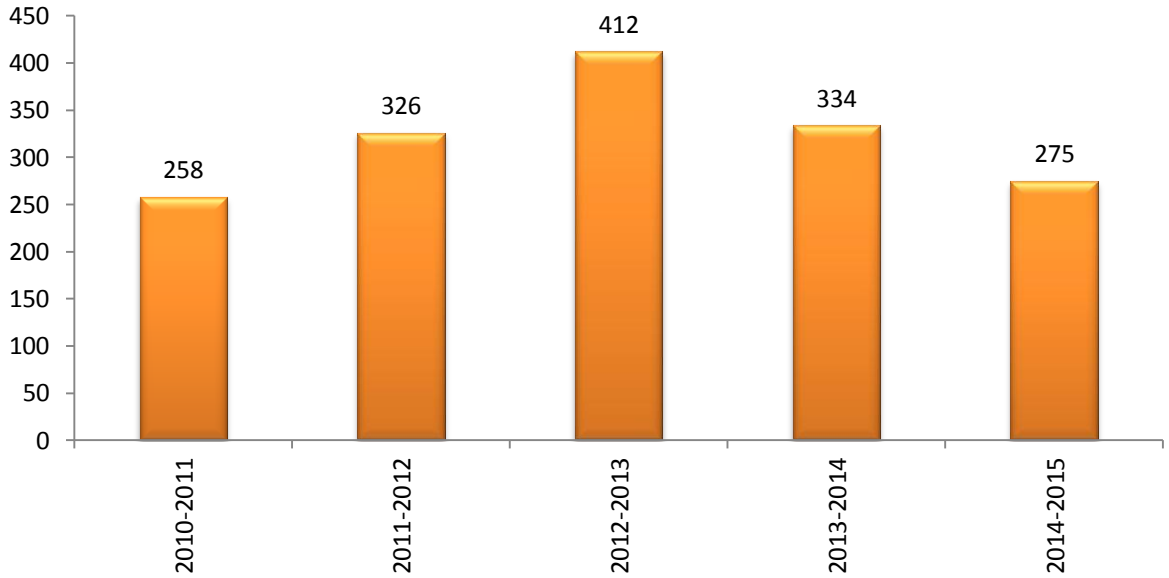


Figure B4: Comparison of new Public Guardianships over the past five years

Joint appointments of the Public Advocate with a Private Guardian

If more than one guardian is appointed for a person, each of the joint guardians must concur in every decision made in relation to that person (*GAA* section 52). The Public Advocate may be appointed joint guardian with a private guardian, usually a person's family member. This can be because the family member, who might otherwise be well able to be sole guardian, lives some distance away, and consequently cannot fully attend to the responsibilities. Sometimes when there is family dysfunction, a family member private guardian may be subject to influence, pressure or abuse in that role, so the joint appointment of the Public Advocate provides support to the private guardian, and may assist in communication with other family members. In other situations there can be uncertainty as to the capability of a private guardian to undertake the role, and the appointment of the Public Advocate as joint guardian acts as an initial check and balance.

There has been a significant reduction in the number of joint appointments of the Public Advocate and a private guardian. This year 27 such orders were made, compared to 43 in the previous year, a 37% reduction.

Closures of guardianship cases

During 2014–15, 247 cases were closed — an 11% decrease in the number of closures overall when compared to 279 closures in 2013–14.

The rate of closure in 2014-15 as a percentage of all orders was 20%, similar to the figure achieved the previous year of 21% and the 17% of the year before that. This however is less than the figures for closures some years back: 24.1% in 2010–11 and 24.5% in 2009–10.

The next figure compares numbers of guardianship cases and closures over a six-year period.

Closures as Percentage of Guardianship Services Provided							
	2008/2009	2009/2010	2010/2011	2011/2012	2012/2013	2013/2014	**2014/15**
Closures	178	173	191	184	203	279	**247**
Active cases	661	705	793	928	1162	1303	**1247**
%	26.90%	24.50%	24.10%	19.80%	17.50%	21.40%	**20%**

Figure B5: Closures 2008–09 to 2014–15 as percentage of all guardianships

The next graph (Figure B6) compares reasons for closure for a six-year period. Note that since 2010-11 there has been a significant decrease in the number of cases closed due to tribunal revocation of orders, however this has increased as a percentage in 2014-15.

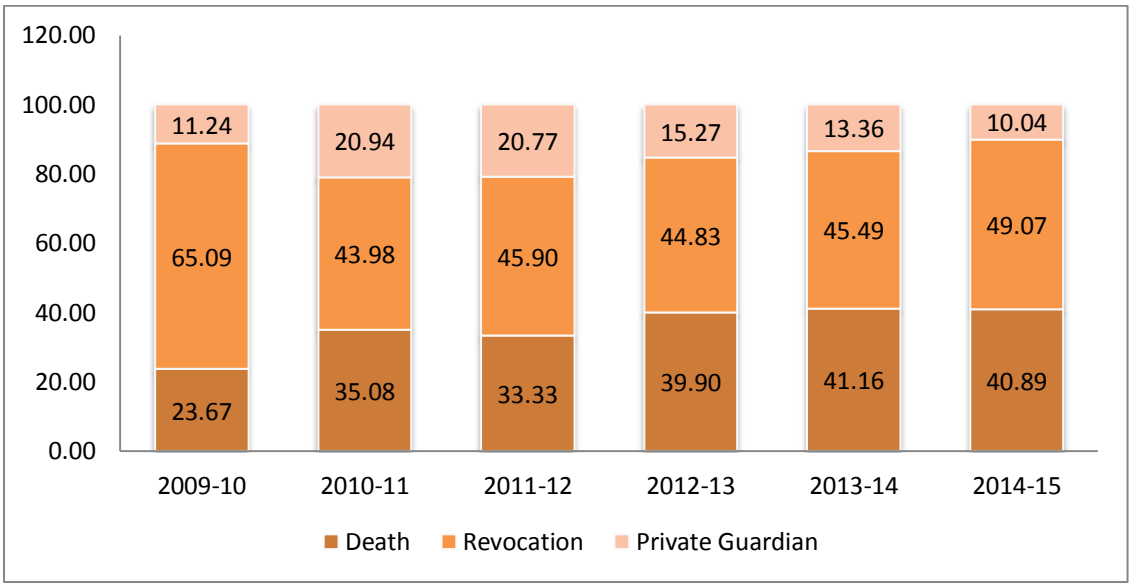


Figure B6: Reasons for closure expressed as a proportion of total closures 2009–10 to 2014–15

While the percentage of closure due to revocations increased over the last year, the absolute number of orders revoked is the highest ever. This is illustrated in Figure B7 (below) which compares the number, rather than percentage (discussed above) of closures in each category over the past ten reporting periods.

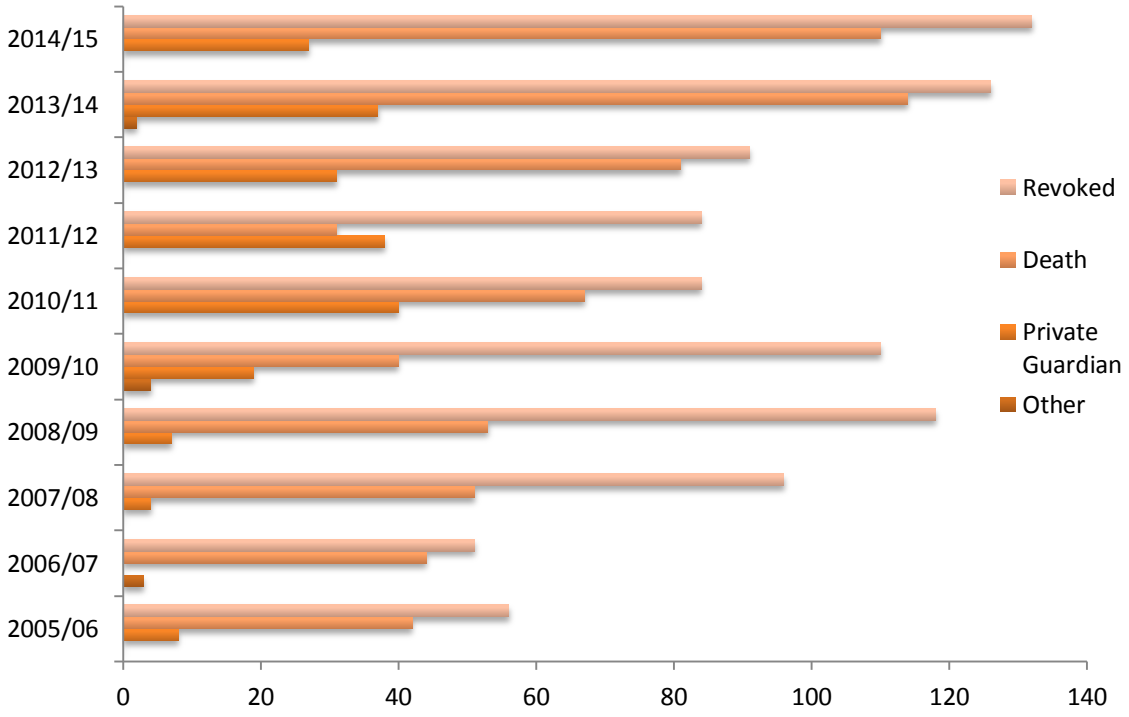


Figure B7: Guardianship numbers by closure type for past ten reporting periods

Average length of guardianship for cases closed in 2014–15 was similar to previous years: 2.1 years (median 1.4 yrs). This has gradually increased over the years. We also report on the duration of guardianship related to diagnostic group, with a particular increase in the duration of guardianship for people with intellectual disability.

Guardianship Cases Closed in 2011–12, 2012-13 and 2013–2014								
Diagnosis and Length (years) of Guardianship								
Diagnosis		Brain Injury	Dementia and degenerative Conditions	Mental Illness	Intellectual Disability	Dual diagnosis	Other	Total
Numbers of clients	2011-12	21	83	29	26	19	9	184
	2012-13	15	84	42	28	20	14	203
	2013-14	21	109	50	49	33	17	279
	2014-15	20	96	50	53	13	15	247
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
	2013-14	1.8	1.6	1.9	2.7	3.5	0.9	1.4
	2014-15	1.8	2.0	1.9	2.9	3.3	0.6	2.1
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
	2013-14	1.3	1.1	1.3	2.1	2.6	0.4	1.3
	2014-15	0.7	1.4	1.3	2.3	3.4	0.4	1.4

Figure B8: Closed guardianships diagnostic profile and length of guardianship

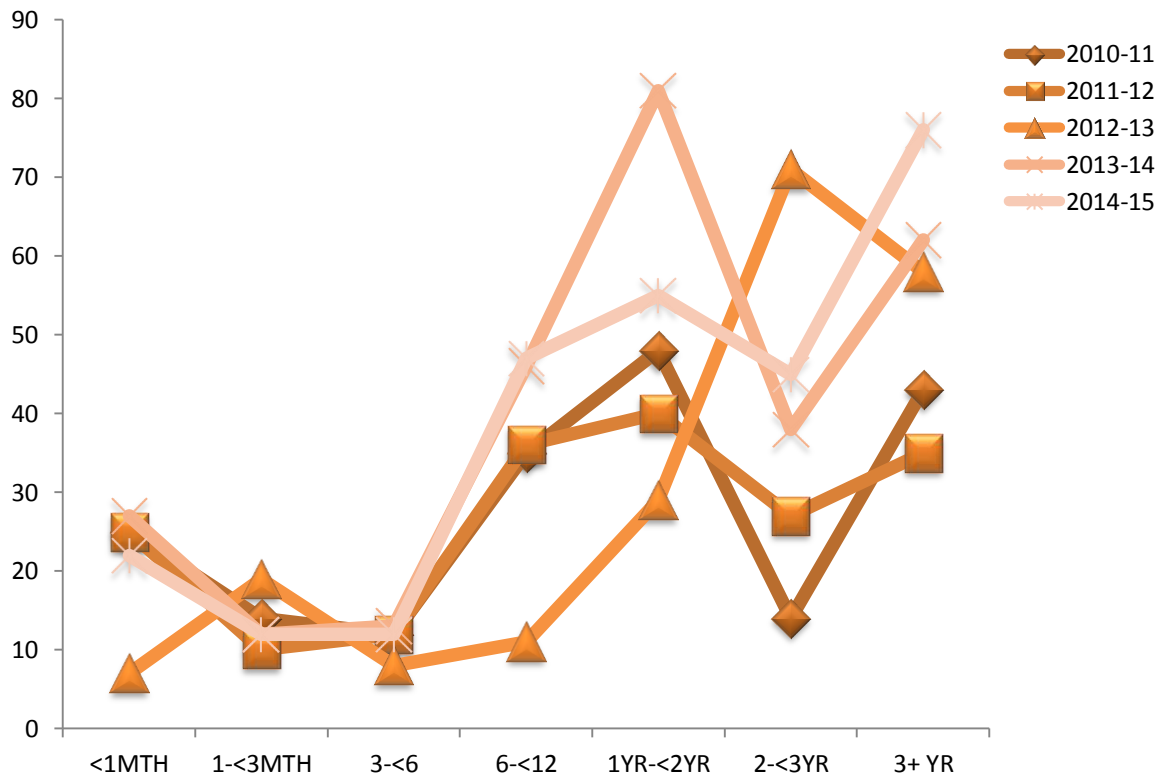


Figure B9: 5-year comparison of length of guardianship for closed cases as at 30 June each year.

The overall pattern of duration of orders is similar across the years, although the absolute volumes have increased, with peaks at 1-2 years duration and 3 years plus.

The age profile of closed, active and new and guardianship cases as at 30 June is compared in the table below (Figure B10).

Age Profile of Closed, Active and New Cases 2010-11 to 2014-15														
Age	Closed Cases (age at closure)					Active Cases (age at 30 June				New Cases (age at opening)				
	10-11	11-12	12-13	13-14	**14-15**	10-11	11-12	13-14	**14-15**	10-11	11-12	12-13	13-14	**14-15**
Age < 41 years	13%	19%	25%	17%	**16%**	30%	27%	27%	**30%**	24%	29%	24%	20%	**21%**
41 to 70 years	30%	37%	29%	32%	**34%**	38%	42%	44%	**45%**	18%	34%	41%	42%	**31%**
> 70 years	57%	45%	46%	51%	**50%**	32%	31%	29%	**25%**	58%	37%	35%	38%	**48%**

Figure B10: Age profile of guardianship clients 2010–2015

Diagnostic profiles of guardianship clients active as at 30 June 2015, and all guardianships active during this reporting period are illustrated in the following table.

Diagnostic Profile of Guardianship Clients				
Diagnosis	Active at 30/06/2015		Active in 2014–2015	
	Number	Percentage	Number	Percentage
Dementia	232	23%	326	26%
Mental Illness	240	24%	290	23%
Intellectual Disability	303	30%	356	29%
Brain Injury	64	7%	84	7%
Dual Diagnosis	123	12%	136	11%
Other	40	4%	55	4%
Total	1002	100%	1247	100%

Figure B11: Diagnostic profile of all active guardianship cases this reporting period

Services to Aboriginal and Torres Strait Islander People

The statistics demonstrate an overrepresentation of aboriginal people as clients.

Aboriginal people constitute 1.9% of the general South Australian population but 8% of the population of people under OPA adult guardianship.

The diagnostic profile is identical between the group of aboriginal people as clients and the total number of clients. This difference is statistically significant (Z – test).

Diagnostic Profile of Active Guardianship Clients (sub group of Aboriginal & Torres Strait Islander)		
Diagnosis	2014-2015	
	Number	Percentage
Dementia	15	23%
Mental Illness	26	24%
Intellectual Disability	30	30%
Brain Injury	13	7%
Dual Diagnosis	14	12%
Other	3	4%
Total	101	100%

Figure B12 - Profile of Active Guardianship for 2015-2015 Aboriginal & Torres Strait Islander

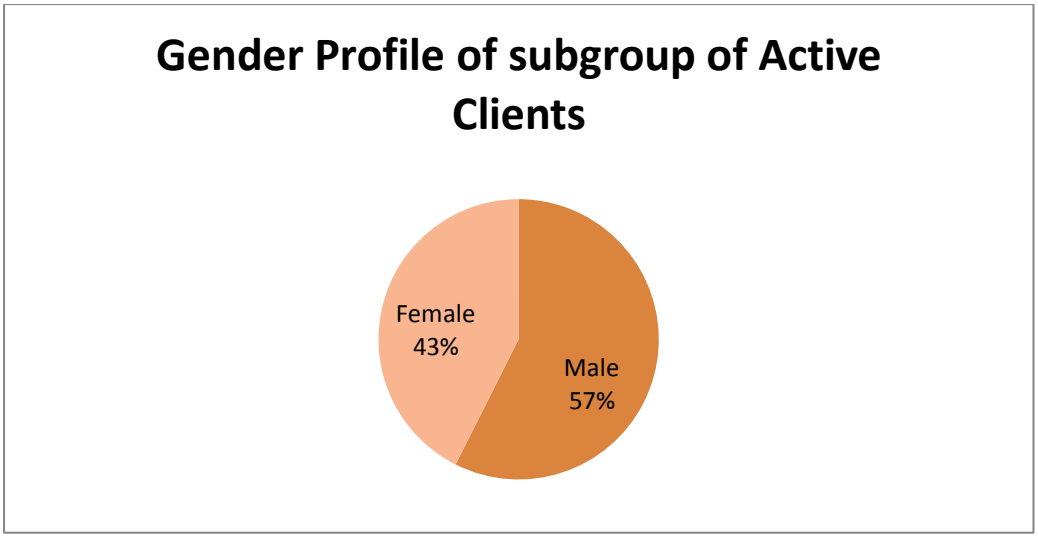


Figure B13 - Gender Profile of Active Guardianship for 2015-2015 Aboriginal & Torres Strait Islander

Waiting list for allocation of an advocate/guardian

In recent years a waiting list has developed for allocation of an advocate/guardian. Below are details of this list over this financial year. This data is also regularly posted and updated on our website.

Waiting for allocation of an advocate/guardian	1st July 2014	30th June 2015
Short Term Team	28	27
Long Term Team	29	28
Awaiting Allocation to a team	3	1
Disability "on hold" group	64	37
TOTAL (excluding disability on hold)	60	56
TOTAL	124	93

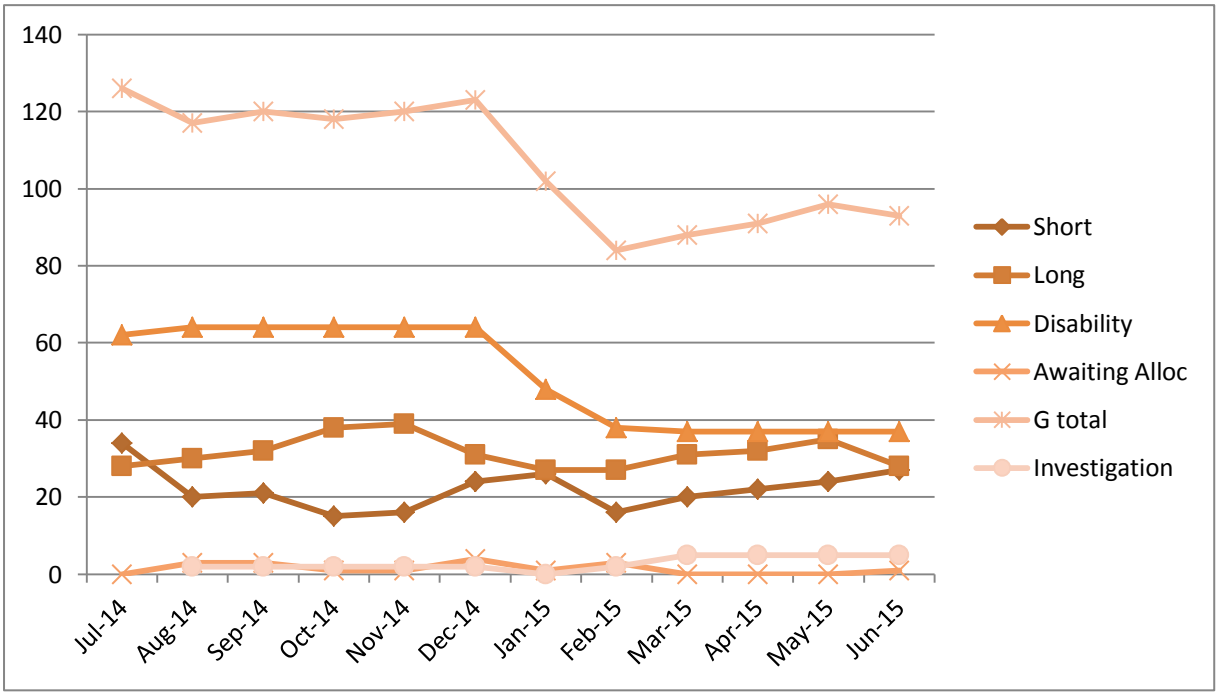


Figure: B14 Waiting list for allocation of new cases July 2014 to June 2015

This waiting list is a serious concern, however it is important to note that it is not a waiting list in the conventional sense – in that the needs of clients on this list are attended to either by our duty officer, or if matters are more complex by a senior staff member. Assistant Public Advocates and a Senior Advocate/Guardian actively manage the waiting list. Key decisions can be made for clients using this system.

As a routine practice, an advocate/guardian from our Office attends most South Australian Civil & Administrative Tribunal hearings in which the Public Advocate has been nominated as a potential guardian, providing an opportunity for our staff member to meet our new client, and other people in their life at that hearing, and speak with them straight after. If it were not for this practice, we would have much greater difficulty responding to calls about unallocated clients.

As indicated in previous Annual Reports, those clients in the disability "on hold" group have not been allocated to an individual guardian as the appointment of a guardian for clients in this group was triggered by a policy change within Disability Services that was subsequently reduced. For this reason the table describing our waiting list gives two figures – a list including the disability on hold group and one without.

Commentary on activity report

As noted in our introduction, Public Guardianship rates in South Australia are high in comparison with other states. This was discussed in more detail in our 2014 Annual Report

The changes that we have seen in the last year to cap and reverse rapid growth, will help bring us in line with other jurisdictions. At the same time other legislative and policy initiatives will help ensure that clients are still assisted, for example through the provisions of the *ACDA* and the *Consent Act*.

Staffing to support guardianship functions

Notwithstanding the reduction in numbers of clients seen during the year by 54 clients, the numbers of clients per staff member are high when compared with other similar jurisdictions. The informal benchmarking between states allows for such comparisons to be made.

While our Office is subject to reducing budgets, as is the rest of Government, we have been reluctant to reduce staff numbers while client numbers are still high. Unlike other human services we do not have the ability to determine access criteria or discharge criteria for our guardianship, and nor should we, given the statutory role that we fulfil and the need for a tribunal to make these decisions.

For these reasons, to maintain staffing, after negotiation with the Chief Executive of the Attorney General's Department funding of $112,000 was brought forward from future years to maintain our staff complement of both professional and administrative staff. This was with the expectation that the number of clients will reduce in the future and that contraction would then be possible in guardianship services, although expansion in Dispute Resolution Services would also be likely.

The activity result this year, while not a reduction in absolute numbers of clients at the end of the year, is a significant change to an ongoing pattern. If our previous rate of increase had continued we would have had 120 extra people under guardianship by the end of the year, and require 3 extra staff. This suggests that our business planning assumptions about the impact of legislative change, and our own work remains correct.

However we begin the next financial year in a very similar situation to 2014-15.

A new redesign activity based on lean thinking principles is now underway. The intention of a key project in this work is to reduce the duplication of effort created by our waiting list. This happens when a number of different staff on duty could become involved in responding to the same issue. It is reasonable to expect that this work could benefit clients as well as reduce avoidable demand on staff. Nevertheless based on benchmarking with other jurisdictions, and our knowledge of the complexity of situations managed it will be important that the Office have resources commensurate with the need it serves.

Court-related Matters — Litigation Guardianship

In civil legal matters, when a person is unable to manage a matter in Court because of a disability, a Court may appoint a 'litigation guardian' also known as a 'guardian ad litem' to 'stand in the shoes' of the person and conduct the matter on their behalf.

This work of the Office is not specifically resourced. It mostly assists parents who have a mental incapacity, in the child protection jurisdiction in the Youth Court. This work is determined by Rule 19 of the *Youth Court Rules 2012* that refers to 'a person who is incapable by reason of disability of adequately conducting proceedings'. Within our own mandate we have considered that this work comes within the overall scope of the advocacy role of the Public Advocate (section 21(1)(d)).

The OPA commenced the reporting period with nine active litigation guardianship matters. A further 31 were opened during 2014–15, and 26 cases closed.

We consider that this work adds value to the child protection Court process, and there are instances where outcomes have been different because of the involvement of a litigation guardian of this Office – to the benefit of children, and parents for whom we walk in their shoes.

This is a small but significant role that the Public Advocate considers should continue, in the absence of other services that can take up this need. However, currently the Office is not resourced to provide this role.

INVESTIGATIONS

Guardianship and Administration Act 1993

28—Investigations by Public Advocate

(1) The Public Advocate must, if the Tribunal so directs for the purposes of this Part, investigate the affairs of a person—

(a) who is the subject of application for an order under this Part; or

(b) who has had an advance care directive revoked by the Tribunal under the *Advance Care Directives Act 2013*.

(2) On completing an investigation carried out at the direction of the Tribunal, the Public Advocate must furnish the Tribunal with a copy of the report of the investigation.

(3) The Tribunal 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 South Australian Civil & Administrative Tribunal (SACAT) to conduct an investigation relevant to an application the Tribunal has received.

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

Investigation reports may be presented as evidence at South Australian Civil & Administrative Tribunal hearings, and considered along with other evidence.

Number of investigations 2014–2015

The Office of the Public Advocate had 53 investigation matters open during the year.

- 17 were open at the beginning of the reporting period
- 29 were opened during the year and
- 11 remained open as at 30 June 2015.

Attendance at initial hearings of applications for Guardianship Orders

Whenever an applicant to the South Australian Civil & Administrative Tribunal nominates the Public Advocate as a potential guardian for an individual, the OPA will receive a copy of, and consider the application. An OPA staff member will attend and participate in the initial hearing whenever possible.

During 2014–2015, the OPA staff reviewed 321 applications which nominated the Public Advocate for appointment as guardian.

In addition, the Public Advocate is sometimes appointed as guardian without the OPA's prior knowledge of the application or participation in the hearing. This is usually when the Tribunal changes the guardian on review of a private guardianship order or when an emergency order is made.

Consequently the number of these initial 'screening' hearings attended by OPA staff is not necessarily an indication of the number of guardianship orders appointing the Public Advocate.

Combining the two kinds of investigative activities (participation at initial hearings and formal investigations), the following picture emerges (Figure B15).

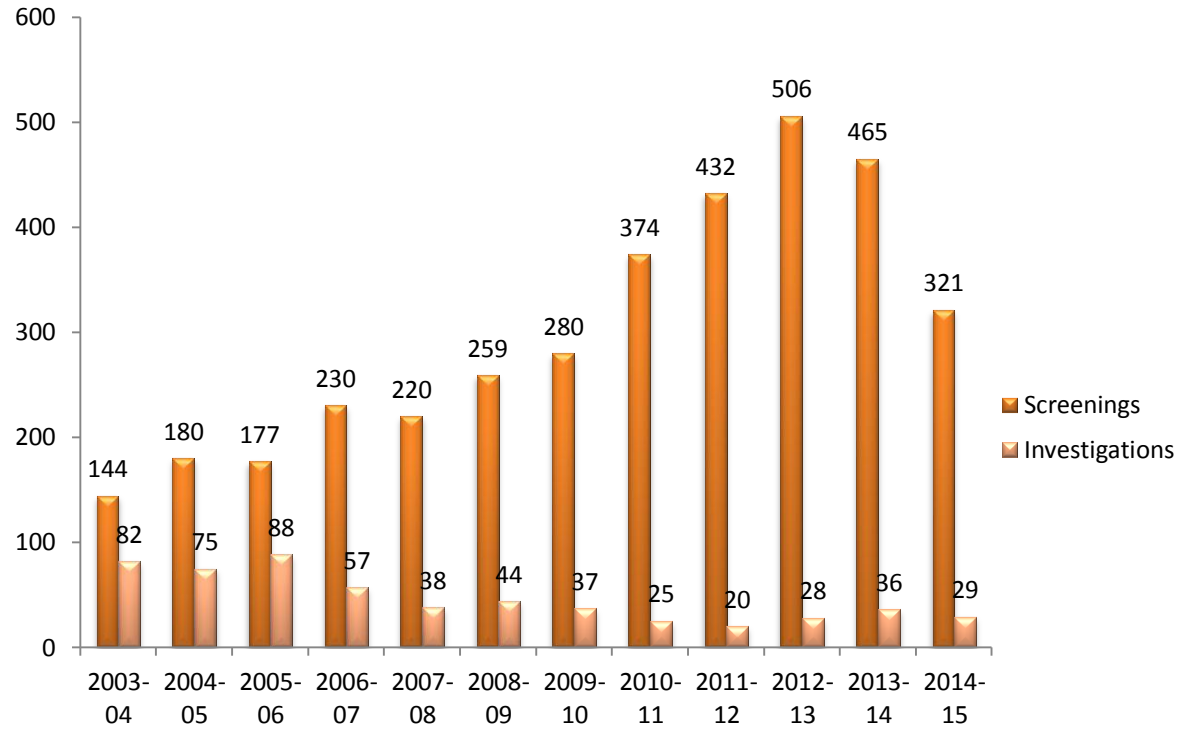


Figure B15: Number of initial guardianship applications screened, & investigations undertaken 2004–05 to 2014–15

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 2014–2015, there were no applications for warrants made by the Public Advocate.

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 a part of our information and advisory service, and through taking on advocacy clients who are not subject to an order. Private guardians may also be assisted to resolve complex issues through OPA advocacy.

There were 49 new advocacy cases opened in 2014–2015. Comparison of the past seven years is featured below (Figure B16).

	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015
New Cases	23	27	43	48	46	34	47	**49**

Figure B16: New advocacy clients in each reporting period

Advocacy in matters before the South Australian Civil & Administrative Tribunal

Lack of routine access to advocacy services for clients appearing before the Tribunal for both *GAA* and *Mental Health Act 2009* matters has been raised previously. 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 people are referred to other agencies.

Our view is that there should be a system which ensures that all people have access to either a lawyer or trained lay advocate for mental health, guardianship and administration matters.

EDUCATION

Information about key legislation, services and systems is provided through the Office of the Public Advocate website. During this reporting period there were 18,041 visitors to the site, who read on average 2.51 pages per visit.

The Office of the Public Advocate provides education sessions, usually in response to specific requests from organisations and groups. 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 was pleased to have the company of representatives from the National Office for the Empowerment of Persons with Disabilities, Thailand, who joined us in 2013 and 2014 for a return visit. Their visit, led by Deputy Director-General Mrs Phatcharamont Pitipanyakul, to South Australia was organised by the non-government sector agency Community Accommodation Respite Agency (CARA). Once again our visitors were particularly interested in the work OPA has undertaken around supported decision making.

From L to R: Mrs Nata-Orn Indeesri (NEP Social Development Official, Ms. Sirinan Nilsook, Representative, Disabled People Organization, Petchaburi, Ms. Sukanya Thongkes NEP Finance and Accounting Analyst, Senior Professional Level, Ms. Issavara Sirirungruang Representative, Thai Association of the Blind, Ms. Kamonthipsongphatkaew, Budget Analyst, Professional Level, Bureau of the Budget, Ms. Sonthaya Boonyaphusit, Legal Officer, Professional Level, Ms. Suteera Nuichan, Head of Pattalung Provicial Social Development and Human Security Office, Mrs. Thitiporn Sengkhunthong, NEP Social Development Official, Senior Professional Level, John Brayley, Public Advocate SA, Mrs. Usa Hongkanjanakul, Deputy Director General Of NEP, Mrs. Phatcharamont Pitipanyakul, NEP Social Worker, Professional Level, Ms. Chutima Duangpracha, NEP Social Development Officer, Professional Level, Mr. Opas Srichantamira,Director of Prapadang Vocational Rehabilitation Centre, Ms. Sirinat On-Sawai, NEP Social Worker, Professional Level, Ms. Sirirut Suttipun, Representative, Thai Disabled Development Foundation.
Back row OPA staff: Julie-Anne Harris - Assistant Public Advocate, Aileen Vincent - Personal Assisant, Elicia White - Advocate/Guardian, David Cripps - Advocate/Guardian, Susan Goldeband - Advocate/Guardian.

The OPA staff have presented to a number of service providers and community groups during 2014–15 regarding Advance Care Directives, the *GAA* and the role of the Office of the Public Advocate and the South Australian Civil & Administrative Tribunal. 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 generally 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 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 prevention of and responses 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.apea.org.au).

ENQUIRY AND INFORMATION SERVICE

The Enquiry and Information Service is coordinated by an Information Officer. The Information Officer provides practical and factual advice on key legislation in adult protection, and South Australian Civil & Administrative Tribunal application processes, or redirects queries to other more appropriate services. Duty advocate guardians provide back-up advice and follow up for more complex matters.

OPA staff are available to discuss complex and urgent matters through the Enquiry Service, including our after-hours on-call system.

This year there were 3912 discrete episodes of enquiry. A comparison with previous years is graphed below (Figure B17). The increase in the last year we attribute to the implementation of the *Advance Care Directives Act*. The associated education to providers and to members of the public is likely to have increased interest in this area, with more people seeking advice.

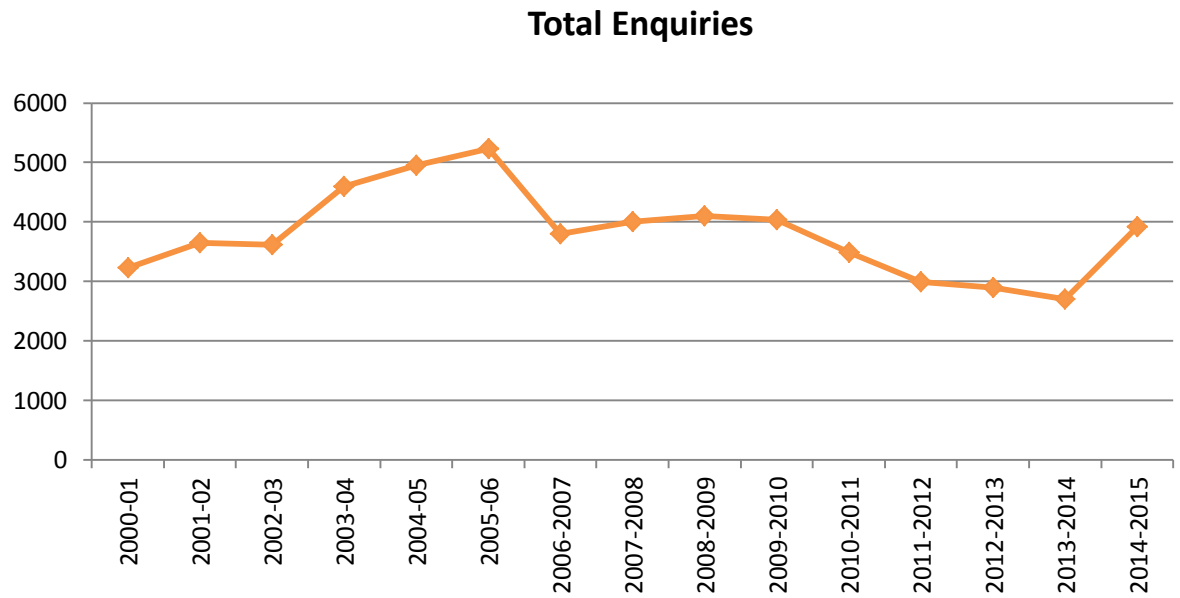


Figure B17: Number of enquiry episodes July 2000 to June 2015

Common reasons for contacting the service include requesting information about advance directives, guardianship and administration orders, the South Australian Civil & Administrative Tribunal, Tribunal hearings and mental health appeals.

Figure B18 below identifies the main issues raised during the last reporting period as advance directives, and guardianship and administration matters.

Main Enquiries Issues	2010-11	2011-12	2012-13	2013-14	2014-15
Mental health issues	370	264	246	187	98
Guardianship issues	1008	1035	811	697	698
Administration issues	866	873	604	499	542
Advance Care Directive	856	737	656	1052*	681
Enduring Power Attorney					602
Consent/Prescribed Treatment					252
Dispute Resolution Service					197
Total issues raised	5012	4181	3811	3763	4342
Discrete Episodes	3490	2995	2984	2704	3912

Figure B18: Issues Raised in Enquiries

After-hours emergency response

An on-call (telephone) service operates 5:00pm to 9:00am on weekdays and 24 hours a day on weekends and public holidays, staffed by rostered OPA senior staff and experienced advocate/guardians. This service acts as the emergency response for existing OPA clients, and an advisory service on the legislation and matters which may require an approach to the South Australian Civil & Administrative Tribunal for emergency orders. Senior Officers of the South Australian Civil & Administrative Tribunal make themselves available to hear urgent applications outside of working hours. On average there are 76 calls per month.

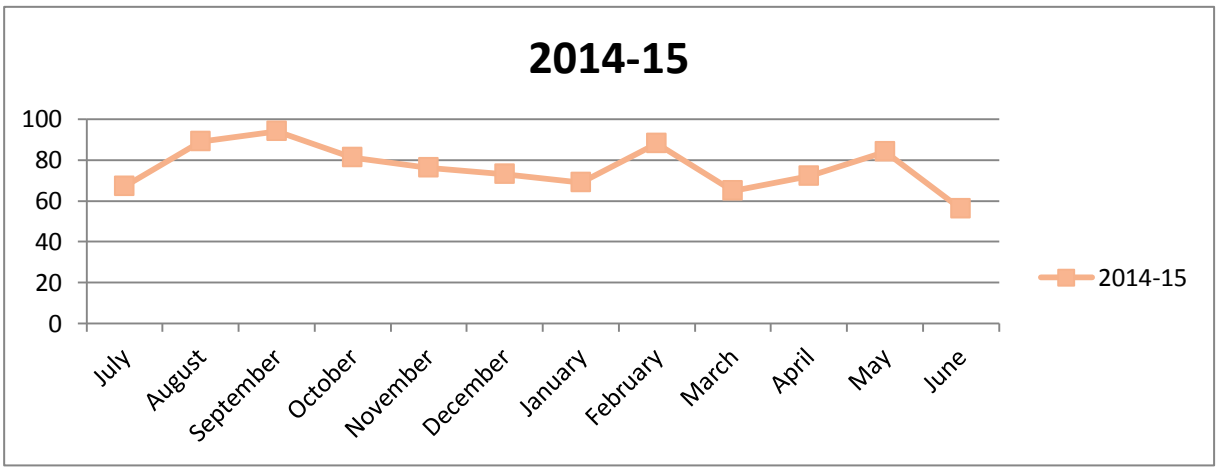


Figure B19: After Hours Call Statistics

COMPLAINTS AND DECISION REVIEWS

The OPA complaint and decision review processes are described in some detail in our 2011 Annual Report (p171 onwards).

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

Complex or potentially contentious guardianship decisions are ratified by senior staff before they are implemented, to ensure that the decision making process has been comprehensive and the decision is thoroughly considered. 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 South Australian Civil & Administrative Tribunal to seek advice and direction under Section 74 of the *GAA.* This can provide an external forum for discussion and review of the issues. Directions then made by the Tribunal are legally binding on all parties. In addition, because this now becomes a decision of the South Australian Civil & Administrative Tribunal, interested parties can appeal the decision to the Administrative and Disciplinary Division of the District Court.

Activity

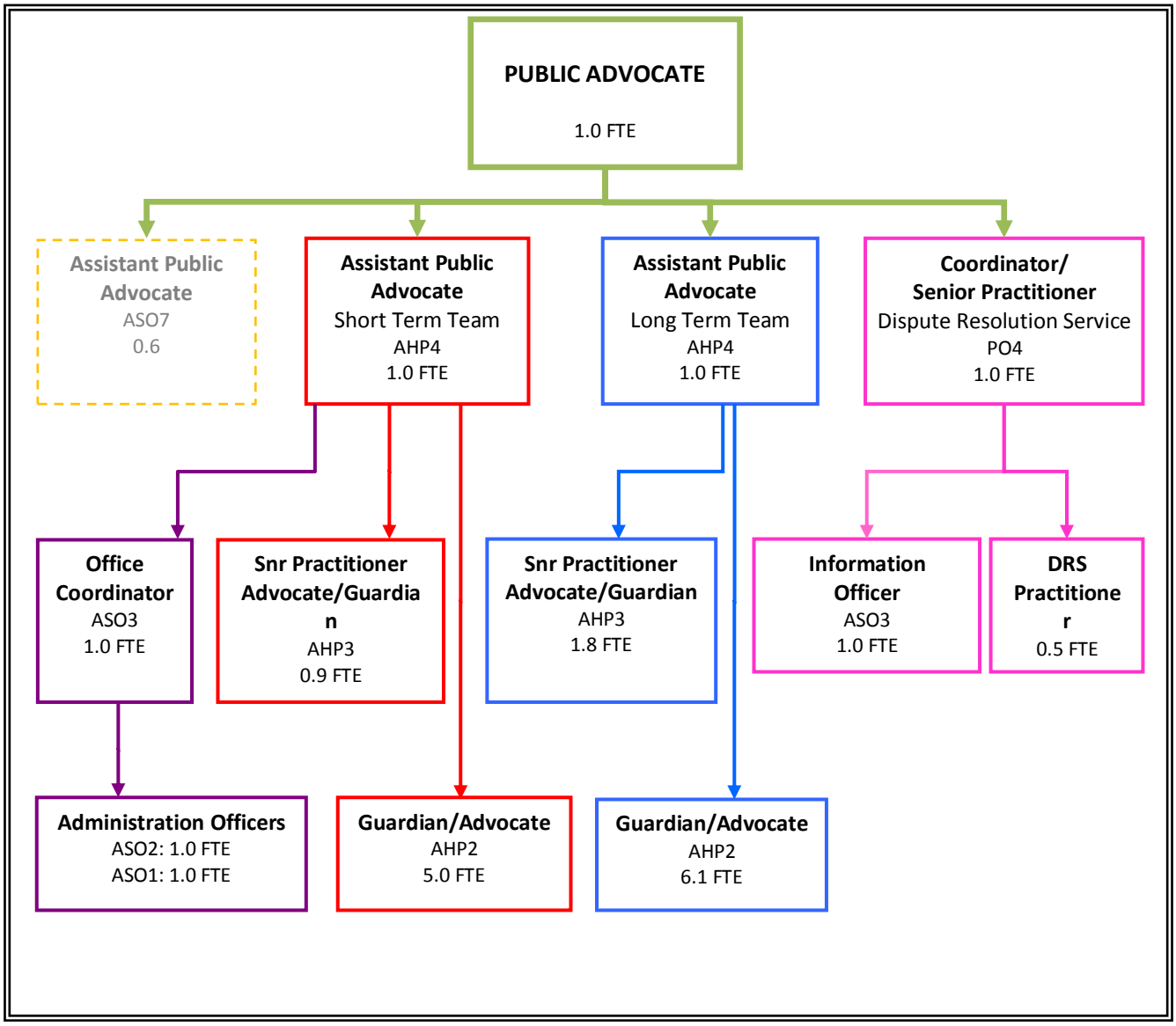
During 2014–15, the OPA acted on 23 separate matters consisting of:

- 18 formal complaints or requests for decision reviews
- 5 Ministerial and Ombudsman's requests

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

EMPLOYMENT AND HUMAN RESOURCES

Deployment of funded positions as at 30 June 2015



Operational: 22.5 FTE as at 30/6/2015

Staff of the Office of the Public Advocate

Popi Amanatidis	Advocate / Guardian
Maria Atkins	Advocate / Guardian
Karen Bowden	Advocate / Guardian
Timothy Braund	Administration Officer
John Brayley	Public Advocate
Stephen Burns	Advocate / Guardian
Sharon Crawley	Administration Officer
David Cripps	Advocate / Guardian
Susan Goldeband	Advocate / Guardian
Julie-Anne Harris	Assistant Public Advocate Guardian Long-term Team
Michelle Howse	Information Officer
Passant Ibrahim	Advocate / Guardian
Bethany Jordan	Assistant Public Advocate Guardian Short-term Team
Margi Keville	Advocate / Guardian
Anna Kleinig	Advocate / Guardian
Belinda Lake	Advocate / Guardian
Erin Larner	Administration Officer
Helen Mares	Assistant Public Advocate
Amy Martin	Advocate / Guardian
Ella Nalepa	Advocate / Guardian
Elly Nitschke	Coordinator/Senior Practitioner Dispute Resolution Service
Rebecca Norman	Advocate / Guardian
Barbara Robertson	Advocate / Guardian
Andrew Sarre	Advocate / Guardian
Renee Sumner-Makris	Administration Officer
Cheryl Thomas	Office Coordinator
Jeannie Thompson	Advocate / Guardian
Margaret Thompson	Advocate / Guardian
Aileen Vincent	Personal Assistant to the Public Advocate
Elicia White	Advocate / Guardian
Tarnia White	Advocate / Guardian

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 is 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.

Risk Review Group

The OPA risk review group meets monthly and involves senior staff, the WHS representative and staff involved in particular incidents, or who are responsible for clients at particular risk. The organisation maintains a register of incidents or situations where it has been assessed that there is a risk to staff, client, or others. The Risk Review Group meets on a regular basis to monitor these individual matters.

Incidents 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, we note, from the relatively low number of incidents and risks registered, that the majority of relationships are positive and respectful, even where differences exist around the issues which the OPA is seeking to resolve.

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, incident reports and general administration of WHS.

FAREWELL TO JOHN BRAYLEY

The OPA team, farewelled Public Advocate John Brayley, at an event held in the ABC Cafeteria, 28th September 2015.

News Release

Deputy Premier John Rau

Attorney-General

Friday, 18th September, 2015

Search begins for new Public Advocate

A search will begin this weekend for a new Public Advocate following the resignation of Dr John Brayley.

Attorney General John Rau said the Governor has accepted the resignation of Dr Brayley who has served in the role since 2008.

“After serving seven years as Public Advocate for South Australia Dr Brayley has taken up an opportunity with the Commonwealth as Chief Medical Officer at the Department of Immigration,” he said.

“In conjunction with this, he will also serve as Surgeon General of the Australian Border Force.

“While this is certainly a great loss for South Australia, I congratulate him and wish him well on his next endeavour.”

Mr Rau said through his integrity, hard work and willingness to listen, Dr Brayley will leave a lasting positive influence on those he worked with and advocated for.

“The steps he took toward achieving a model of supported decision making, has had a significant impact in the sector,” he said.

“This work assists people to make decisions for themselves wherever possible, instead of having them made by others.”

“He also contributed to the Disability Justice Plan, the implementation of a new Dispute Resolution Service and to the Strategy to Safeguard the Rights of Older South Australians.

“Dr Brayley has highlighted the challenges faced by forensic mental health patients in the corrections system, while his work in limiting restrictive practices has had a significant influence on practice in the disability sector in this state.

“His final day in the role will be Friday, 2 October 2015 when it is expected an Acting Public Advocate will be appointed until the recruitment process is finalised.

“On behalf of the State Government, I would like to thank Dr Brayley for his service to South Australia."

www.premier.sa.gov.au **Twitter: @sa_press_sec**

FINANCIAL INFORMATION

The Office of the Public Advocate's budget is allocated, managed, audited and reported through the Attorney-General's Department.

During 2013–2014, the core program expenditure of the OPA was as follows. This includes $112,000 brought forward from future years to maintain guardian staffing levels while awaiting anticipated reductions in the rate of appointment brought about by new legislated initiatives such as the Dispute Resolution Service (see the section of this report on "Public Guardian"):

Income	
Grants	$0
Recoveries:	$1669
Total Revenue:	$1669
Expenditure:	
Employee entitlements	$2,527,207
Supplies and Services	$470,365
Depreciation	$19,058
Total Expenditure	$ 3,016,630

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