

OPA

OFFICE OF THE PUBLIC ADVOCATE SOUTH AUSTRALIA

2025-26 ANNUAL REPORT

OFFICE OF THE PUBLIC ADVOCATE SOUTH AUSTRALIA

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Date presented to Minister: 24 September 2026

Acknowledgement of **Country**

We acknowledge that this report was prepared on the traditional lands of the Kaurna people and that we respect their spiritual relationship with their country.

We also acknowledge the Kaurna people as the custodians of the Adelaide region and that their cultural and heritage beliefs are still as important to the living Kaurna people today.



To:

Hon Kyam Maher MLC
Deputy Premier
Minister for Aboriginal Affairs
Attorney-General
Minister for Industrial Relations
Minister for Arts
Special Minister of State

Dear Deputy Premier

In accordance with section 24 of the *Guardianship and Administration Act 1993* (SA) and the requirements of Premier and Cabinet Circular *PC013 Annual Reporting*, I am pleased to submit the Office of the Public Advocate Annual Report for presentation to Parliament.

This report outlines the work of the Public Advocate and the Office of the Public Advocate during the financial year ending 30 June 2026 and is verified to be an accurate for the purposes of reporting to the Parliament of South Australia.

Yours sincerely



Anne Gale
Public Advocate

24 September 2026

About the **artwork**



The artwork by Ngarrindjeri artist, Jordan Lovegrove, illustrates the important role of the Public Advocate in supporting people with disabilities who need help making decisions.

At the centre of the artwork is a meeting place that represents the Public Advocate. Surrounding it are four coloured rings, each symbolising our core value:

- People focused: advocating for the dignity and rights of vulnerable individuals.
- Agile: adapting to meet the needs and expectations of the community and clients.
- Accountable: acting truthfully, fairly, and professionally.
- Resilient: supporting each other in a challenging environment.

Smaller meeting places throughout the artwork represent the diverse individuals and communities supported by the Public Advocate. A pathway connects these elements, showing how the Public Advocate assists people and families through:

- Guardianship: making important life decisions (such as where someone lives, their health care, and the services they receive).
- Information and education: helping South Australians understand how to support people who need decision-making assistance while respecting their rights.

- Mediation: helping resolve disagreements within families about decision-making responsibility.
- Advocacy: promoting the rights and safety of adults with impaired decision-making ability.

The Public Advocate is supported by the Office of the Public Advocate (OPA), which works to protect and promote the rights of people with impaired decision-making ability across South Australia. Public Advocate clients live in a range of settings, including homes, supported disability housing, residential facilities, and aged care. OPA is committed to understanding and respecting the wishes of people with guardianship orders which appoint the Public Advocate as their guardian.

The OPA acknowledges that First Nations peoples' spiritual, social, cultural, and economic practices are deeply connected to their traditional lands and waters. We recognise the importance of First Nations culture, heritage, languages, and laws.

Terminology **in this report**

First Nations: Used respectfully to refer to all Aboriginal and Torres Strait Islander peoples living in South Australia.

Client: Refers to a person for whom the South Australian Civil and Administrative Tribunal (SACAT) has appointed the Public Advocate as guardian.

Impaired decision-making ability: Preferred term used in this report, except where the legal term 'mental incapacity' is required under the *Guardianship and Administration Act 1993* (SA)

People with disabilities: Refers to the disability community. The OPA acknowledges diverse views on language and supports individuals' right to self-identify.

Acronyms and initialisms: Refer to Appendix 2 for a complete list of acronyms used in this report.

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Message from the **Public Advocate**



South Australians with disability are living through a time of constant change. Reforms to the National Disability Insurance Scheme (NDIS), limited housing options, short supply of aged care home packages, access to mental health services and cost-of-living pressures are key issues faced by many people who rely on the disability support or aged pension.

Our work is enabled through the *Guardianship and Administration Act 1993* (SA) (GAA) and, the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) (the Consent Act), the *Advance Care Directives Act 2013* (SA) (ACD Act) and the *Mental Health Act, 2009* (SA) (MH Act).

During 2025–26, South Australia continued to experience growth in adult guardianship appointments. My office assisted 2,942 guardianship clients during the year, and the state continues to have one of the highest rates of guardianship appointments per capita in Australia. Growth is approximately 7% per annum and increasing demand highlights the need to review the GAA, which is now more than 30 years old.

A review of the GAA presents an opportunity to modernise the Act, strengthen safeguards, and reflect contemporary approaches to decision-making and human rights. Priorities for reform include closing legislative gaps that require guardianship appointment solely to enable people with disability to transition into residential aged care, improving alignment with the United Nations Convention on the Rights of Persons with Disabilities (CRPD), and implementing relevant recommendations of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (Disability Royal Commission (DRC)).

Advocacy remains central to the work of the office. Over the past year, I have continued to raise critical issues affecting individuals with a guardianship order. These matters are explored in greater detail later in this report, particularly in the Unmet Need section. Critical issues include:

- The limited supply of social housing, including robust accommodation.
- The need for all health services in addition to NDIS supports with clear Commonwealth and state roles and responsibilities.
- An assertive and accessible community mental health system.
- Access to mental health services for clients living with intellectual disability (ID), borderline personality disorder (BPD), autism and complex trauma.
- The need for an upgrade or replacement of James Nash House (JNH) with more capacity.
- Development of a residential forensic disability service in the community.
- Adjusting to changes to the NDIS and future reforms including provider regulation.
- Limited aged care placements for clients who are placed long-term in hospital.

Ongoing NDIS reform creates improvements and some uncertainty. The main reforms concern the transition toward foundational supports, which sit outside of the NDIS and are jointly funded by the state and Commonwealth governments, standardising functional assessments, and reforms to plan management, local area coordination and support coordination. The impacts for Public Advocate clients will be closely monitored in the coming year, with more reforms to be implemented.

Advocating for the rights of people with impaired decision-making capacity requires sustained commitment and collaboration. I thank the Deputy Premier and Attorney-General, the Hon Kyam Maher MLC, for his support for the work of the Office of the Public Advocate during the year.

I also extend my sincere thanks to the many individuals and organisations who have supported the OPA in this work. In particular, I acknowledge the professionalism, dedication, and expertise of my staff, who work in a complex and often high-pressure environment and acknowledge their commitment to protecting the rights, dignity and wellbeing of some our community's most vulnerable people.

2025-26 **Snapshot**

Guardianship

598 new clients

2,942 clients assisted during the year

2,496 active clients on 30 June 2026

70% of active clients had a National Disability Insurance Scheme (NDIS) plan

448 files closed

2,061 client visits

Dispute resolution

107 new dispute resolution applications

113 finalised dispute resolution applications

Systemic advocacy

11 written submissions by the Public Advocate

Information service

2,144 queries to the OPA Information Service

37 information sessions delivered

972 people attended an information session

Functions **of the Public Advocate**

Purpose and role

The Public Advocate is appointed under the *Guardianship and Administration Act 1993* (SA) (GAA) to promote and protect the rights of people with mental incapacity (impaired decision-making capacity).

Under the *Advance Care Directives Act 2013* (SA) (ACD) and the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) (the Consent Act), the Public Advocate has legislative authority to provide dispute resolution related to advance care directives and consent to medical treatment.

In fulfilling these statutory obligations, the Public Advocate also:

- Reviews programs and advises the minister of unmet, or inappropriately met, need.
- Advocates for people with impaired decision-making ability, both individually and systemically.
- Provides public information on guardianship, administration, advance care directives, Powers of Attorney and related matters.
- Conducts investigations as directed by SACAT and acts as guardian when no suitable alternative is available.

The OPA is situated within the portfolio of the Attorney-General and supported by the Attorney-General's Department for corporate services.

Our **strategic focus**

Our purpose

The Public Advocate promotes quality in decision making and systemic advocacy that enhances and protects the dignity, safety and rights of South Australian adults with impaired decision-making ability.

Our vision

South Australians living with impaired decision-making capacity are afforded the right to self-determination and are supported in decision-making to maintain their safety, independence and dignity.

Our values

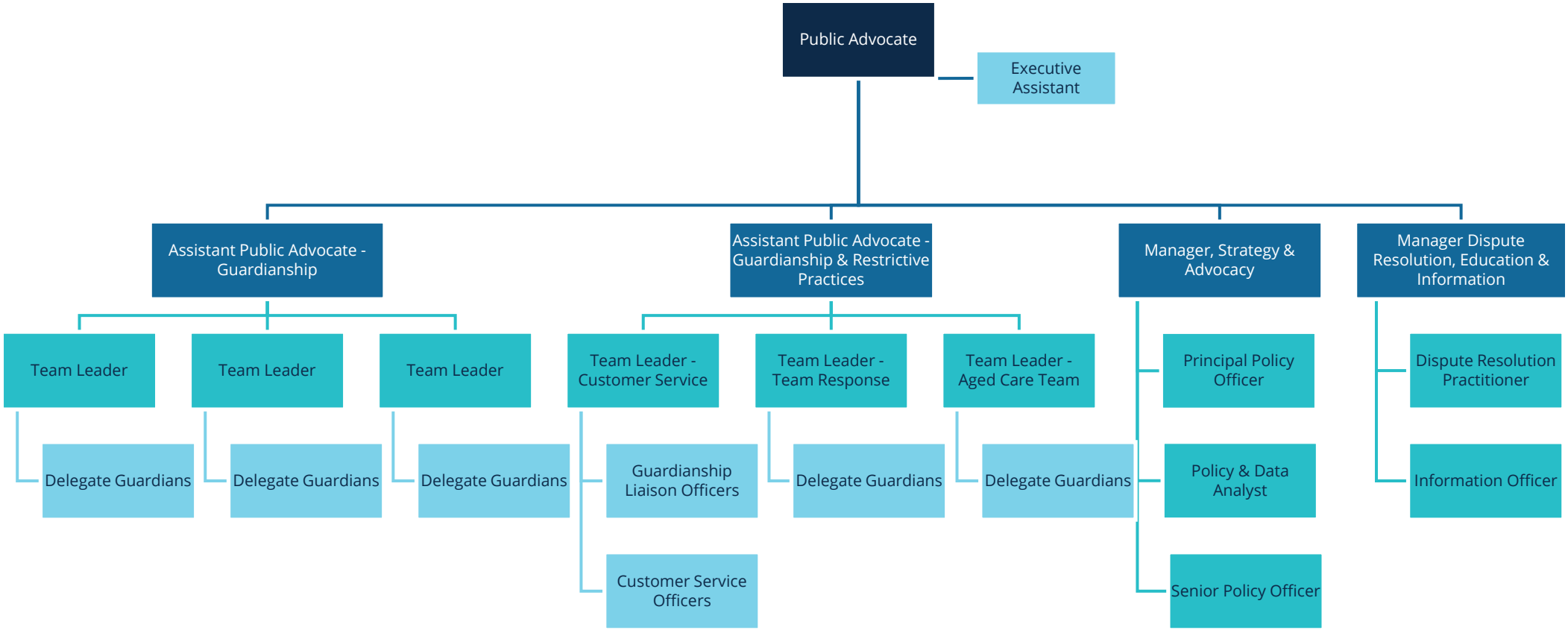
Public Sector Values – We are committed to the Public Sector Values.

We also adopt the following commitments:

Accountable – We act truthfully and fairly and expect professionalism and excellence in ourselves and those we collaborate with.

Connected – We establish, maintain and value collaborative partnership with other stakeholders to share responsibility for vulnerable adults with impaired decision-making capacity (including Public Advocate guardianship clients).

Organisation chart



Key **services**

The OPA works with and on behalf of South Australian adults with impaired decision-making capacity by providing the following services:

Guardianship (decision-making)

Act as the guardian for adults when appointed by SACAT for lifestyle, medical and accommodation decisions. This arises when SACAT deems that there is no other suitable person to assist the adult with decision-making.

Investigating

Conduct enquiries into a person's circumstances when directed by SACAT, especially if the person's decision-making capacity is impaired and there is a risk of harm.

Advocacy

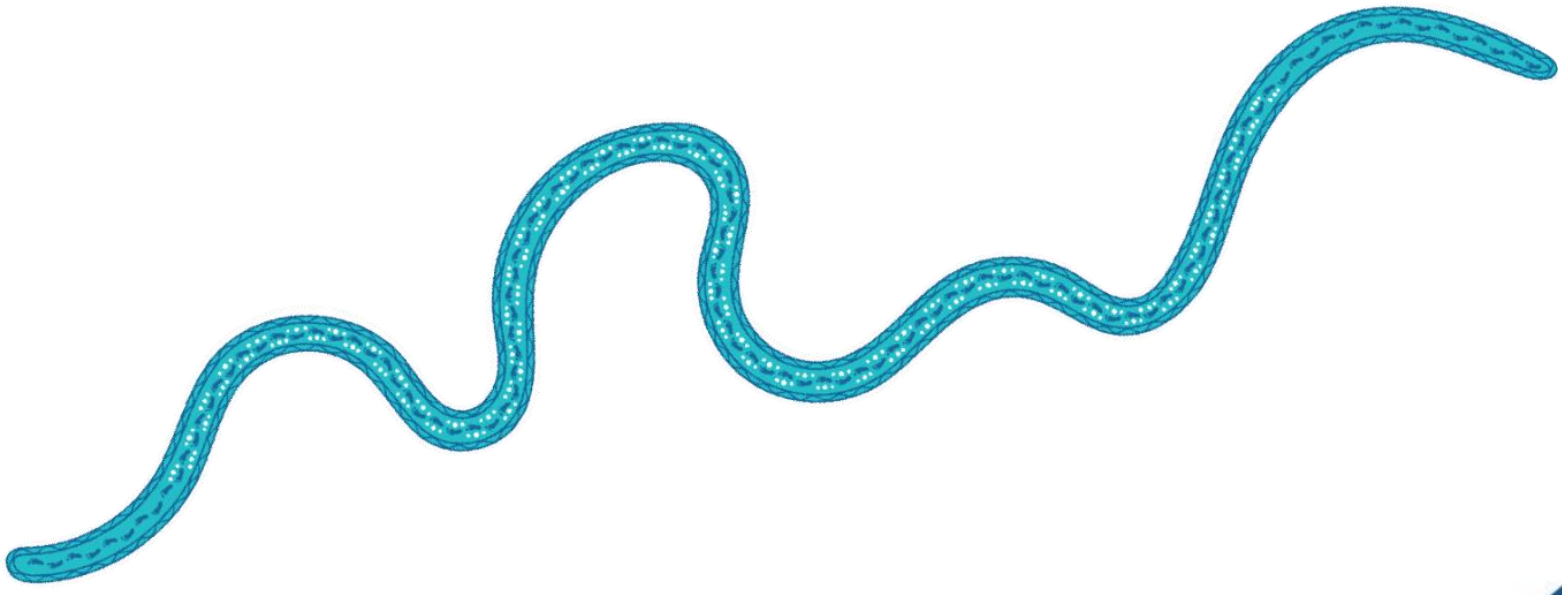
Advocate for the rights of individuals with decision-making impairment, alongside systemic advocacy for legislative and operational change.

Dispute resolution

Provide preliminary assistance and mediation for disagreements regarding Advance Care Directives or consent to medical treatment.

Information

Offer resources, fact sheets, and information on guardianship, mental health, and decision-making laws.



Key issues and **reform**

Reform of the *Guardianship and Administration Act 1993* (SA) (GAA)

The GAA is over 30 years old and requires review to better protect the rights and autonomy of people with impaired decision-making capacity and reduce unnecessary guardianship appointments when less restrictive alternatives are available.

Public guardianship in South Australia has doubled over the past five years, and data indicates that South Australia has the highest rate of new public guardianship orders per capita (3.2 per 10,000) compared with other Australian jurisdictions[1]. While most jurisdictions have modernised their guardianship legislation, South Australia has yet to undertake a comprehensive review.

A review would provide an opportunity to:

1. Align the GAA with the United Nations Convention on the Rights of Persons with Disabilities (CRPD), which post-dates the current legislation.
2. Clarify the interpretation of 'detention' and 'use of force' under s32 of the GAA. Current provisions require the appointment of a guardian for the purpose of detention in secure residential aged care and disability services.
3. Implement key recommendations of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (DRC), including:
    - Separating restrictive practice authorisations from guardianship appointments.
    - Strengthening supported decision-making arrangements; and
    - Modernising with contemporary references and practice.
4. Introduce an early dispute resolution mechanism to avoid Public Advocate appointments where a suitable alternative decision-maker may exist.

The DRC Final Report (Recommendations 6.4–6.10) called on all jurisdictions to reform their guardianship laws. More recently, the South Australian Law Reform Institute's (SALRI) report, Improving Legal Frameworks for People with Impaired Decision-Making Capacity, recommended that the South Australian Government undertake a comprehensive review of the Act, with a view to either enacting new legislation or substantially amending the existing legislation.

[1] Australian Guardianship and Administration Council 2024-25 report on Guardianship Orders (link), and Australian Bureau of Statistics population data 31-12-2025 (link)

Review of after-hours service

The OPA currently provides an after-hours service for matters that cannot wait for the next business day, including consent for urgent medical treatment, and facilitating urgent guardianship or special powers orders through SACAT.

During 2025-26, the OPA continued to review the service, noting a number of other jurisdictions have moved away from a 24/7 model to a more limited service or ceased after-hours services altogether.

The review considered legislation and practices in other jurisdictions, legal matters, data on after-hours service usage and consultation with SACAT. A sample found that approximately 80% of calls did not require urgent decision-making.

The review identified issues to be addressed in relation to the service. This included limitations within the Consent Act relating to emergency medical treatment, and restrictions on SA Ambulance Service's (SAAS) authority when patients refuse transport to hospital. The OPA continues to work with the Department for Health and Wellbeing (DHW) to create a more efficient service for the OPA and health practitioners in emergency situations.

Housing - unmet need

Access to safe, affordable and stable housing remains a major challenge for Public Advocate clients, many of whom are at risk of homelessness and rely on the Disability Support Pension.

The OPA works with SA Housing Trust (SAHT), Department of Human Services (DHS), DHW, the National Disability Insurance Agency (NDIA), community housing providers and homelessness services to improve housing outcomes. The Public Advocate has also advocated for a statewide disability housing strategy, including increased housing supply, better use of Specialist Disability Accommodation (SDA) funding, and measures to reduce evictions.

According to the latest NDIS Quarterly Report (Q3 2025-26), only 3.3% of all participants with an approved NDIS plan are eligible for SDA funding, reflecting the focus on individuals with extreme functional impairment or very high support needs. This underscores the relatively complex needs and circumstances of participants who are Public Advocate clients, 27% of whom have been approved for SDA funding. While the overall supply of SDA continues to expand, many participants are unable to find accommodation that matches their required location, dwelling type and design category, particularly robust housing for people with complex support needs.

The OPA is partnering with SAHT, DHS and Access 2 Place on a project to deliver bespoke SDA housing for 27 state clients, including 11 Public Advocate clients, with specific needs that the housing market has proven unable to meet. Several Public Advocate clients have

already moved into their new and purpose-built homes. This housing will significantly improve their stability, wellbeing, and support in the community.

Key challenges:

- Limited access to public and community housing, including lease non-renewals and evictions.
- Heavy reliance on private rental housing and Supported Independent Living (SIL) arrangements.
- Insufficient supply of SDA, particularly single-tenancy and robust housing options.
- Limited access to emergency accommodation and homelessness services.
- Inadequate housing options for First Nations clients, often resulting in displacement from Country and community.
- Shortages of disability-specific social housing and specialist housing providers.

Many clients face barriers to accessing social housing due to complex support needs, leaving them reliant on unstable private rentals or SIL arrangements with limited tenancy protections. Housing shortages frequently result in homelessness, hospital admissions, hotel accommodation, or extended stays in institutional settings.

Community Mental Health Services and borderline personality disorder

Public Advocate clients with complex mental health needs face significant barriers to accessing assessment, treatment and ongoing support. Community Mental Health Services (CMHS) operate on a voluntary engagement model, and guardian consent is often not recognised, resulting in service exclusion, premature case closure and limited access for clients with complex or co-occurring conditions.

People with intellectual disability (ID), autism, attention deficit hyperactivity disorder, acquired brain injury (ABI), psychosocial disability, substance misuse issues and borderline personality disorder (BPD) are particularly affected. Mental illness is often overlooked or misattributed to disability-related behaviours, leading to unmet treatment needs and poor access to specialist care.

As a result, a small but high-needs cohort repeatedly cycle through crisis services, emergency departments, hospitals and, at times, correctional settings. Many only receive support once their condition deteriorates to the point of requiring involuntary treatment. Fragmented responsibilities between NDIS funded and mainstream mental health services further contribute to gaps in care and poor service coordination.

At any given time, around 15 to 20 Public Advocate clients present with extremely complex needs, chronic suicidality and significant trauma histories. BPD diagnosis is prevalent in this cohort. Acute mental health services are not designed to provide the long-term, intensive

support this group requires, resulting in repeated admissions, re-traumatisation and ongoing instability. Access to BPD services is limited and requires an open community mental health file.

There is a need for more flexible, trauma-informed and assertive CMHS, supported by clearer eligibility criteria, recognition of guardian consent, and improved coordination for people with complex and overlapping needs.

Forensic Mental Health Services

The forensic mental health system faces a shortage of beds along with the outdated and unsuitable environment at James Nash House (JNH). The limited availability of housing and specialist service providers to support individuals with complex needs upon release results in unmet need and inappropriate placements. These gaps contribute to delayed transitions from secure care, increased pressure on hospitals and correctional facilities, and poorer outcomes for forensic clients.

The shortage of forensic mental health beds at JNH means some Public Advocate forensic patients are detained in prisons under Ministerial direction (under s269V(2) of the *Criminal Law Consolidation Act 1935* (SA)) or occupy acute hospital and Psychiatric Intensive Care Unit (PICU) beds for extended periods. This shortage creates pressure across multiple state systems.

The facilities at JNH are outdated and no longer fit for purpose. The prison-like design does not provide an appropriate therapeutic environment, particularly for people with disability. Clients admitted to JNH or the Tarnanthi and sub-acute services can experience lengthy stays due to a lack of specialist forensic disability accommodation and treatment options.

Frequent movement between JNH and correctional facilities creates operational challenges and uncertainty about the most appropriate placement. Fragmented responsibilities across the disability, mental health, forensic and correctional systems create gaps in service delivery and continuity of care.

Clients often experience disruptions to home rental arrangements and NDIS-funded supports when transitioning between health, forensic and correctional systems, as funding ceases while a person is in a forensic mental health facility. This results in the cost of support transferring to state agencies.

On discharge, clients are often placed in unsuitable accommodation with insufficient specialist support, increasing the risk of behavioural escalation, service breakdown and hospital readmission. This is compounded by ongoing disputes between state and Commonwealth agencies about whether a person's needs are primarily forensic, mental health or disability-related, and can delay support, increase administrative burden and lead to poorer client outcomes.

The Public Advocate attends the bi-monthly Forensic Patients in Prison Oversight Meeting, to advocate for clients in FMHS. The meeting is a collaboration between the FMHS, the

Office of the Chief Psychiatrist (OCP), Department for Correctional Services (DCS), Prison Health, Prison Assessment and Consultation Team, and the OPA. It is concerning that the client cohort presented at each meeting continues to increase in number, with an over-representation of First Nations clients, and a newer trend of highly vulnerable younger women in the Adelaide Women's Prison.

SAPOL and THRIVE model

In September 2025 the South Australian Police (SAPOL) expanded its THRIVE (Threat, Harm, Risk Investigation, Vulnerability and Engagement) initiative to include additional criteria for dispatching police to mental health related incidents and to attend to missing persons. Under this model, SAPOL has indicated it will not attend incidents requiring general security functions and has directed relevant agencies to implement their own risk-mitigation strategies. The change is affecting Public Advocate clients, many of whom present with complex mental health, cognitive and psychosocial needs and may experience significant risks during periods of crisis or instability in the community.

The OPA has experienced situations where SAPOL welfare checks and missing persons reports are not being accepted for several vulnerable Public Advocate clients, with SAPOL determining the circumstances do not meet their reporting criteria. If SAPOL is not able to attend, an alternative response model is required. The OPA is committed to working with SAPOL to address these concerns to improve safety and welfare outcomes for Public Advocate clients and the community.

Challenges in aged care access and placement

The shortage of aged care beds has delayed the timely and safe discharge of Public Advocate clients from hospital. In some instances, delays in Support at Home packages have seen Public Advocate clients placed prematurely into residential aged care or discharged without consultation or consent from the Public Advocate. In the last year, legislative reforms such as the *Guardianship and Administration (Tribunal Proceedings) Amendment Act 2025* (SA) and the *Statutes Amendment (Health and Wellbeing) Act 2025* (SA) sought to expedite transitions from hospital. While both are designed to facilitate a timely discharge from hospital, it does not address the shortage of Support at Home packages and residential aged care placements in South Australia.

The OPA has observed residential aged care facilities (RACFs) increasingly rejecting clients with complex needs such as people with disabilities, mental health conditions or dementia, resulting in prolonged hospital stays and repeat re-admissions. To address this issue, policy responses need to focus on increasing specialist supports to RACFs, strengthening their admission obligations to reduce discriminatory practices and establishing a specialised provider of last resort. This needs to be addressed through an increase in supply of home care packages, aged care beds and legislative reform mandating facilities to accept clients

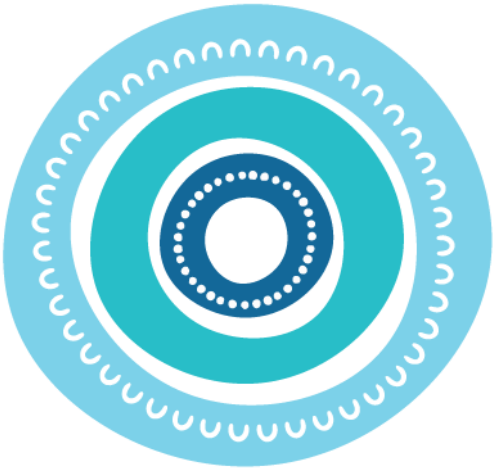
with higher and more complex needs and/or establishing a specialised provider of last resort.

National Disability Insurance Scheme

The OPA continues to work with the NDIS on improving systems and security for Public Advocate clients who are NDIS participants. In 2026 the OPA successfully trialled MyID to connect staff to the Relationship Authorisation Manager (RAM) so that the NDIA staff could verify that they had authority to speak to the OPA staff member about Public Advocate clients. Fifty per cent of OPA staff are now authorised to speak to the NDIA about Public Advocate clients. This, in conjunction with the dedicated guardianship phone line, has made it easier for staff to speak to the NDIA about Public Advocate clients who are NDIS participants.

On 4 July 2025 the Public Advocate was the first statutory officer to sign the schedule under the Memorandum of Understanding for Information Exchange between the NDIA and the Public Advocate. The schedule supports sharing of data between the agencies for common clients. Quarterly data has been shared twice so far through this agreement. The information supports OPA and the NDIA to better understand the supports that Public Advocate clients receive from the NDIA and ensure the appropriateness of clients' supports.

The OPA continues to face significant work generated by the NDIA including reviewing 8,300 service agreements, dealing with paper NDIS plans, correspondence and endorsing providers in the Provider and Participant Communication Environment (PACE) system.



Decision-**making**

Guardianship

When a person has impaired decision-making capacity and no other suitable support, SACAT may appoint the Public Advocate as their guardian. Under the *Guardianship and Administration Act 1993* (SA) (GAA) this person is known as the 'protected person'. Decision-making in the domains listed below is delegated to trained staff within OPA who observe the section 5 principles of the GAA when making substitute decisions for the protected person.

Decisions may include:

- **Accommodation:** choosing appropriate living arrangements or alternative housing options.
- **Health:** consenting to medical or dental treatment, palliative care, or withdrawal of treatment when necessary.
- **Lifestyle:** supporting decisions about social activities, education or employment.
- **Access:** who the protected person has contact with.
- **Services/Support:** consenting to service provision by providers.

Client profile

The Public Advocate was guardian for 2,496 clients on 30 June 2026.

- **Gender identity[2]:** 1,411 clients (57%) were male, 1,080 (43%) were female, and 5 were non-binary.
- **NDIS participants:** 1,753 clients (70%) had an NDIS plan.
- **Age:** 897 clients (36%) were 65-years-of-age or older and 1,599 (64%) were under 65.
- **First Nations People:** 325 clients (13%) identified as First Nations.

First Nations people are over-represented in public guardianship in South Australia, comprising 13% of clients but only 2.4 % of the population[3].

[2] The Public Advocate is seeking enhancements to the client information recording system to enable non-binary gender information recording

[3] 2021 census of population and housing (Australian Bureau of Statistics: link)

Age

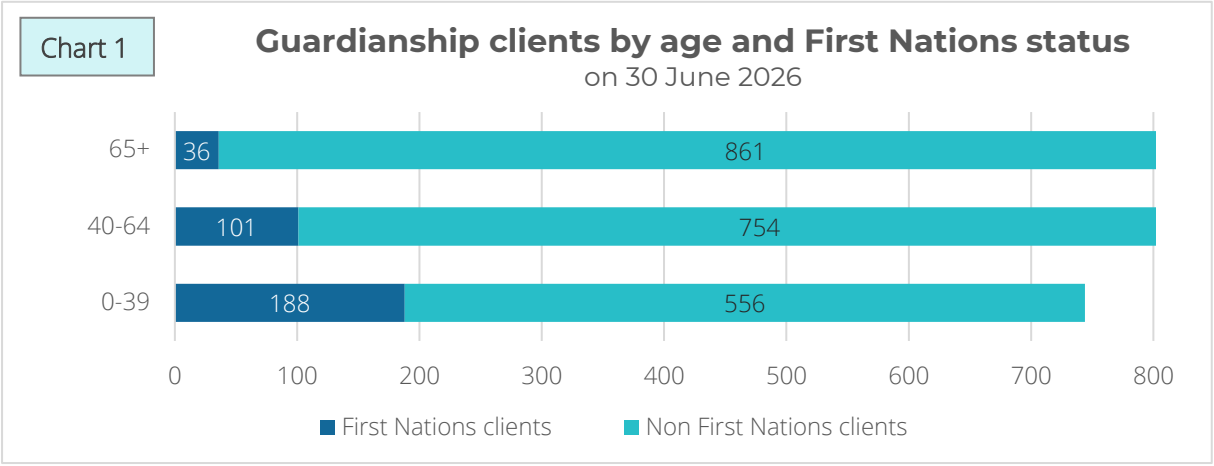
56 years was the median age for clients with active guardianship orders on 30 June 2026.

Table 1: Client age and First Nations status on 30 June 2026

	All clients
65+ years	897 (35.9%)
40-64 years	855 (34.3%)
18-39 years	744 (29.8%)

	First Nations clients	Non-First Nations clients
65+ years	36 (4.0%)	861 (96.0%)
40-64 years	101 (11.8%)	754 (88.2%)
18-39 years	188 (25.3%)	556 (74.7%)

Chart 1



First Nations people are further over-represented among guardianship clients who are under 40 years-of-age (25.3%). Over-representation drops significantly as age increases, reflecting the lower life expectancy of First Nations people.

Diagnoses

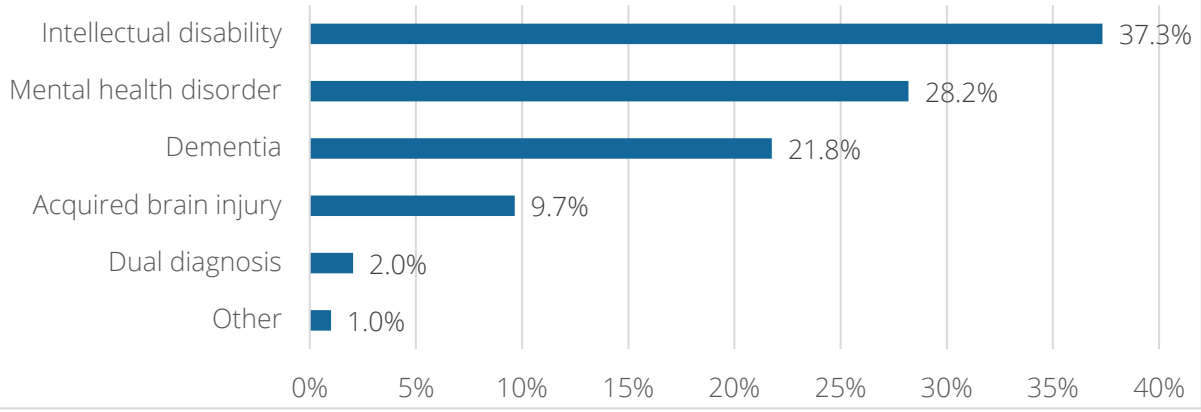
Of the clients with active guardianship orders as of 30 June 2026, 97% were diagnosed with a decision-making impairment falling within four primary categories:

- intellectual disability (37%)
- dementia (22%)
- mental illness (28%)
- acquired brain injury (10%)

Compared with 2024-25, mental illness increased by 1%, while dementia decreased similarly.

Chart 2

Broad diagnosis of guardianship clients
on 30 June 2026



First Nations clients followed a similar diagnostic profile with some exceptions:

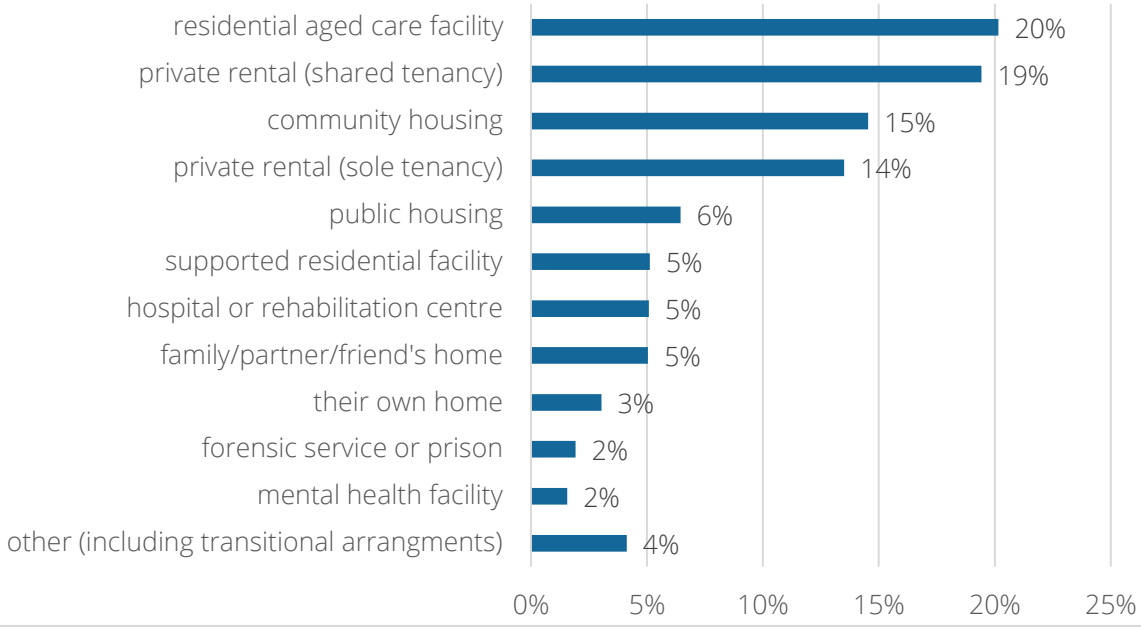
- Significantly lower rate of dementia (8.6% for First Nations clients), likely reflecting the lower life expectancy of First Nations people.
- Higher rate of intellectual disability (44%) and mental illness (34.2%).

Accommodation

Most clients with guardianship orders appointing the Public Advocate reside in disability-specific accommodation, including supported single-living arrangements and group homes, or Residential Aged Care Facilities (RACFs).

Chart 3

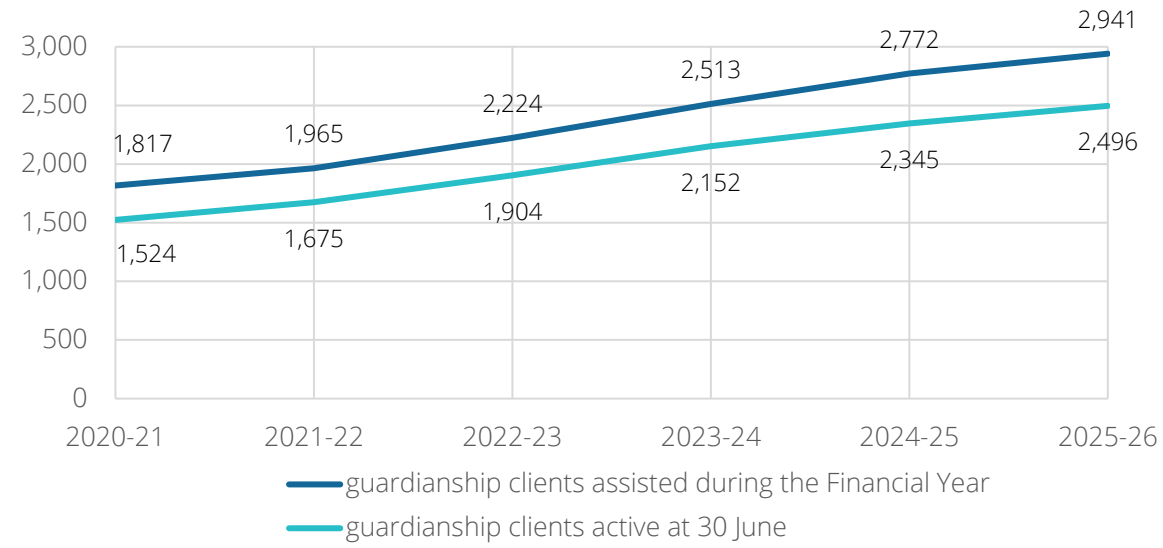
Accommodation arrangements for guardianship clients



Growth in guardianship

The number of people with guardianship orders appointing the Public Advocate rose 6.4% (from 2,345 to 2,496) during the 2025-26 financial year.

Chart 4



Guardianship client numbers have increased by 64% over the past five years, rising from 1,524 in June 2021 to 2,496 in June 2026.

The increase in appointments reflects the impact of:

- An increased number of older people affected by dementia or stroke.
- The implementation of the NDIS.
- Changes to the regulation of restrictive practices in disability and aged care sectors.
- The Full Court of the Supreme Court of South Australia's decision[4] in May 2019 regarding the detention of people in RACF or disability-specific accommodation, and the subsequent reduced capacity to revoke guardianship orders where the Public Advocate's role as guardian has otherwise ceased in terms of regular decision-making.

[4] The Public Advocate v C, B [2019] SASCFC 58

New appointments

The OPA attends initial SACAT hearings for guardianship applications that nominate the Public Advocate as guardian, or where SACAT considers it likely that the Public Advocate will be appointed.

During 2025-26:

- Staff attended 891 initial hearings.
- The Public Advocate was appointed as guardian for 598 people (67%) with impaired decision-making capacity.

Table 2: Guardianship applications and appointments

	2024-25	2025-26
SACAT hearings for guardianship applications^	889	891
New guardianship appointments^^	606	598

^ where the Public Advocate is nominated or considered likely to be appointed
^^ where the Public Advocate is appointed guardian

Closed matters

The OPA closed 448 guardianship matters during 2025-26, representing 15% of all guardianship matters that were active at any point. New appointments (598) exceeded matter closures by 150.

Matters are closed for the following 4 reasons:

- Clients passing away (50%)
- SACAT revoking guardianship orders (20%)
- Urgent temporary guardianship orders expiring (18%)
- Appointment of a private guardian (12%).

The Public Advocate seeks revocation of guardianship orders through SACAT if there is no longer a decision-making role for the Public Advocate as guardian.

Certain orders and circumstances require the Public Advocate to play an ongoing role as guardian, including for people:

- Who are NDIS participants, because NDIS plans and services are regularly reviewed and changed, and a guardian must make NDIS-related decisions.
- Who have restrictive practices in place, as their use is regularly reviewed.

While the use of restrictive practices can sometimes be eliminated or reduced over time, the need for detention orders for people who are living in 'closed' facilities or accommodation (where the person is not permitted to leave the location at will, particularly for safety reasons) will usually remain.

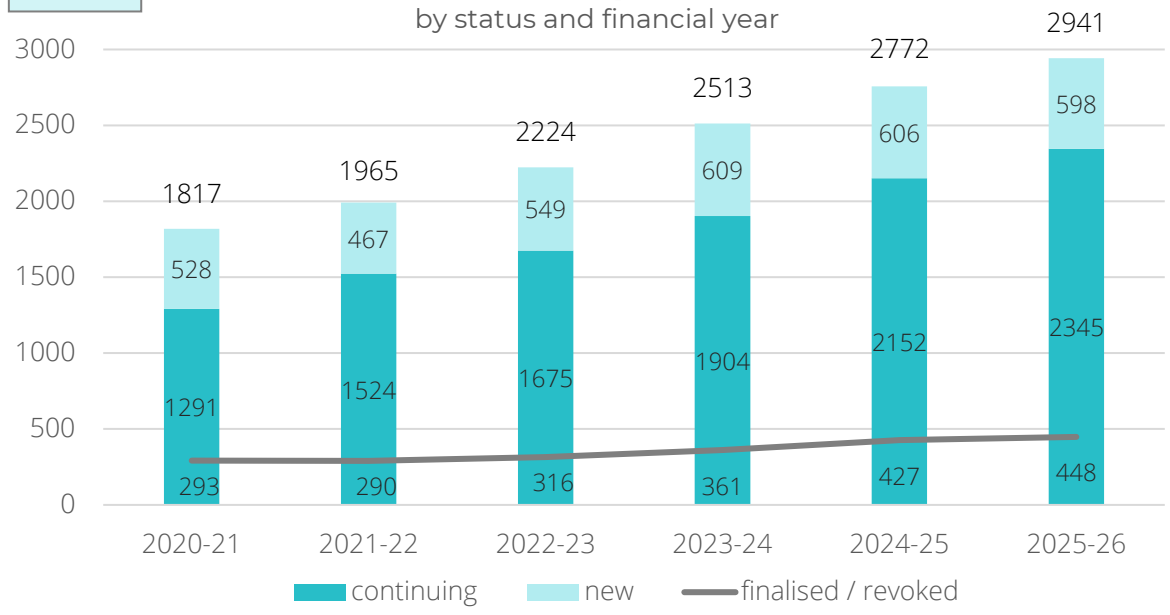
Of the 448 guardianship matters that were closed in 2025-26, 136 matters (30%) were in place for over three years. Two hundred and three matters (45%) were in place for less than one year, usually due to expiry of short-term orders made for urgent medical and accommodation decisions or the appointment of a private guardian.

The most common reason for closures across all guardianship matters was death (50%) of older people, reflecting the growth in guardianship orders for an ageing population.

Table 3: Length of closed guardianship matters

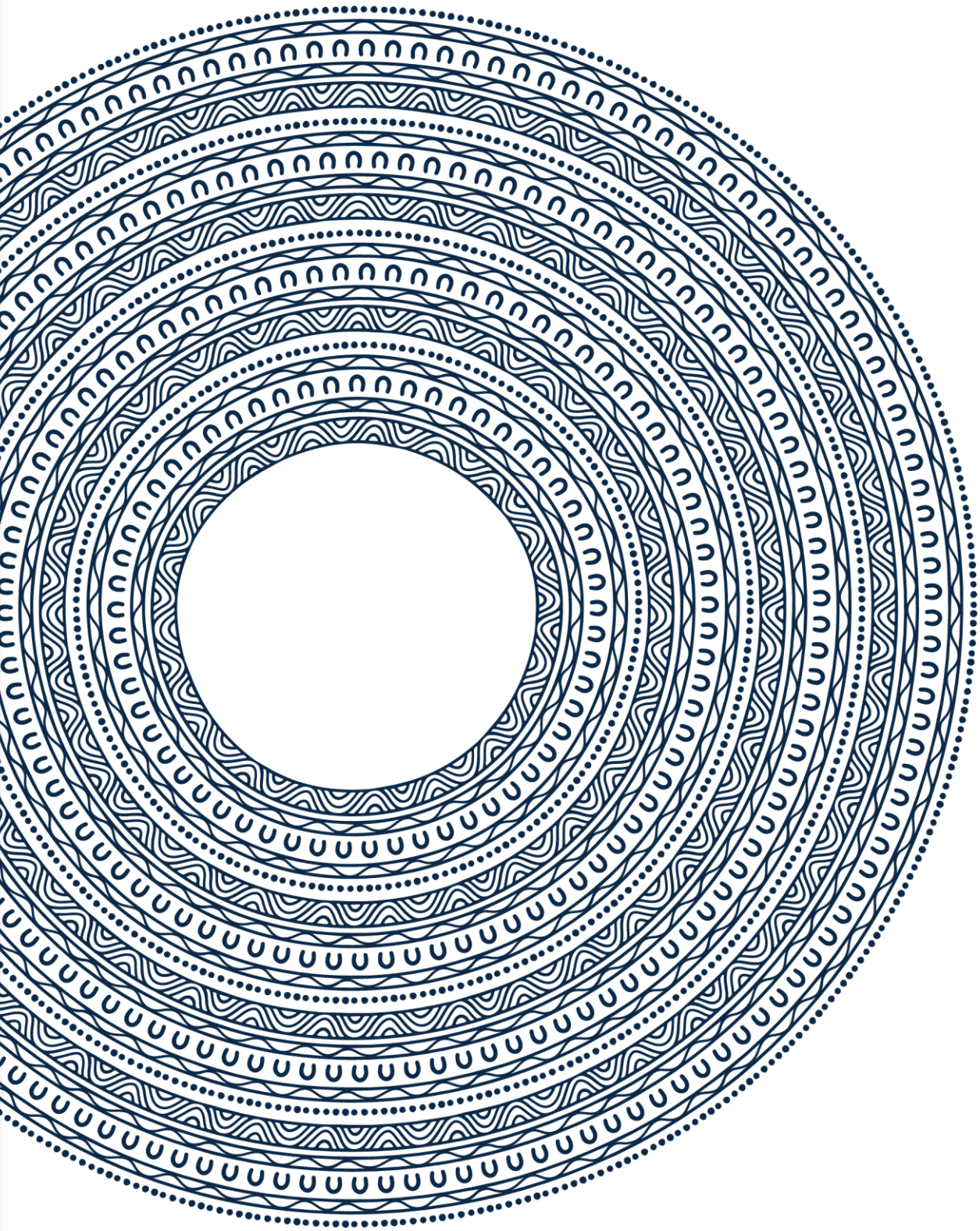
Length of guardianship matter	2024-25	2025-26
0 – 12 months	197	203
1 – 2 years	66	73
2 – 3 years	40	36
3+ years	124	136
Total closed matters	429	448

Chart 5



Further information on guardianship

Further information about guardianship can be found on the OPA website in fact sheets. Data for the last five-years can be found at Data SA.



Decisions

A key role of the Public Advocate is to make decisions for people with impaired decision-making ability when no other appropriate person can be appointed as guardian. These decisions relate to health care, accommodation, services and supports, lifestyle and access.

In 2025-26, the Public Advocate and OPA staff made the following decisions for people with guardianship orders:

Table 4: Decisions made for guardianship clients

Decisions	2024-25	2025-26	% ↑/↓
Health care	2,770	3,135	+ 13%
Accommodation	1,855	1,774	- 4%
Service / support	2,132	3,637	+ 71%
Lifestyle	571	748	+ 31%
Access	747	691	- 7%
Other[5]	186	185	- 1%
Total decisions	**8,261**	**10,170**	**+ 23%**

In the past year, decisions required for guardianship clients increased by 23%, compared with a 6% growth in client numbers, continuing a three-year trend. Since 2022-23, client numbers have increased by 31%, but required decisions increased by 98%.

The most significant factor driving this increase is the need for guardianship consent for services and supports for NDIS participants. Other contributing factors include the steady increase in guardianship clients, ongoing instability in the disability sector and housing market, and improvements in OPA's recording practices to more accurately capture decision-making activity.

After-hours decision-making

The OPA provides an after-hours service to assist with urgent medical or emergency decision-making. This may require an urgent application to SACAT for an order. The service operates outside of standard business hours on weekdays, weekends, and public holidays.

[5] Category "other" includes legal decisions and decisions to apply for SACAT orders

In 2025-26, the OPA responded to 2,397 after-hours calls, with a monthly average of 200 after-hours calls. The peak call periods were 5pm to 9pm on weekdays, and 9am to 6pm on weekends and public holidays.

During 2025-26, the OPA made 507 urgent after-hours decisions for clients, a rate of one decision for every five calls (21%). A significant majority of decisions were health related (438 or 86% of decisions).

The use of OPA's after-hours service has shifted, with more health practitioners seeking SACAT hearings outside business hours. The service is also being used for non-urgent matters, including provider operational issues. OPA is reviewing the operating model and reinforcing that the service is for urgent matters only.

Investigations

SACAT can direct the Public Advocate to investigate and report on whether guardianship or administration orders are needed, and the most suitable appointee. These reports offer a clear, balanced summary of the individual's circumstances.

Public Advocate staff conduct these investigations by interviewing the person involved and other relevant parties. Key issues examined include:

- Need for guardianship and/or administration orders
- Accommodation
- Access
- Health
- Finances
- Appropriateness of sterilisation
- Suitability of proposed private guardians.

Reports are presented at SACAT hearings and considered alongside other evidence.

Table 5: Investigations for SACAT in 2025-26

Investigations	2024-25	2025-26
New investigations undertaken for SACAT	16	15
Finalised investigations	15	18
Active at end of financial year	10	7

Litigation guardianship

A litigation guardian can be appointed by the courts for people with impaired decision-making capacity when they are unable to provide instructions to a lawyer.

Section 83 of the GAA relates to matters a court must consider when deciding to appoint the Public Advocate as litigation guardian including:

- Whether the Public Advocate has been appointed as the guardian for the client.
- Whether there is another relative, friend or associate willing and able to act.
- Whether the Public Advocate is the most appropriate person to act as litigation guardian.

When appointed in this role, the Public Advocate:

- Reviews legal advice.
- Consults with the individual.
- Provides instructions to the lawyer.
- Supports the person's understanding of legal proceedings.

In 2025-26 the Public Advocate acted as litigation guardian for 3 Public Advocate clients and referred a further 3 matters to the Uniting Communities Law Centre (UCLC).

UCLC is funded by the Attorney General's Department (AGD) to provide litigation guardian services in Youth Court care and protection matters under the *Children and Young People (Safety) Act 2017* (SA).

The Youth Court may request a litigation guardian when a parent has impaired decision-making capacity which impacts their ability to participate in legal proceedings. Most Youth Court referrals are directed to UCLC. The Public Advocate continues to accept requests when already the appointed guardian.

The OPA also receives regular requests to act as litigation guardian in criminal, civil, family, tenancy, and immigration matters for people who are not Public Advocate clients. These requests fall outside the Public Advocate's statutory role, expertise and available resources.

The limited availability of litigation guardian services outside the Youth Court remains a significant systemic gap for adults with impaired decision-making.

Complaints and decision reviews

In 2025-26, the OPA addressed 67 complaints or decision reviews, received 5 compliments and 27 ministerial enquiries. These matters involved OPA staff decisions, communication concerns, or conflict amongst parties.

There were 2 Freedom of Information applications. The OPA is an exempt agency (in respect of client matters, but not administrative matters) under the *Freedom of Information (Exempt Agencies) Regulations 2023* (SA).

Complaints and decision review requests concerned only 2% of the 2942 clients assisted during the year. Ministerial enquiries concerned 1% of the 2496 clients.

Table 6: Complaints and decision review requests 2025-26

Complaints and decision review requests	2024-25	2025-26
Complaints and decision reviews	60	67
Ministerial enquiries	38	27
Freedom of Information requests	5	2

Warrants

Under section 69 (3) of the GAA, SACAT may issue a warrant requiring a person to undergo a mental capacity assessment. This assessment must be conducted by a psychiatrist, psychologist, or medical professional who submits a report to SACAT. In 2025-26 there was one SACAT order under section 69 (1) of the GAA, which directed a person to have a mental capacity assessment. A warrant under s69 (3) from SACAT was not required as the person ultimately cooperated with having an assessment.

Resolving and **mediating**

Dispute resolution

The Public Advocate delegates authority to the Dispute Resolution Service (DRS) staff to resolve disputes under the *Advance Care Directives Act 2013* (SA) (ACD) and the *Consent to Medical Treatment and Palliative Care Act 1995* (SA) (the Consent Act). The DRS employs qualified mediators who are trained in mediation and complex conflict resolution.

Following the inclusion of elder mediation as a specialisation in the Australian Mediator and Dispute Resolution Accreditation Standards mediation guidelines/code, the OPA employs the *first* practitioner in Australia to be registered under the new practitioner specialty (elder mediation) with the Elder Mediation Australasian Network.

Where an application is received from an eligible person, the Public Advocate can assist or mediate in:

- Disputes about Advance Care Directives under the ACD Act
- Disputes about consent to medical or dental treatment, including for children under 16, under the Consent Act
- Disputes about decisions or decision-makers under both Acts.

An eligible person is someone who demonstrates a proper interest in the matter.

Advance Care Directives Act 2013

The ACD Act enables adults with decision-making ability to write an ACD outlining their wishes for future healthcare, living arrangements and personal matters if they later become unable to make a decision or communicate. It does not cover financial matters.

The Act also permits the appointment of substitute decision-makers (SDMs) who must act according to the preferences and values expressed in the ACD wherever possible.

Consent to Medical Treatment and Palliative Care Act 1995

If a person cannot consent to medical or dental treatment, valid consent must be obtained from an authorised person under the Consent Act. Approval must be sought first from an SDM under an ACD. If no SDM is available, consent can be given by a 'person responsible' as defined in section 14 of the Consent Act, who must be available and willing to decide, in the following hierarchical order:

1. A guardian appointed by SACAT to make healthcare decisions.

2. A 'prescribed relative', who is a spouse/domestic partner/relative by blood or marriage, or an adult related to the person by blood, marriage, adoption, or First Nations kinship/marriage, with a close and continuing relationship with the person.
3. An adult friend who has a close and continuing relationship with the person.
4. Someone charged with the person's ongoing day-to-day care and wellbeing (such as a director of care in aged or supported care, except for chemical restraint).

The Consent Act often eliminates the need for SACAT to make a guardianship order for health decisions. In 2025-26, the OPA received 5 formal dispute resolution applications under the Consent Act and addressed many more consent disputes alongside ACD issues. The OPA Information Service also responded to 128 enquiries about the Consent Act and prescribed treatment.

Prescribed treatments are medical procedures that require special consent from SACAT due to their nature or impact. Under the *Mental Health Act 2009* (SA), these include electro-convulsive therapy and neurosurgery for mental illness. The *Guardianship and Administration Act 1993* (SA) (GAA) identifies sterilisation and termination of pregnancy for people with a mental incapacity as prescribed treatments. Where a person lacks the ability to give their own consent for these treatments, consent must be sought through SACAT.

Dispute Resolution Service (DRS) applications

The DRS provides dispute resolution assistance for issues arising from ACDs, such as preventing visits, disagreements about living arrangements, and concerns about substitute decision-makers.

The DRS helps families resolve conflict and repair relationships, encouraging families to avoid formal SACAT processes and work together to uphold the relevant person's rights and wishes.

In 2025-26, 100 (93%) of the 107 new matters related to a person aged over 65. The most common age bracket was 80-89 years, with the average age across all matters being 81.6 years.

Most applications came from family and friends, but they can also come from health care professionals, social workers, service providers, and SACAT under section 49 of the ACD Act.

Table 7: DRS matters 2025-26

DRS matters	2024/25	2025/26
Interested parties assisted	211	387
Matters brought forward from previous year	10	19
New matters opened	63	107
Referrals to DRS by SACAT (Figure also included in new matters)	1	9
Matters closed	54	113
Open matters carried forward to following year	19	13

Service model for dispute resolution and conflict management

The DRS model addresses disputes involving a high level of conflict through preliminary assistance and mediation.

The OPA's qualified mediators have undertaken national elder mediation[6] and family dispute resolution training.

The DRS prioritises the rights and voice of the person at the centre of the dispute. The model, based on state legislation (*Advance Care Directives Act 2013,* the Consent Act) and Commonwealth and International laws (United Nations Convention on the Rights of Persons with Disabilities (CRPD), *Disability Discrimination Act 1992* (Cth)) integrates various dispute resolution and conflict management approaches.

Mediators use a range of mediation styles and approaches to assist parties in dispute, depending on the type of conflict. They include:

- Facilitative negotiated mediation— the mediator helps parties negotiate to reach their own solution.
- Narrative mediation—focuses on storytelling to separate individuals from issues and reshape narratives for better understanding and resolution.
- Transformative mediation— aims to empower parties to resolve their conflict by recognising each other's needs and interests.

The DRS primarily uses the facilitative approach but will adopt others as needed to address each family's unique requirements and uphold the vulnerable person's rights.

[6] Elder Mediation Australasian Network – Elder Mediation Australasian Network (elder-mediation.com.au)

Finalised DRS matters

Table 8: DRS finalised matters 2025-26

Finalised DRS matters	2024/25	2025/26
Resolved	19	39*
No further action	20	48
Referred to SACAT	3	0
Referred to Adult Safeguarding Unit	0	1
Application withdrawn	9	15
Relevant person deceased	3	10
Total	54	113

* 39 total resolved (preliminary assistance + mediation), 19 through preliminary assistance (13 without agreement, 6 with agreement) and 20 resolved through formal mediation. (18%) with a total resolution rate of 35%.

The DRS finalised 113 matters involving 387 interested parties. No action was possible in 48 matters due to unwillingness to mediate, lack of response, or scope issues; 15 applications were withdrawn; and 10 clients passed away during the process.

Of the 39 resolved cases:

- 28 mediations were facilitated, including 5 matters where multiple mediations were attended.
- 26 were resolved by parties reaching agreement, including 20 through formal mediation, and 6 through preliminary assistance.
- 13 additional matters were resolved with preliminary assistance without the need for a written agreement.

Out of the 9 matters referred by SACAT (either informally or via formal s49 referral):

- 5 matters were resolved with preliminary assistance or a mediated agreement.
- 2 matters closed, relevant persons deceased.
- one matter closed, parties not willing to mediate.
- one matter closed, parties failed to respond.

Conflict coaching

Since 2020, the DRS has included conflict coaching in the preliminary assistance stage to help individuals manage interpersonal conflicts. Coaching supports people to:

- Understand the conflict from a new perspective.
- Build skills for difficult conversations.
- Understand their own and others' values, needs, and beliefs, and
- Explore options for a preferred future.

Conflict coaching emphasises resolving underlying issues, de-escalating conflict, and improving communication, with a focus on modelling respectful language and behaviour.

Case study: Advance Care Directive

Mary, 83, lives in Ceduna with her partner, Jack. During a visit to her daughter, Elena, in Adelaide, Mary became disoriented, fell, and was admitted to hospital. Tests showed Mary's previously mild dementia had advanced, and she would need much higher levels of care after discharge from hospital.

Jack and his daughter, Chloe, flew to Adelaide to be with Mary. The hospital care team held a family meeting, where Elena – who is also Mary's substitute decision-maker – said she thought it was in mum's "best interests" to find an aged care placement in Adelaide. Jack insisted that Mary would prefer to come home to Ceduna where he hoped to care for her. The meeting ended without agreement, and the hospital applied to the OPA DRS for mediation.

Within 2 days, the dispute resolution practitioner (mediator) met with Elena, Jack (supported by Chloe), and the hospital social worker. The mediator gave each one information about decision-making principles under the *Advance Care Directives Act 2013* and helped them begin to explore the issues and possible solutions, and they all agreed to attend mediation the following week.

Before the session, the mediator met privately with Mary. Mary expressed that she didn't want to burden her family. She preferred Jack to provide her care but understood that aged care might be necessary. Mary wanted to attend the mediation but planned to leave if she was overwhelmed.

At the mediation, Mary, her family, and key hospital staff were present, along with her financial advisor. Mary read a short statement about her wishes, then left as she was tired. The mediator kept Mary's wishes central to the discussion, externalised the grief of the dementia diagnosis, recognised the needs of the family members, and helped them

talk calmly about her future care. Elena was able to move from her own idea of Mary's "best interests" to supporting decision-making and wishes.

The family agreed that Mary should return to Ceduna but live in aged care there, as her needs would soon exceed Jack's capacity to care for her. They also agreed that she would have regular visits with her Adelaide-based family, as this connection was important to her.

Within 2 weeks of the DRS application, Mary was safely discharged from hospital and moved into respite care in Ceduna while she waited for her preferred aged care placement.

Informing

The OPA provides information to community members, health professionals and service providers regarding adult safeguarding, SACAT application process, decision-making ability, Guardianship and Administration orders and Advance Care Directives.

Information is provided in 3 ways:

- Consulting with the Information Officer by phone and email.
- Face-to-face information sessions.
- The OPA website.

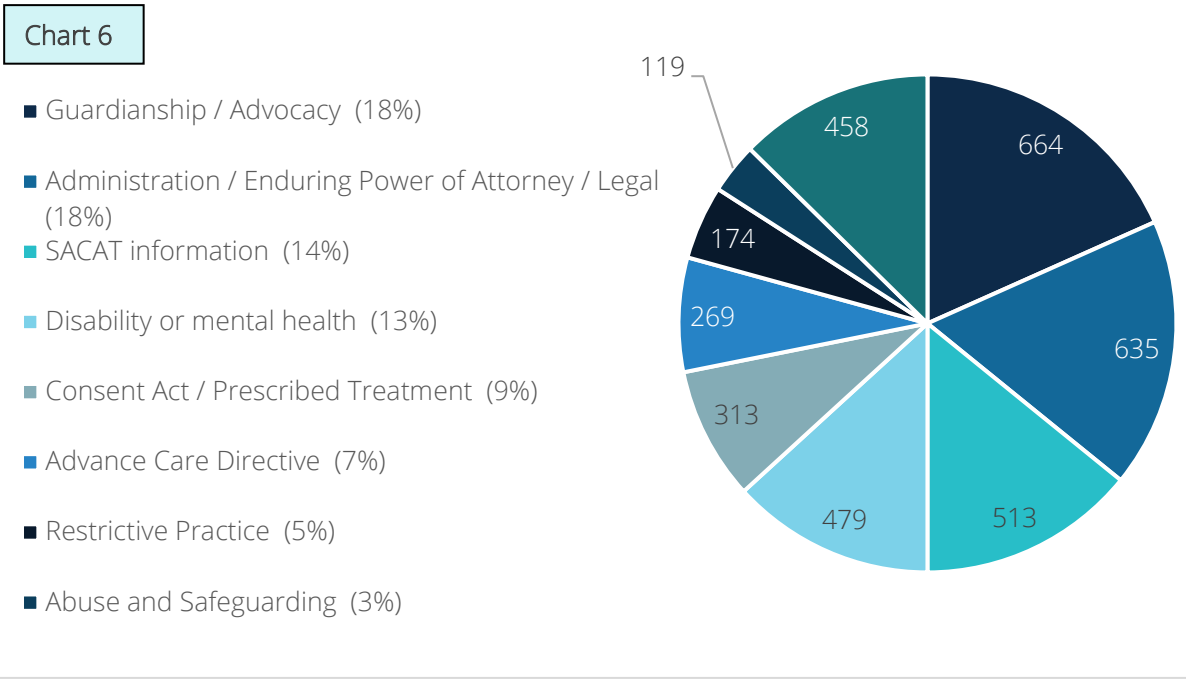
Information Service statistics

In 2025-26, the OPA recorded 2,144 enquiries (phone and email) resulting in 3,624 instances of information provided across a broad range of issues. The most common enquiries were about Guardianship (463, or 13%), SACAT information (355, or10%), Advance Care Directives (269, or7%), Administration (259, or 7%) and Enduring Powers of Attorney (207, or 6%). The remaining 57% of enquiries covered a broad range of topics including s32 powers (*Guardianship and Administration Act 1993* (SA) (GAA), Dispute Resolution Service (DRS) information, dementia and other disorders, SACAT after hours and other matters including NDIS, non-specific queries, appeals and complaints. The 'Other' category includes a wide range of non-decision-making topics including legal queries, NDIS queries, appeals and complaints. Referrals are often made to other relevant authorities in these instances.

The OPA website provides a range of information and resources including easy read and plain English fact sheets. In 2025-26, the website had 35,196 visitors with 85,909 page views.

Table 9: Enquiries

Chart 6



*Other includes legal, NDIS and non-specific queries, appeals and complaints.

Information sessions

The Information Service supports South Australians and service providers by clarifying advance care planning documents, SACAT processes and the role of the Public Advocate. It also delivers information sessions on the GAA, *Advance Care Directives Act 2013* (SA) (ACD Act) and *Consent to Medical Treatment and Palliative Care Act 1995* (SA) (the Consent Act).

Table 10: Information sessions 2025-26

Information session	2024-25	2025-26
Sessions delivered	45	37
Participants	1,207	927

Information sessions are generally provided where there are at least 20 participants in each session. In 2025-26, the Information Service exceeded the session efficiency goal by recording an average attendance of 25 participants.

The Information Service continues to present the sought-after "Find Me a Decision-Maker" presentation, to support health professionals in identifying authorised decision-makers. This presentation explains the role of a person responsible under the Consent Act, offers

resources on dispute resolution, and encourages professionals to contact the OPA before seeking a guardianship order. In 2025-26, OPA presented 14 “Find Me a Decision-Maker" sessions.

This approach promotes timely, rights-based decision-making, helps avoid unnecessary guardianship applications, and ensures SACAT and OPA resources are utilised for cases with no other available decision-maker.

Twenty-one sessions were presented to hospital staff and medical students, representing the largest category of requests. A key target of the information service for this year was to increase reach into hospitals and the number of sessions presented to hospital staff increased from 8 last financial year to 17 this year. Other groups requesting information were aged care facilities, service providers, community groups and other government agencies.

The proclamation of the *Statutes Amendment (Health and Wellbeing) Act 2025* (SA) in July 2026 prompted 2 information session requests by hospitals in June, and the OPA continues to be a primary resource for hospital staff seeking information about the implementation of this legislation.

The OPA Information Service also presented at 3 key industry events: the Advance Care Planning International Conference 2025, the International Elder Mediation Conference, and the Conciliation and Public Sector Dispute Resolution Symposium.

Advocacy and **promoting rights**

Systemic advocacy

The Public Advocate undertakes systemic advocacy on issues affecting people who require support with decision-making.

Under section 21 (1) (a-h) of the *Guardianship and Administration Act 1993* (SA) (GAA), the Public Advocate recommends improvements to legislation, policies, programs and services to the Attorney-General, and other relevant ministers. This work focusses on addressing unmet need and improving outcomes for vulnerable South Australians. Advocacy is undertaken through regular engagement with Ministers, providing advice and written submissions.

Key areas of systemic advocacy included improving access to the NDIS, My Aged Care (MAC), housing, health and mental health services, forensic mental health services and the criminal justice system.

The Public Advocate continues to advocate for reform of the GAA, including implementation of recommendations from the Disability Royal Commission, and the Royal Commission into Aged Care Quality and Safety. Reform efforts seek to modernise the GAA to better align with the principles of the United Nations Convention on the Rights of Persons with Disabilities (CRPD), and National Decision-Making Principles[7].

Under section 21 (3) of the GAA, the Public Advocate may establish advisory committees to support this work.

The Public Advocate convenes the OPA Disability Forum, and the Public Advocate Clients and Domestic Violence Working Group. These groups bring together government and non-government stakeholders to improve service access, coordination and outcomes for people with complex needs, helping address barriers across multiple service systems.

In 2025-26 the Public Advocate convened meetings of public advocates and guardians from other states and jurisdictions together with the NDIA to collaborate on issues such as information sharing, verification of identity of OPA staff communicating with the NDIA, and legislative reforms related to the NDIS.

[7] National Decision-Making Principles | ALRC

Australian Guardianship and Administration Council (AGAC)

The Public Advocate is a member and Deputy Chair of the Australian Guardianship and Administration Council (AGAC). AGAC was established in 1993 and brings together 23 membership organisations including public advocates, public guardians, tribunal heads and public trustees from across Australia.

The AGAC meets biannually with meetings on 17 October 2025 in Sydney and online on 24 April 2026. Separate guardian, trustee and heads of tribunal meetings were held on the 2 preceding days.

Topics discussed included:

- Reform priorities across guardianship and administration.
- Recommendations from the DRC.
- Use and oversight of restrictive practices in aged care and disability services.
- NDIS funding, reform, and information sharing.
- Supported decision-making practices.

AGAC plays a role in shaping national policy and systemic advocacy, particularly in areas such as enduring powers of attorney, supported decision-making, restrictive practices, and adult safeguarding. More information, including statistics on guardianship and administration/ financial management applications from across jurisdictions is available on the AGAC website.

The Public Advocate is also a member of the AGAC Conference Organising Committee with the next national conference to be held on 8-9 October 2026 in Brisbane.

Minister meetings

In 2025-26, the Public Advocate met with the following South Australian Ministers:

- Hon Kyam Maher MLC, Deputy Premier, Attorney-General and Minister for Aboriginal Affairs.
- Hon Chris Picton MP, Minister for Health and Wellbeing.
- Hon Katrine Hildyard MP, Minister for Human Services (after March 2026).
- Hon Nat Cook MP, Minister for Human Services (until March 2026).

Topics and systemic issues raised included:

- Growth in guardianship appointments and key drivers.
- Guardianship law reform.
- Impact of the *Statutes Amendment (Health and Wellbeing) Act, 2025* and *Guardianship and Administration (Tribunal Proceedings) Amendment Act 2025* (SA).
- Adult safeguarding.
- Housing and homelessness, including for people with complex needs.
- Housing supply and supported accommodation options.

- Trauma-informed services to reduce hospital admissions.
- Mental health service availability and access.
- Forensic mental health services and JNH.
- Use of restrictive practices.
- Domestic, family, relationship and sexual violence.
- Disability Royal Commission (DRC) recommendations.
- NDIS Review outcomes and legislative reforms.
- Aged care reforms, including restrictive practices.
- South Australian Law Reform Institute (SARLI) recommendations on improving legal frameworks for people with impaired decision-making capacity.
- Information sharing and interagency collaboration.

Meetings

The Public Advocate meets regularly with the Chief Psychiatrist, Forensic Mental Health Services, Department's for Health, Human and Correctional Services (DCS), Aged Rights Advocacy Service, the NDIA and the NDIS QSC.

The Public Advocate and/or representatives advocate for and obtain information on behalf of Public Advocate clients through participation in a range of committees, reference groups and forums, including:

- Forensic Patients in Prison Oversight Meeting (FMH)
- DHS ASU and Restrictive Practices Unit (RPU)
- Department for Child Protection (DCP)
- NDIS Commission
- NDIA
- South Australian Disability Reform Interdepartmental Committee (DHS)
- Advance Care Directives Collaborative Forum (Office for Ageing Well)
- Advance Care Planning Discovery Project (Australian Digital Health Agency) and stakeholder engagement activities (Queensland Office of the Public Guardian)
- Interjurisdictional Communications and Engagement Working Group (Queensland Office of the Public Guardian)
- South Australian Council for Intellectual Disability (SACID)
- Public Trustee Engagement/Reference Group
- South Australian Disability Sector Reference Group (DHS)
- Interjurisdictional Guardianship Meeting
- Electoral Commission SA Disability Engagement Advisory Committee (Electoral Commission of South Australia)
- South Australian Government Steering Committee for the National Redress Scheme (Attorney-General's Department).

Through these engagements, the Public Advocate contributes to policy discussions, promotes the interests and rights of clients, and facilitates information sharing across government and community sectors.

Written submissions

The Public Advocate contributes to proposed legislative and systemic reform affecting clients and adults with impaired decision-making capacity.

In 2025-26, the following submissions were made:

- Adult Safeguarding Unit Code of Practice and Charter of Rights
- Review of Aged Care Rules
- Mental Health and Wellbeing Bill 2025
- Review of *Mental Health Act 2009* Supplementary Consultation
- Australian Banking Association Response
- *Disability Discrimination Act 1992*
- NDIS Support Rules
- SA Intellectual Disability Health Service (SAIDHS) Steering Committee
- SACAT website consultation
- Disability Safeguards Consultation
- Select Committee on the Children and Young People (Safety and Support) Bill 2024.

In 2025-26 the Public Advocate provided advice on legislative and policy reforms impacting people with impaired decision-making capacity. This included:

- Engagement with State First Nations Voice to Parliament
- Attorney-General's Disability Access and Inclusion Plan 2025-2029
- Australia's Disability Strategy
- National Plan to End Abuse and Mistreatment of Older People
- Draft State Ageing Plan 2026-2036
- Australia's Disability Strategy Implementation Report
- NDIS Rules related to the New Planning Framework
- Disability DRC bi-annual report.

Safeguarding adults

The Public Advocate plays a vital role in safeguarding adults with impaired decision-making capacity in South Australia. This includes providing individual advocacy for guardianship clients and undertaking systemic advocacy to improve laws, policies and services that support vulnerable adults.

To carry out this work effectively, the OPA works closely with a range of state and Commonwealth safeguarding agencies. These include:

- DHS ASU
- DHS Restrictive Practices Unit (RPU)
- DHS Exceptional Needs Unit (ENU)
- SAPOL Multi Agency Protection Service (MAPS)
- SAPOL Public Protection Branch
- the NDIA
- NDIS Quality and Safeguards Commission
- Aged Care Quality and Safety Commission.

The OPA shares information with state agencies in accordance with the Information Sharing Guidelines and Information Sharing Privacy Principles. It also maintains formal information-sharing arrangements through memoranda of understanding with the Department for Child Protection (DCP), the DHS RPU, the NDIA and the NDIS Quality and Safeguards Commission. The Public Advocate is also currently reviewing the existing Memorandum of Administrative Arrangement with the ASU following reforms to the *Ageing and Adult Safeguarding Act 1995* (SA).

Representatives from these agencies attend meetings such as the OPA Disability Forum and the Public Advocate Clients and Domestic Violence Working Group. OPA leadership staff also convene regular meetings with specific agencies to collaborate to support clients at an operational level.

Unmet **need**

Housing

Unmet need in housing

Housing and homelessness continue to be one of the most significant gaps for people with disability impacting their safety, welfare, and basic human rights.

Key issues include:

- Lack of supply and access to public and community housing.
- Over reliance on private rental and SIL.
- Lack of single tenancy SDA, particularly robust housing.
- Evictions and lease non-renewals in Public Housing.
- Lack of access to emergency accommodation and homelessness pathways.
- The need for a disability housing strategy and action plan.

Lack of supply and access to Public and Community Housing

The South Australian Housing Trust (SAHT) has approximately 33,000 public housing properties accommodating around 50,000 people across South Australia. There are around 13,000 households living in properties managed by community housing providers.

Only 6% of Public Advocate clients reside in public housing due to eligibility criteria. Increasingly, community housing providers are fulfilling the role of landlord for people with disability who require supported accommodation. Tenants generally pay 25% of their income in rent, with community housing tenants also eligible for Commonwealth Rent Assistance. However, housing supply has not kept pace with demand and many people are housed in the expensive private rental market.

Public Advocate clients, particularly younger people with psychosocial disability, are at risk of eviction and homelessness. Inadequate NDIS funding and supports, exclusion from voluntary community programs, or ineligibility for mental health services contribute to their inability to maintain public or community housing. Homelessness services may not meet their needs, and private rental housing is unaffordable for clients on income support.

Over reliance on private rental and Supported Independent Living (SIL)

The shortage of public and community housing, including Specialist Disability Accommodation (SDA), increasingly requires the Public Advocate to consent to 'closed' SIL arrangements to prevent Public Advocate clients from becoming homeless. In these arrangements, a SIL provider leases a property at market rent rates and then sublets to the client resulting in no separation of tenancy services from support services. This creates co-

dependency on the landlord for support services which is inconsistent with the recognised principle of separating landlord/tenancy services from support services. More than 200 clients are subject to closed SIL arrangements at any point in time.

While this model can provide an immediate housing solution, it often provides limited security and clients on disability pensions pay a full market rent. In this model Public Advocate clients are often not protected by the *Residential Tenancies Act 1995* (SA) and may lose both their housing and support services if the relationship with the provider breaks down. When relationships break down, clients can experience housing instability, transience and homelessness, often leading to costly outcomes such as hospital admissions, hotel accommodation, or extended stays in inpatient and correctional settings. These arrangements rarely reflect the client's preferences.

Despite longstanding OPA policy separating housing and support services, support providers continue to act as landlords, and clients with complex needs are often directed to SIL accommodation arrangements rather than being prioritised for social housing. As protected people of the state, Public Advocate clients should have access to social and community housing where they pay 25% of their income in rent (plus Commonwealth Rent Assistance in community housing). The growing reliance on expensive private rental arrangements highlights the urgent need for greater investment in social and community housing.

Lack of single tenancy Specialist Disability Accommodation (SDA)

SDA is designed for NDIS participants with extreme functional impairment or very high support needs. Properties must meet strict design standards, be assessed by an accredited assessor and registered with the NDIS Quality and Safeguards Commission to attract SDA funding.

While the NDIA estimates that around 6% of participants are eligible for SDA, OPA data shows that 27% (443) of Public Advocate clients who are NDIS participants have SDA funding in their NDIS Plan. Despite this, demand continues to outstrip supply of single occupancy robust SDA dwellings, which many clients require. Most SDA housing is shared accommodation, as it is more cost effective to house multiple tenants, however many clients require single occupancy accommodation.

OPA continues to work with SAHT, the Department of Human Services (DHS), and Access 2 Place (a Community Housing Provider) on an SDA project that will deliver bespoke housing for approximately 27 state clients (including 11 OPA clients) experiencing housing instability. During the year, land was purchased for 6 clients, construction commenced for 3 clients, and 2 additional clients were approved for a new SDA build in the future.

Evictions and lease non-renewals in public housing

Public Advocate clients living in public housing can be at increased risk of eviction due to issues such as neighbour complaints, behavioural matters, property maintenance, and other tenancy breaches. The South Australian Housing Trust's Good Neighbour Policy, introduced in September 2025, includes a three-strike warning system, conciliation processes, and behaviour agreements, with persistent breaches potentially leading to proceedings before SACAT. This can result in eviction and exclusion from public housing for up to 12 months. While eviction is intended as a last resort, displaced tenants are often referred to homelessness services which often cannot meet Public Advocate client's complex disability support needs.

Lack of access to emergency accommodation and homelessness pathways

Public Advocate clients often have limited housing options, as homelessness services are frequently at capacity and are not always equipped to support people with disability and other complex needs. The DHS is currently reviewing all commissioned homelessness services following recommendations from the 2024 Auditor-General Report. The current DHS Homelessness Outcomes Framework does not specifically address the needs of people with disability. It is hoped the review will identify opportunities to better support people with disability with complex needs, who are not currently recognised as a priority cohort within homelessness services. This reflects an assumption that their emergency accommodation and homelessness support needs are met through disability services and accommodation providers. The Public Advocate continues to advocate for a broader range of emergency housing options for clients and others who face similar barriers to accessing appropriate support.

The need for a disability housing strategy and action plan

South Australia needs a dedicated housing, homelessness and support strategy for people with complex disabilities. While the Homelessness Outcomes Framework, and the More Homes for South Australians Housing Road Map 2024 provide broad direction around housing and homelessness, they are led by different agencies and do not form a coordinated approach addressing the needs of this vulnerable cohort.

Although the Department for Housing and Urban Development (DHUD) is not an SDA provider, the state has an important leadership and support role in growing both community housing and SDA stock. The OPA has developed principles and model contracts to support engagement with SDA providers, but strategic leadership, planning and investment on a broader scale is required.

Public Advocate clients often struggle to access suitable housing and the supports needed to sustain tenancies. A consistent supply of specialised housing, including SDA for people with psychosocial disabilities or complex behaviours, is essential to avoid homelessness and placement in inappropriate settings. Inappropriate placement comes at great cost to a range of state agencies and compromises client wellbeing.

Illustrative case study (de-identified)

Michael is a 52-year-old Public Advocate client. He lives alone in South Australian public housing and has a psychosocial disability, cognitive impairment, and limited informal supports.

Over several months, SAHT received complaints from neighbours about loud arguments, frequent visitors, and damage to common areas. Michael struggled to understand his tenancy obligations and found it difficult to regulate his behaviour when distressed. Under the Good Neighbour Policy, he received written warnings and was required to participate in conciliation meetings and a behaviour agreement.

Despite some periods of improvement, further incidents occurred. Michael's support provider was unable to offer the intensive assistance he needed, and workforce shortages mean additional supports could not be arranged quickly. SAHT commenced proceedings in SACAT, which ultimately resulted in the termination of his tenancy.

Following eviction, Michael was referred to homelessness services. However, local crisis accommodation services were at capacity, and several advised they were unable to support someone with his level of behavioural complexity and support needs. The Public Advocate explored private rental options, but Michael's Disability Support Pension was insufficient to meet market rents, and landlords were reluctant to offer a lease due to his tenancy history and limited rental references.

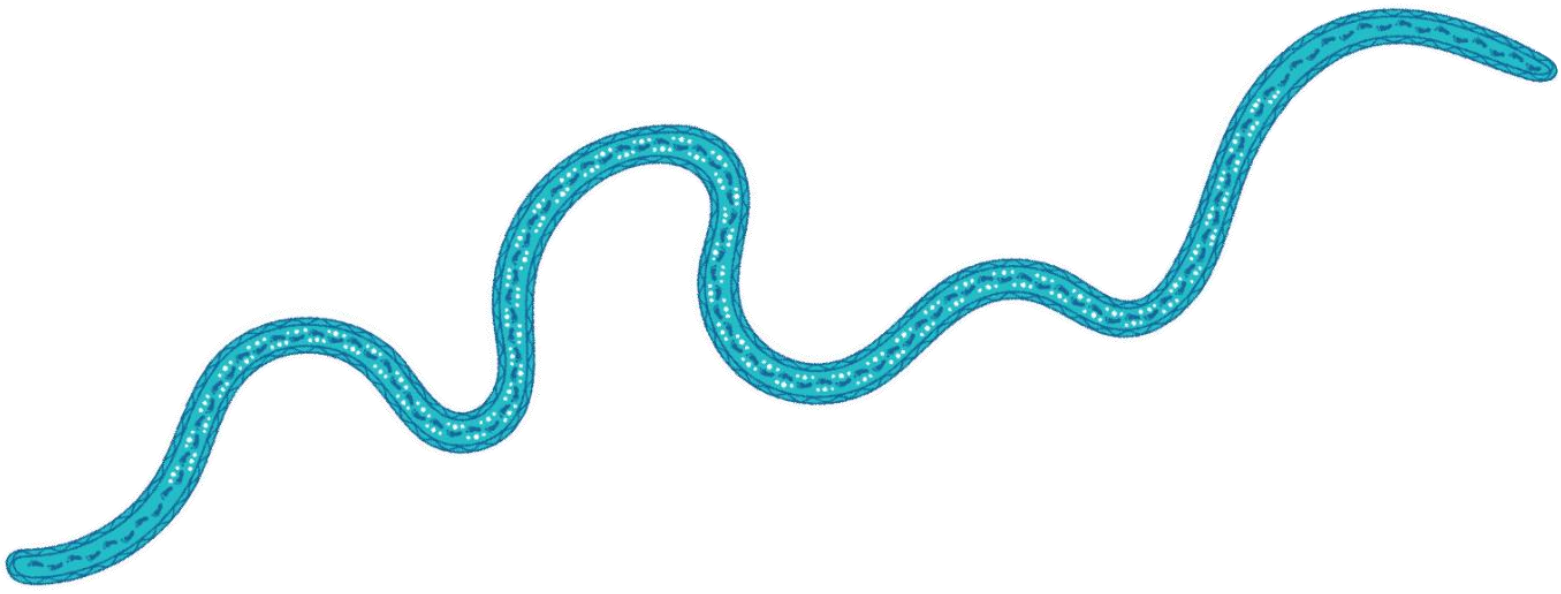
With no suitable housing available, Michael experienced periods of homelessness, alternating between emergency accommodation, short-term motel placements, and hospital presentations. His physical and mental health deteriorated, and his engagement with disability supports became increasingly unstable. What began as tenancy issues ultimately resulted in homelessness and a significant decline in his wellbeing.

Note: This is a de-identified example drawing on the experiences and circumstances of Public Advocate clients to illustrate the potential impacts of eviction on Public Advocate clients with complex support needs.

Addressing unmet need in housing

Priority actions identified by the Public Advocate to address gaps in housing.

1. Develop a State Disability Housing Strategy to:
    a) Expand the supply of social, community, and SDA housing.
    b) Strengthen policies to prevent evictions and lease non-renewals, reducing hospital admissions, homelessness, and reliance on unsuitable housing (e.g. hotels).
    c) Create a coordinated system to match housing supply with demand and support relocation for state clients at risk of eviction.
2. Increase the availability of housing and robust SDA accommodation, for people with disabilities, especially those with complex or psychosocial needs.
3. Support for community housing providers to grow the supply of SDA, with a focus on robust builds for clients with high support needs.
4. Prioritise access to community housing for NDIS participants who do not receive SDA funding.
5. Ensure tenancy agreements comply with the *Residential Tenancies Act 1995* (SA) to protect the rights and stability of tenants with disability.



Disability

Issues in disability services

The most pressing issues for people with disabilities who are NDIS participants continue to be:

- Interactions between the NDIA and Public Advocate clients.
- Changes to the NDIS.
- Timely review processes when NDIS plans are inadequately funded.
- Increasing incidents of fraudulent actions and behaviours of service providers.
- Sourcing support workers with appropriate skills and experience to support complex clients.
- State and NDIS funding for clients with safety and security needs.
- The lack of case management support.
- The lack of crisis responses and clear escalation pathways.
- The need for a service provider of last resort.

Interactions between the NDIA and Public Advocate clients

Over two-thirds of Public Advocate clients are NDIS participants.

As of 30 June 2026:

- 1753 clients (70%) had an NDIS plan: 1,516 clients under 65 years of age, and 237 clients over 65.
- 83 clients under 65 were not identified as NDIS participants, mostly because they were new clients of the Public Advocate. OPA staff investigate the circumstances of all clients under 65 who are not NDIS participants and ensure they gain access.

As at April 2026, the average annualised NDIS plan funding for Public Advocate clients[8] was $412,000, which is more than 350% higher than average annualised plan funding for all participants[9]. This reflects the significant complexity of support needs of Public Advocate clients and is also influenced by the strong advocacy undertaken by OPA staff to secure appropriate funding and supports.

In 2025-26, two significant developments strengthened OPA's ability to support clients who are NDIS participants:

1) Data-sharing arrangements between OPA and the NDIA.
2) Implementation of myID for staff identity verification.

A major milestone was achieved in July 2025 with the signing of the information-sharing schedule under the Memorandum of Understanding for Information Exchange between the National Disability Insurance Agency and State Government agencies. Development of

[8] funding data from OPA client plans as of 30 April 2026
[9] $90,600 as of 31 March 2026 – source: NDIS Quarterly Report, March 2026

the schedule began in 2019, making its completion a significant achievement. Following its implementation, OPA and the NDIA established processes for the secure exchange of data.

OPA has since received two quarters of data, providing an aggregate view of NDIS funding for Public Advocate clients. This information supports client safeguarding by helping ensure individuals receive appropriate funding and supports. The South Australian Public Advocate is the first public guardian in Australia to establish such an arrangement.

In early 2026, OPA successfully trialled the use of myID to verify staff identity when contacting the NDIA on behalf of Public Advocate clients. As myID becomes the Commonwealth Government's preferred identity verification system, its adoption has streamlined interactions with the NDIA and reduced administrative barriers. Following the successful trial, myID was rolled out across the organisation.

While these initiatives have significantly improved OPA's engagement with the NDIA, several challenges remain. These include delays in responses through the dedicated guardianship phone line, emails being sent from generic NDIA mailboxes without client names or NDIS numbers, which makes them difficult to identify and action, and administrative burdens associated with provider endorsements and paper-based correspondence.

Regular meetings with NDIA representatives and participation in stakeholder forums continue to play an important role in resolving urgent client issues and addressing broader systemic concerns.

Changes to the NDIS

The *National Disability Insurance Scheme Amendment (Getting the NDIS Back on Track No 1) Act 2024* (Cth) commenced on 3 October 2024 and aims to refocus the NDIS on its original purpose. The reforms are designed to clarify eligibility and funded supports, strengthen measures to address fraud, and update governance and administrative arrangements. Importantly, the definition of NDIS supports in section 10 of the NDIS Act replaced the former Applied Principles and Tables of Support.

On 14 May 2026 the National Disability Insurance Scheme Amendment (Securing the NDIS for Future Generations) Bill 2026 (Cth) was introduced. If passed in its current form, the Bill proposes changes including a 50% reduction in funding for Social, Civic and Community Participation (SCCP) supports and a 10% reduction in capacity-building funding for daily activities when plans are reassessed or renewed. These changes would have a significant impact on Public Advocate clients who rely on NDIS-funded supports, particularly to engage with their communities. Full implementation of these proposed reforms would reduce annual funding to Public Advocate clients by 9%, and up to 43% for the most impacted clients.

Other areas of concern include:

- Part 2: Unscheduled plan reassessments can only be requested by the participant, their nominee, or (for children) a guardian, and only in specified circumstances. It appears the Public Advocate would not be able to request plan reviews, since the Public Advocate is not the plan nominee (unlike private guardians who are likely to also be the nominee).
- Part 3: Funding is restricted to supports directly related to impairments that meet NDIS access requirements. This may see plan reductions where previous, funding has included disability related needs beyond that of the primary disability.
- Part 7: The NDIA may suspend a participant's plan and revoke access where reasonable attempts to contact the participant have been unsuccessful. This may impact Public Advocate clients who are unlikely to respond to communications from the NDIA and usually lack informal supports and are hard to engage.

While the Public Advocate supports measures to ensure the long-term sustainability of the NDIS, meaningful consultation with states and territories is essential to ensure that reforms do not place people with disability at increased risk of harm through unmet disability related support needs.

Some proposed reforms of the NDIS are welcome and have long been supported by the Public Advocate including:

- Broadening of registration to include SIL and platform providers.
- Potential consolidation of Support Coordination and Local Area Coordination.
- Support Coordination functions sitting outside of individual plans.
- Rationalising the plan management market.

Timely review processes when NDIS plans are inadequately funded

The NDIA is required under the *National Disability Insurance Scheme Act 2013* (Cth) (NDIS Act) to report on its performance against the Participant Service Guarantee. Despite this, delays in plan reviews continue to have a disproportionate impact on Public Advocate clients.

Delays were further exacerbated by an increase in review requests last year following changes to the definition of NDIS supports under s10 of the NDIS Act. There are also concerns that, if the National Disability Insurance Scheme Amendment (Securing the NDIS for Future Generations) Bill 2026 (Cth) passes without amendment, NDIS plans will be reduced and who can request a plan review will be restricted.

Reduced funding and diminished advocacy pathways risk leaving Public Advocate clients without safe and appropriate support arrangements, further disadvantaging them in an increasingly marketised disability system.

Applications for review lodged with the Commonwealth Administrative Review Tribunal (ART) can cause additional delays for reasonable and necessary funding decisions to be resolved.

Increasing incidents of fraudulent behaviour

Over the past 12 months, the Public Advocate has observed an increase in concerning, unethical, and potentially fraudulent practices by both registered and unregistered providers operating within the NDIS market. The Public Advocate is increasingly required to intervene where providers use assertive, coercive, or inappropriate practices, including financial incentives, to attract and retain people with disability who have significant funding in their NDIS plans.

The Public Advocate has reported a number of serious matters to the NDIS Quality and Safeguards Commission, including:

- Direct and assertive recruitment of vulnerable people with disability.
- Providers offering financial incentives or subsidies to influence service choice.
- Providers seeking appointment as guardians or administrators for the people they support.
- Providers refusing to facilitate a participant's transition to a different service provider after a decision has been made to change services.
- Providers isolating participants from family members and other support networks, reducing informal oversight and safeguards.
- Providers using tribunal and court processes to pursue outcomes that primarily advance their own interests.

The Public Advocate is increasingly required to take action to protect vulnerable people with disability from exploitation and misconduct within the NDIS market. While the NDIA and the NDIS Quality and Safeguards Commission respond to significant cases of fraud and non-compliance, much of the responsibility for identifying, reporting, and addressing poor provider conduct falls to guardians, family members, advocates, and other informal safeguards. This places a significant burden on individuals seeking to protect people with disability from unscrupulous providers operating in an increasingly complex market.

Sourcing support workers with skills and experience in supporting complex clients

Recruitment and retention challenges continue across the disability and aged care sectors, limiting providers' ability to deliver consistent and high-quality support. These challenges are particularly significant for people with complex needs, who require experienced and skilled workers. Historically, the sectors have been characterised by low pay, insecure employment arrangements and high levels of casualisation, contributing to workforce instability and high staff turnover.

The Disability Royal Commission (DRC) recognised these issues in Recommendation 10.8 of its final report, which proposed a national support worker registration scheme to support workforce development and professionalisation. The DRC noted that an effective registration scheme could help attract, develop and retain a skilled workforce.

In South Australia, measures have been introduced to improve workforce retention. From 1 October 2025, the Portable Long Service Leave Scheme was expanded to include the Community Services Sector Fund under the *Portable Long Service Leave Act 2024* (SA). This allows eligible workers to accrue long service leave across multiple employers within the sector, rather than being tied to a single employer.

As noted throughout this report, many Public Advocate clients present with highly complex needs, requiring skilled and appropriately trained workers to provide safe and effective support. Meeting this demand is increasingly difficult as the disability sector grows with unregistered sole traders creating additional challenges for oversight, quality assurance and safeguarding.

Some specialist support coordinators and support coordinators have limited experience in working with complex clients, addressing housing needs and preparing evidence for funding requests, plan reviews and reassessments.

Uncertainty about the future of support coordination and plan management, including proposals to replace these functions with the proposed NDIS navigator role, has also affected market confidence. As a result, some providers have withdrawn from the sector. This has been particularly evident in support coordination and specialist support coordination, where stagnant pricing and policy uncertainty have contributed to the loss of experienced practitioners and reduced support options for participants, especially those with complex needs.

NDIS funding for clients with safety and security needs

While the new definition of NDIS supports in section 10 of the NDIS Act intends to provide greater clarity about what the NDIS will and will not fund, uncertainty remains for participants involved in the justice and forensic mental health system.

The NDIS does not fund supervision or monitoring to prevent offending behaviour, supports required to comply with justice system conditions, day to day care and in-reach support while a person is in custody, pre-sentence psychological or psychiatric reports, or secure accommodation intended to protect the community or prevent reoffending.

As the NDIS does not fund custodial supports, delays can occur in collating evidence and completing risk assessments needed to support release from custody. Disputes often arise over whether support needs are disability-related or related to offending behaviour. Court ordered supervision requirements may also exceed available NDIS funding, and community safety supports have no clear funding source. Consequently, people with disability can remain in custody or a forensic mental health service longer than necessary because appropriate community supports cannot be secured.

Lack of case management support

Public Advocate clients need case management support to coordinate NDIS and other services and supports. Some clients may also require more assertive case management to help them engage with services. The Public Advocate has consistently advocated for funding of support coordination for clients, which is the closest role in the NDIS to case management. However, support coordination has always been an inadequate substitute for comprehensive case management, as it is limited by both the funding availability in the participants plan, the duration of the plan and the availability after business hours. The Public Advocate, therefore, continues to advocate for a case management model that operates independently of NDIS plan funding.

If the National Disability Insurance Scheme Amendment (Securing the NDIS for Future Generations) Bill 2026 (Cth) passes in its current form, proposed reductions to community participant and capacity building budgets from 1 October 2026 would reduce funding streams that include support coordination. While a new support coordination and connection service is proposed to sit outside participant budgets, it is not scheduled to commence until 1 July 2028. This will likely create a significant gap between the reduction of existing support coordination funding and the commencement of the replacement service. The OPA is already affected by misunderstandings about the role of its staff, whose decision-making authority is limited by SACAT orders and the *Guardianship and Administration Act 1993* (SA) (GAA). As a result, OPA staff are frequently expected to fill case management and clinical coordination gaps that fall outside the statutory role of the Public Advocate.

Lack of crisis responses and clear escalation pathways

Crisis responses were not initially built into the design of the NDIS, as reflected in the lengthy timeframes set out in the NDIS Participant Service Guarantee. The NDIA later established the NDIS After Hours Crisis Referral service, which can only be accessed through approved referrers, including ambulance, public hospitals, police, acute mental health services and state justice officers. The Public Advocate has successfully negotiated for OPA SA to be a recognised approved referrer.

The OPA also uses several other escalation pathways including Critical Services Issues Response, the Exceptionally Complex Support Needs program, and a dedicated guardianship phone line. However, these avenues rarely provide same day crisis support.

When timely Commonwealth support is unavailable, responsibility often shifts to the state where crisis responses are limited and frequently rely on unsuitable alternatives such as hospitals or hotels.

While the OPA has developed strong working relationships with the NDIA's National Service Delivery Team in South Australia, resulting in more timely outcomes for clients, there remains an urgent need for a dedicated and responsive crisis pathway. This is particularly important for temporary and emergency accommodation, including consideration of a provider of last resort.

The need for a service provider of last resort

The DRC Final Report recommendation 10.10 is for a provider of last resort scheme to address market failure and safeguard people with disability who are excluded from services and have no other support options.

The NDIS has created a largely market-based system in which providers can choose who they support. While the NDIS Quality and Safeguards Commission regulates providers, fewer than 10% are registered. Unregistered providers are only required to comply with the NDIS Code of Conduct, limiting the commission's regulatory powers. The DRC also highlighted concerns about provider registration and made recommendations to strengthen safeguards in the disability sector.

Public Advocate clients are particularly vulnerable to service failure due to the complexity of their support needs. Providers can withdraw services with little notice, leaving individuals homeless or without essential supports. This can lead to hospitalisation to keep them safe as an interim measure, as securing replacement services quickly is difficult. In these cases, the OPA may contact the NDIS Commission who can require a provider to continue supporting a participant until an alternative arrangement is found. However, providers may lack the workforce capacity to do so, resulting in costly and restrictive outcomes that are rarely consistent with the person's wishes and preferences.

The National Disability Insurance Scheme Amendment (Securing the NDIS for Future Generations) Bill 2026 (Cth) proposes expanding registration requirements from 1 July 2026 to include supported independent living and platform providers. While it is a welcome reform, it does not include all NDIS service providers. Further, registration alone may not prevent providers from withdrawing services or excluding participants, and quality control and compliance is required by the NDIS Commission. A provider of last resort remains an important safeguard for people with disability who are at risk of losing essential services.

Illustrative case study (de-identified)

Sarah is a Public Advocate client and NDIS participant with an intellectual disability, autism, and complex behaviours. She is funded for SIL and relies on a highly skilled support team to manage her daily needs, maintain her tenancy, and prevent crises.

Following an NDIS plan reassessment, Sarah received a reduced plan that does not adequately reflect the intensity of her support needs. As a result, her support hours were reduced, and some specialist supports were no longer funded. Although her provider has extensive experience supporting people with complex needs, it struggled to recruit and retain suitably qualified staff. Staffing shortages led to inconsistent support, increased behavioural incidents, and a deterioration in Sarah's wellbeing.

As funding was exhausted before the end of the funding period, the provider advised it could not continue delivering the required level of support. With no alternative supports available and concerns for Sarah's safety, she was admitted to hospital despite having no acute medical need. Sarah remained in hospital as a social admission until her funding period was reset and support arrangements were reinstated.

The extended hospital stay was distressing for Sarah, limited her independence, and placed additional pressure on the health system.

Note: This is a de-identified example drawing on the experiences and circumstances of Public Advocate clients to illustrate the potential impacts of NDIS funding reduction on Public Advocate clients with complex support needs.

Addressing unmet need in the disability sector

Strategies identified by the Public Advocate to address unmet need in the disability sector.

1. Better regulation and accountability of NDIS providers via the NDIS Quality and Safeguards Commission and other regulatory bodies.
2. The introduction of comprehensive case management in the NDIS for participants, which is not time or funding limited.
3. Establishment of a provider of last resort to address the current market failure for highly vulnerable and at-risk adults with impaired decision-making ability.
4. Establishment of responsive crisis pathways and gateway services to safeguard vulnerable clients who are in urgent need of crisis, temporary and immediate accommodation (including after business hours).
5. Greater supply of suitably trained providers and support specialists, who are experienced in the care and support needs of vulnerable adults with impaired decision-making ability, and who present with complex needs including dual diagnosis, psychosocial disabilities, and challenging behaviours.

Mental Health

Issues in mental health

Access to mental health and forensic mental health services for Public Advocate clients is a particular area of concern.

Issues include:

- Eligibility and access to mental health services for people with cognitive disabilities.
- The capacity of the SA Intellectual Disability Health Services (SAIDHS).
- The need for a specialist forensic disability service.
- James Nash House (JNH) and Tarnanthi Sub-Acute Forensic Service.
- NDIS issues and gaps in funding for safety and security.
- Voluntary modes of engagement.
- Referral processes and mental health care for clients with borderline personality disorder.
- Overuse of South Australian Ambulance Service (SAAS) in the absence of appropriate support responses.
- The need for a trauma informed step-down service.

Eligibility and access to mental health services for people with cognitive disabilities

Mental health care can be delayed or difficult to access for people with cognitive disabilities. People with intellectual disability (ID), autism spectrum disorder (ASD), borderline personality disorder (BPD), or complex trauma, face disadvantage when the mental illness presentation is misattributed to the person's disability. This is recognised as diagnostic overshadowing resulting in missed opportunities for timely assessment, treatment and support for their mental health condition.

Access to Community Mental Health Services (CMHS) can also be limited by eligibility criteria that prioritise a primary mental health diagnosis. People with ID are often considered ineligible for mental health services. As a result, people with co-occurring ID, Acquired Brain Injury (ABI) or substance use issues may be excluded from services despite having significant mental health needs. CMHS will often close files due to difficulties with client engagement, often disadvantaging Public Advocate clients who may have long histories of non-engagement with services due to several factors. This occurs in circumstances where the Public Advocate has given consent for engagement of services as a substitute decision maker, but CMHS do not assertively engage in these situations.

While amendments to the NDIS Act clarify what is and is not an NDIS support, overlap between disability and mental health needs continues to create uncertainty about funding and service responsibility. This can leave individuals caught between state funded mental health services and the NDIS, with neither system taking clear responsibility for meeting

their needs. This disproportionately affects Public Advocate clients who are young, socially mobile and have complex presentations, and often interact with the justice system.

These gaps often result in poor discharge planning, repeated crisis presentations, and ongoing reliance on emergency departments, inpatient units and custodial settings rather than coordinated, preventative support.

Addressing these challenges requires stronger collaboration between the NDIS and state mental health systems, clearer accountability for service provision, and more flexible, person-centred models of care for people with cognitive disabilities and complex mental health needs. It also requires acceptance of the Public Advocate's consent for services even when the client is uncooperative. An assertive mental health service approach is required in these circumstances. Improving diagnostic accuracy through specialised assessment and multidisciplinary approaches is also critical to reducing diagnostic overshadowing and improving outcomes.

South Australian Intellectual Disability Health Services (SAIDHS)

There is a need to increase the capacity of the SAIDHS to better meet the urgent and complex needs of people with disability.

The SAIDHS provides general health and mental health services for adults with ID and complex needs, including ASD, mental illness, and behavioural challenges. However, the service does not currently provide emergency or crisis support, ongoing psychiatric care or assessments.

Demand for the service exceeds current capacity, resulting in long wait times and limited availability for urgent referrals. This can lead to delays in critical assessments and medication reviews, negatively impacting outcomes for clients. In the absence of appropriate crisis intervention options, individuals often rely on emergency departments, SAAS and SAPOL, which may not be best equipped to respond to their complex needs.

Expanding the capacity of SAIDHS to respond to urgent presentations would help ensure timely support for high-priority cases and complement the existing memorandum of understanding between OPA and SAIDHS.

The need for a specialist forensic disability service

A specialist, community based forensic disability service and an increase in forensic mental health beds and community forensic service capacity is urgently needed. The current forensic mental health system is designed to support people with psychiatric conditions and does not adequately meet the needs of individuals with cognitive disability who are involved in the criminal justice system.

Limited forensic mental health beds and capacity means some forensic patients are detained in prison under Ministerial direction (s269V(2), *Criminal Law Consolidation Act 1935*

(SA)). Prisons are not equipped to meet the complex clinical, behavioural and disability support needs of these individuals.

The shortage of appropriate beds and accommodation results in clients cycling between prison, hospital and community settings without consistent, long-term support, leading to poor outcomes for individuals and inefficiencies across the health, disability and justice systems.

Dedicated state funding is needed to support forensic clients to live safely and securely in the community. While many Public Advocate clients are NDIS participants, section 10 of the NDIS Act clearly sets out which supports the NDIS will fund and which remain the responsibility of other service systems. Disagreement about whether a person's behaviours are disability-related or criminogenic can delay release from forensic settings. Where ongoing supervision is required to manage criminogenic behaviour and community safety risks, this support is not funded by the NDIS because it is not considered a disability support. In the absence of dedicated state funding, these clients can remain detained longer than necessary.

NDIS funding generally ceases while a person is detained in a forensic mental health facility, with state agencies responsible for meeting these costs. Following release, clients are often placed in under-resourced disability accommodation staffed by workers who may not have the specialist skills required to support people with forensic needs. This increases the risk of behavioural escalation, service breakdowns, and placement failure.

Disability-specific settings, such as Supported Independent Living (SIL) arrangements, are often not suitable for forensic clients because disability support workers are not typically trained to manage the additional risks and complexities associated with forensic disability. Dedicated housing and secure, specialist accommodation options are needed to meet these clients' support and community safety requirements. Without appropriate alternatives, avoidable crises, and service failures place increasing pressure on state-funded systems and services.

James Nash House and Tarnanthi Sub-Acute Forensic Service

The Public Advocate continues to advocate for improvements to JNH and the Tarnanthi Sub-Acute Forensic Service. JNH, South Australia's secure forensic mental health facility, is custodial in design and lacks the therapeutic environment needed to support recovery and rehabilitation, particularly for people with disability. Similarly, the Tarnanthi Sub-Acute Service at Glenside is a ward-based setting with limited space and is not suitable for long-term accommodation and support and many clients spend lengthy periods of time at Tarnanthi. A dedicated forensic disability services in a community residential setting would address these issues.

JNH remains subject to conditions imposed by the Chief Psychiatrist through a gazettal notice issued on 4 July 2024. While originally intended as an interim measure to support the safety of patients, visitors and staff, the notice has since been extended until 2027. The conditions reflect ongoing concerns about infrastructure, security, safety and operational

capacity within forensic mental health services, particularly at JNH, and reinforce the urgency of planned upgrades, replacement works and service relocation.

Key infrastructure issues include:

- JNH requires urgent refurbishment or replacement. The condition of the facility is affecting clinicians' ability to provide safe, effective and therapeutic care.
- Tarnanthi Sub-Acute Forensic Service, which supports people with disability, requires relocation from the Glenside campus. This location for this service was intended to be temporary. Appropriate long-term, community-based residential accommodation is needed to meet patients' ongoing needs.

The Public Advocate and the Principal Community Visitor have raised these concerns in previous annual reports; however, they remain unresolved.

NDIS issues and gaps in funding for safety and security

Public Advocate clients who are NDIS participants in forensic mental health settings face many of the same challenges as those in the justice system, including funding gaps, inadequate supports, and uncertainty about funding responsibilities. Despite being on the NDIS Exceptionally Complex Support Needs pathway, people with diagnoses such as borderline personality disorder (BPD), Post Traumatic Stress Disorder (PTSD), autism spectrum disorder (ASD), or forensic related behavioural needs often receive insufficient funding and support ratios that do not reflect clinical recommendations. Ongoing uncertainty about whether needs are disability-related or attributable to forensic or mental health status continues to create funding disputes. Role clarification and responsibilities for funding is required in relation to NDIS and state mental health services.

The introduction of s10 of the NDIS Act intends to clarify what is, and is not, an NDIS support. While mental health related supports such as clinical treatment, pharmaceuticals, addiction services, hospital-based care, clinical rehabilitation, and residential treatment are now clearly excluded from NDIS funding, ambiguity remains due to fragmented responsibilities across disability, health, mental health, and justice systems.

There is also concern about foundational support reforms. Although initially focused on children through the Thriving Kids approach, people with psychosocial disability have also been identified as a cohort that will transition from the NDIS to state-funded foundational supports. Combined with proposed changes in the National Disability Insurance Scheme Amendment (Securing the NDIS for Future Generations) Bill 2026 (Cth) which would reduce funding for Social, Civic and Community Participation (SCCP) supports, and capacity building supports, there are concerns that clients may lose access to the support needed to sustain stable community living.

People with psychosocial disability were slower to enter the NDIS, reflecting the fluctuating nature of their disability, the historical location of mental health services within the health system rather than the disability sector, as well as previous reliance on block funded

community programs. It appears that this cohort may not be supported by the NDIS in the future.

As in custodial settings, NDIS funding generally ceases during detention in a forensic mental health facility, with state agencies responsible for these costs. Following discharge, individuals are often placed in under-funded accommodation with disability support workers, rather than mental health workers. This can lead to behavioural escalation, service breakdowns, and avoidable hospital presentations and admissions, increasing pressure and costs across state funded systems.

Voluntary engagement with community mental health services

Community Mental Health Services (CMHS) are largely based on voluntary engagement, which can unintentionally exclude Public Advocate clients who experience mental illness alongside other complexities. These models often assume that a person can provide consent and actively participate in their treatment, which is not always possible for this cohort.

When clients miss appointments or appear disengaged, CMHS may close their case. However, for people with impaired decision-making capacity, disengagement is often a symptom of their condition rather than a lack of need. These clients are more likely to benefit from assertive outreach, trauma informed practice and flexible service delivery that actively supports ongoing engagement.

Without early intervention and sustained community-based support, many clients deteriorate to the point where involuntary measures, such as Community Treatment Orders, become necessary to ensure they receive treatment. This reactive approach misses opportunities for earlier, more person-centred care and can contribute to poorer outcomes.

Although the Public Advocate may have legal authority to make healthcare decisions on behalf of a person under guardianship, some services are reluctant to rely on guardian consent and continue to require voluntary engagement from the person. This can create barriers to accessing timely mental health care.

A more inclusive mental health service model is needed, supported by clear protocols and staff training that:

- Recognises ambivalence, fear and avoidance as clinical indicators rather than non-compliance.
- Accepts guardian consent for service engagement where appropriate under guardianship orders.
- Uses assertive outreach and trauma informed, flexible approaches to engagement.
- Includes regular assessments of decision-making capacity and supports individuals to participate in decisions wherever possible.

Without reforms to engagement practices, mental health services will continue to be most accessible to those who can navigate complex systems independently, leaving some of the most vulnerable people without the support they need.

Referral process and mental healthcare for clients with borderline personality disorder

Clients with BPD often present with complex and high support needs that require coordinated, multi-agency responses. Access to specialist BPD services in South Australia remains limited, with the BPD Collaborative currently the only dedicated service. However, referral pathways are complex, as access requires active engagement with CMHS, despite BPD alone often not meeting CMHS eligibility criteria. This creates barriers and delays in accessing appropriate care for a highly vulnerable cohort. Improved referral pathways and greater service integration are needed to support timely access to specialist services and improve outcomes for people living with BPD.

Overuse of South Australian Ambulance Service (SAAS) in the absence of appropriate support responses

Adults with disability make up a substantial proportion of SAAS's most frequent callers, with common presentations including BPD, ASD, ID, self-harm, PTSD and trauma-related conditions.

This disproportionate representation highlights a lack of accessible specialist services and coordinated community responses resulting in repeated ambulance callouts and emergency department presentations which are often driven by gaps in disability, mental health, behavioural support and care coordination services rather than acute medical needs.

Frequent reliance on ambulance and hospital services reflects the broader systemic failure in service integration and access to community-based supports, specialist mental health care and disability services.

Collaboration between the OPA and SAAS has improved identification of high use clients, information sharing and the development of individual response plans. Strengthening specialist BPD services, trauma informed care and cross agency coordination is critical to reducing preventable crisis presentations and improving long-term outcomes.

The proposed SAAS and Southern Adelaide Local Health Network (SALHN) CARE Ability pilot offers a promising model for coordinated, multidisciplinary support, with potential to reduce avoidable emergency service use and improve person-centred care for people with complex needs.

The need for a trauma-informed step-down service

At any given time, 15–20 Public Advocate clients present with extremely complex needs and are at high risk of exploitation, abuse and repeated crisis. Many have co-occurring

conditions such as ASD, BPD and Complex Post-Traumatic Stress Disorder, and may engage in self-harm or experience suicidal ideation.

These clients frequently interact with SAAS, hospitals and SAPOL, often receiving responses that address only their immediate needs. As a result, they continue to cycle between crisis, emergency, health and justice systems without access to the longer-term support required to achieve stability. While this is a relatively small cohort, their complex needs place significant demand on emergency and hospital services.

A trauma-informed step-down service would help break this cycle by providing a structured therapeutic response focused on recovery, stabilisation and maintaining suitable accommodation and avoid hospitalisation. The service would include therapeutic support, outreach clinical services and wrap around, person-centred care tailored to people with complex trauma and support needs. This approach would reduce reliance on emergency departments, inpatient units and custodial settings, while supporting better long-term outcomes.

The Public Advocate has previously advocated for the establishment of a trauma-informed step-down service in both the Mental Health and Clients of the Public Advocate report (2025) and the Domestic, Family Violence and Exploitation – Findings of the Public Advocate report (2023).

Illustrative case study (de-identified)

John is a 42-year-old Public Advocate client with schizophrenia, an Acquired Brain Injury (ABI), and complex support needs. He is an NDIS participant and lives in supported accommodation. While CMHS are available to support him in the community, engagement with these services is voluntary. John has limited insight into his mental illness and is often reluctant to engage with clinicians or participate in treatment.

Over time, John disengaged from CMHS, stopped taking prescribed medication, and withdrew from other supports. As his mental health deteriorated, concerns grew about his safety and wellbeing. Despite repeated attempts by clinicians and support providers to encourage his engagement, John continued to decline treatment. His condition eventually deteriorated to the point where an Inpatient Treatment Order (ITO) was required and he was admitted to a mental health unit.

As John stabilised in hospital, clinicians determined that he was not yet ready to return directly to the community. He would benefit from a step-down service that could provide structured psychosocial support, assist him to rebuild daily living skills, and support his gradual re-engagement with community-based treatment and disability services. However, no such service exists. As a result, discharge planning relied on a return to community supports that were not designed to provide this level of transitional care.

At the same time, disagreements arose about which supports should be funded by the NDIS and which are the responsibility of the health system. Delays in recommencing NDIS funded supports and securing appropriate service providers further complicated discharge planning.

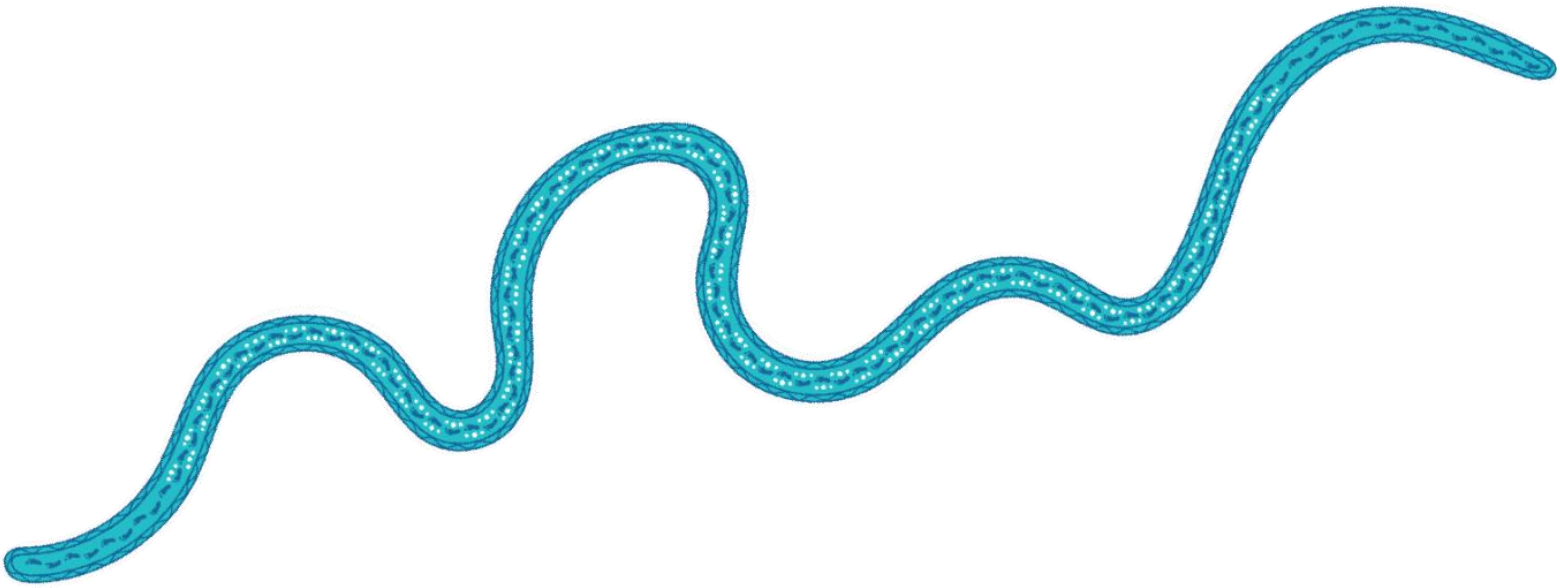
Although John was clinically ready to leave hospital, the absence of step-down services, unresolved funding responsibilities, and delays in reinstating disability supports meant he remained in hospital longer than necessary. His situation highlights how the voluntary nature of CMHS, the lack of transitional step-down options, and gaps between the mental health and disability systems can contribute to avoidable mental health crises and prolonged hospital stays.

Note: This is a de-identified example drawing on the experiences and circumstances of Public Advocate clients to illustrate the potential impacts on Public Advocate clients with complex support needs.

Addressing unmet need in the mental health sector

Priority actions identified by the Public Advocate to address gaps in support for **people with mental health conditions**.

1. Develop new models of mental health care that are inclusive of individuals with cognitive disabilities and complex behaviours.
2. Expand the SAIDHS to meet the growing demand for mental health services for individuals with cognitive disabilities and complex comorbidities, including crisis situations.
3. Upgrade or replace James Nash House with increased capacity.
4. Develop a specialised forensic disability service which is residential, and community based for individuals with cognitive impairment to replace the Tarnanthi Sub-Acute Service.
5. Establish an inclusive and assertive model of engagement that qualifies Public Advocate clients as voluntary patients of mental health services when consent is provided by the Public Advocate.
6. Establish a trauma-informed step-down service for individuals with complex trauma and complex diagnoses, who repeatedly present at hospital emergency services and repeatedly demand emergency service responses from SAPOL and SAAS.



Aged care

Issues in aged care

Key issues for Public Advocate clients in aged care include:

- Hospital discharge
- Increased guardianship appointments
- Accessing MAC
- Support at Home Packages
- Residential Aged Care placement
- Use and authorisation of restrictive practices.

Hospital Discharge

A high number of older Public Advocate clients in hospital are medically fit but cannot safely return home due to shortages of Support at Home packages and the inadequate supply of suitable aged care placements. It is not only a capacity issue but also a system coordination failure between health, My Aged Care (MAC) and providers. While the DHW, Central Adelaide Local Health Network (CALHN) has introduced step-down and transitional care models, including Care of the Older Person and Community Transition Service (CO-ACT) at Hampstead Rehabilitation Centre, the Transition Care Service at the Pullman Adelaide, and College Grove, demand continues to exceed capacity with many older adults still awaiting support through MAC. While step-down programs are a positive move, they do not resolve the underlying shortage of ongoing support and aged care beds.

The South Australian Government has responded with legislative reforms. The *Guardianship and Administration (Tribunal Proceedings) Amendment Act 2025 (SA)* is intended to streamline SACAT processes, while the *Statutes Amendment (Health and Wellbeing) Act 2025* (SA) facilitates the transfer of patients from public hospitals to residential aged care facilities where detention authorisation is required. While these measures may improve patient flow, they do not address the underlying issue that Commonwealth-funded aged care systems are often too overwhelmed to respond. In addition, there is insufficient supply of aged care placements, and some providers are reluctant to accept clients with complex or challenging behaviours.

At the end of 2025-26, Public Advocate clients occupied 34 hospital beds across South Australia due to unmet discharge accommodation needs. A further 23 transitional care beds were similarly occupied, including under the Care of the Older Person and Community Transition (CO-ACT) and Care Awaiting Placement South (CAPS) programs.

Increase in guardianship appointments

The demand for Public Advocate appointments is driven by both an ageing population, and system pressures, notably faster discharge expectations requiring decision-makers. The Public Advocate is often appointed to support timely decision-making for older people in hospital who have impaired decision-making.

Family conflict about the care of older South Australians has also contributed to a rise in Public Advocate appointments. This reflects more complex family structures and an ageing population. The Public Advocate encourages families and services to identify a "person responsible" under s14(1)(a) of the Consent Act to assist with decision-making. The Public Advocate can mediate disputes under this Act with the objective to avoid public guardianship.

Reforms to the GAA introducing a mediation and dispute resolution function, like those in the Consent Act and the ACD Act, could help families resolve disputes and, where a suitable family member is available, reduce the need for public guardianship.

Accessing My Aged Care

Although the role of a guardian is now recognised under s28 of the new *Aged Care Act 2024* (Cth), this has not flowed through to Commonwealth systems resulting in challenges in verifying OPA staff identity when acting on behalf of a client. This makes it difficult to advocate for Public Advocate clients with MAC. Public Advocate staff are not able to be registered as supporters in MAC. Delays in identity verification has flow-on effects such as delaying access to essential services needed to support hospital discharge, residential aged care placement, or admission avoidance. The OPA is currently trialling MyID for verification of identity with the NDIA. This approach makes it easier for Public Advocate staff to speak to the NDIA, and a similar approach with MAC would assist OPA staff advocating for aged clients.

Support at Home Packages

In 2021, the Aged Care Quality and Safety Commission's Royal Commission Recommendation 39 called for an immediate increase in home care packages. Despite this, Public Advocate clients continue to experience delays in aged care assessments, assessment outcomes and access to Support at Home funding. These delays can result in clients remaining in hospital longer than necessary or being placed prematurely in residential aged care, contrary to their wishes, making it more difficult to uphold the principles set out in section 5 of the GAA.

Residential Aged Care Placement

The shortage of suitable residential aged care placements often results in Public Advocate clients remaining in hospital unnecessarily. While the DHW has introduced transitional care models and legislative reforms have occurred to support timely decision-making and discharge, access to appropriate residential aged care remains a significant barrier.

Public Advocate clients frequently have complex needs and are more likely to be concessional residents who cannot pay a Refundable Accommodation Deposit placing them at a disadvantage in a competitive aged care market. Public Advocate clients are also unlikely to be able to afford the Higher Everyday Living Fee, which provides access to enhanced everyday living services such as upgraded dining options, digital and technology services, and other services.

This reluctance to accept people with complex needs, including those with cognitive disability, mental illness, dementia, culturally and linguistically diverse backgrounds, or family conflict can make securing a placement difficult. The Public Advocate must also comply with the GAA, including considering the client's past and present wishes.

Historically, respite placements often led to permanent care arrangements. This is now less common, contributing to repeated hospital admissions and urgent searches for alternative placements. The OPA works closely with the DHW to facilitate timely and appropriate aged care placements where possible.

Use and authorisation of restrictive practices

In South Australia, SACAT may appoint the Public Advocate or a private guardian to consent to restrictive practices in aged care. Where no guardianship order is in place, consent has generally been sought in accordance with the decision-making hierarchy under the Consent Act.

The *Aged Care Act 2024* (Cth) provides temporary provisions to establish a hierarchy for consent to restrictive practices in states and territories without a specific legislative framework. These provisions allow a Restrictive Practices Substitute Decision-Maker to consent to restrictive practices where the older person lacks decision making capacity, and no Tribunal appointed substitute decision-maker exists. The provisions are temporary and expected to cease on 1 December 2026. By this time states and territories are required to have established their own legislative framework.

When considering consent to restrictive practices, the Public Advocate must balance the principles set out in section 5 of the Guardianship and Administration Act, including respect for the person's wishes and preferences, with the need to protect them from harm. The Public Advocate supports the reduction and, where possible, the elimination of restrictive practices. Where the use is necessary, consent will only be provided when there is an appropriate behaviour support plan in place that includes regular review and a strategy to reduce and ultimately eliminate the restrictive practice. While the aged care legislation

refers to consent of restrictive practices, the Public Advocate considers authorisation to be a more appropriate reference.

The Public Advocate supports a restrictive practices authorisation process like the model used to authorise the use of restrictive practices for NDIS participants under the *Disability Inclusion Act 2018* (SA). In this model, restrictive practices are authorised by the Senior Authorising Officer in the DHS Restrictive Practices Unit (RPU). The scheme does not extend to 'detention orders', which SACAT continues to authorise under the GAA. Although the Public Advocate no longer authorises these restrictive practices in the disability sector, the office is consulted on their use and can seek reviews of decisions made by NDIS providers and the Senior Authorising Officer. This arrangement sees the consent for restrictive practices removed from the Public Advocate and overseen by an independent external practitioner who has expertise in restrictive practices. This is currently not in place for aged care clients and would be an efficiency and provide quality oversight, if introduced.

Historically, SACAT authorises the detention of people in Residential Aged Care (RAC). The recent commencement of the *Statutes Amendment (Health and Wellbeing) Act 2025* (SA) gives substitute decision-makers under an Advance Care Directive (ACD) and guardians, including the Public Advocate, the power to decide that a person must reside in a residential aged care facility upon discharge from an incorporated public hospital. They can authorise detention at the facility and for the purposes of transporting the person between the hospital and the residential aged care facility (RACF).

These powers only apply when the person is "an inpatient at an incorporated hospital" and they are to be discharged directly to a specified RACF.

Residential aged care facilities require education about consent requirements for restrictive practices, particularly chemical restraint. The OPA is often asked to consent to a psychotropic medication prescribed for a diagnosed mental health condition. However, when medication is used to treat a mental illness, not to manage behaviours of concern, there is ambiguity as to whether it is a restrictive practice.

The Public Advocate continues to provide consent for restrictive practices in RACFs, in consultation with care providers and general practitioners. However, without a central authorising body, it remains difficult to track the type and extent of restrictive practices in use. Ultimately, the DHS RPU would be the logical authorising body, including for restrictive practices in RACFs. This would support consistency, expertise, education and a coordinated approach to minimisation of restrictive practices in aged care.

Illustrative case study (de-identified)

Margaret is an 84-year-old woman who lives alone in her own home. Following a fall, she was admitted to hospital with a fractured wrist and dehydration. During her admission, clinicians identified that she has significant memory impairment and is no longer able to safely manage medications, meals, personal care, or decisions about her accommodation and support needs.

Margaret had no family able to assist her. The hospital applied to SACAT, which appointed the Public Advocate as her substitute decision-maker.

Although Margaret recovered from her injuries and was medically stable, she was assessed as unsafe to return home. The Public Advocate agreed that residential aged care was the most appropriate option and applications were lodged for placement. However, Margaret required a memory support unit due to her cognitive impairment and risk of wandering. Such placements were in short supply.

Over several months, only a limited number of placements became available, most of them located a significant distance from her local area. The Public Advocate sought a placement that could meet Margaret's care needs while maintaining her connection to her local community. As a result, Margaret remained in hospital long after she no longer required acute medical care.

The prolonged hospital stay contributed to a decline in her mobility, independence, and quality of life, while also occupying a hospital bed that could otherwise be used for patients requiring acute treatment. Her situation highlights the impact of shortages in residential aged care placements, particularly memory support units, for older people who are medically stable but unable to return home safely.

Note: This is a de-identified example drawing on the experiences and circumstances of Public Advocate clients to illustrate the potential impacts on Public Advocate clients with complex support needs

Addressing unmet need in the aged care sector

Strategies identified by the Public Advocate to address unmet need in the aged care sector.

1. Increase the number of concessional funded RACF beds.
2. Increase the number of Support at Home packages and implement Recommendation 39 of the Aged Care Royal Commission, to ensure timely access to home care packages.
3. Expand the number of RACFs equipped to support complex clients, including mental health conditions and address the non-acceptance of clients with minimal assets and complex needs by RACFs.
4. Align regulatory frameworks for restrictive practices across aged care and NDIS services.
5. The Commonwealth Government introduce a senior practitioner to authorise restrictive practices in aged care, like the disability sector. Alternatively, the state expand the DHS RPU to include authorisation of restrictive practices in the aged care facility sector.

Innovating

OPA initiatives and projects

My Life My Wishes and Supported Decision-making in practice for Public Advocate clients

Supported decision-making involves helping a person understand information, consider the potential consequences of their choices, and make their own decisions wherever possible.

While the Public Advocate is appointed as a substitute decision-maker under the *Guardianship and Administration Act 1993* (SA) (GAA), OPA staff apply the s5 principles of the Act and supported decision-making principles in practices whenever possible. This includes supporting people to exercise autonomy and participate in decisions affecting their lives by documenting their wishes, values and support needs.

Since 2023, the OPA has used the My Life My Wishes (MLMW) tool to record clients' preferences and important personal information. Although the tool does not replace consultation with the person when decisions are required, it helps capture:

- Wishes and preferences across all areas of life, including end-of-life care.
- Personal history, values and beliefs that assist guardians to understand the person.
- Communication methods and other supports the person may need to participate in decision-making.

Wishes and information have been recorded through the MLMW tool for 53% (1,555) of guardianship clients who were assisted during 2025-26.

Evaluation of the My Life My Wishes tool

Since the commencement of the use of the MLMW tool in 2023 the OPA has undertaken further projects to trial the tool with different client groups, including First Nations clients through the Culturally Safe Supported Decision-Making project and clients living in residential aged care through the Supported Decision-Making in Residential Aged Care project. In 2025 the University of South Australia (now part of Adelaide University) independently reviewed the MLMW tool used by the OPA. The review, completed in January 2026 made recommendations to improve processes and refine the tool, which are informing its practical use by OPA staff.

The final report can be found in Living My Life – Volume 3 on the OPA website.

Further development of guardianship services for First Nations clients

Following the successful completion of the Culturally Safe Supported Decision-Making Project in 2024, the OPA has employed a cultural broker to work alongside an OPA staff member when visiting Public Advocate clients who identify as First Nations. This initiative promotes culturally safe engagement, strengthens relationships with clients and communities, and supports decision-making that reflects clients' cultural values and preferences. Since April 2026, 25 First Nations clients have been visited through this initiative.

The subsequent visits identified 3 strategic areas for ongoing improvement:

- Policy – Strengthen policies, systems and processes to better meet the needs of First Nations clients.
- Educational – Identify, support and empower support coordinators to champion culturally safe and supported decision-making practices.
- Client-Focused – Build a deeper understanding of the First Nations client cohort, comprising approximately 300 identified clients, to inform service delivery and improve outcomes.

These strategic approaches will guide the OPA's ongoing efforts to enhance culturally responsive practice and deliver better outcomes for First Nations clients.

Supported decision-making in residential aged care

The Supported Decision-Making in Residential Aged Care Project was a collaboration between OPA and the Office for Ageing Well which ran from July 2024 to June 2025. The project focused on Public Advocate clients living in residential aged care and developed practical resources to enhance supported decision-making.

In 2025–26, the OPA published 3 videos, a guideline and 2 articles for Weekend Plus magazine on supported decision-making and the use of the My Life, My Wishes tool:

- Supported Decision-Making Principles at the OPA.
- Using My Life, My Wishes to Understand the Wishes of Public Advocate clients.
- Communication Strategies.
- Guideline: Completing the My Life, My Wishes Tool.
- Weekend Plus magazine articles - Supported decision-making in aged care and Supported decision-making resources.

These resources are available on the OPA website.

Business improvement projects

Information Exchange with NDIA

In July 2025, the OPA and NDIA finalised an agreement, establishing arrangements for sharing information about mutual clients. The agreement provides the OPA with quarterly data on all Public Advocate clients who are also NDIS participants, supporting the Public Advocate's advocacy role through access to aggregate and client level information.

The OPA has now received 2 quarterly data sets. The information exchange helps both agencies improve outcomes and enhance safeguards for mutual clients. It also supports the OPA to identify clients' current NDIS eligibility status and assess whether appropriate supports are in place.

Implementation of verification of identity through Relationship Authorisation Manager to speak to NDIA

OPA recently completed a successful trial with the NDIA using MyID and Relationship Authorisation Manager (RAM) to verify that OPA staff are authorised to discuss Public Advocate clients who are NDIS participants. Following the trial, MyID is being rolled out across the office.

Staff use this verification process when calling the NDIA's dedicated guardianship line. NDIA staff confirm their identity using three verification points. Staff have reported that the new process makes it easier to engage with the NDIA and allows them to discuss multiple clients during a single call. OPA will continue to work with the NDIA and monitor the effectiveness of the process.

OPA calling card and magnet

In 2026, the OPA, with support from the AGD Strategic Communications Unit, developed a calling card and magnet for distribution to clients and stakeholders. Both resources include OPA contact details and QR (Quick Response) codes linking to the OPA website and newsletter subscription page. These materials complement the Welcome Pack introduced in 2025 and help improve access to OPA information and services.

Easy read fact sheets

Following the review of the National Guardianship Guidelines in 2025, the OPA developed a suite of plain English and easy read fact sheets covering topics such as the role of the office, interpreters, making complaints to the Ombudsman and freedom of information. These resources also complement the Easy Read Welcome Pack introduced in 2025 and improve the accessibility of information for client and stakeholders in alignment with the AGD

Disability Access and Inclusion Plan 2026-2030. A total of 18 easy read fact sheets are now available on the OPA website.

Service Provider Recommendation Report

In 2025, the OPA trialled a new Service Provider Recommendation Report with a small group of service providers. The report provides a structured template for support coordinators to recommend service providers for consideration by OPA staff.

The template requires support coordinators to present at least 3 provider options and consider factors such as the client's wishes, potential conflicts of interest, provider registration status, and the provider's skills, experience and capacity to meet the client's needs. It also requires a recommendation and supporting rationale.

The report has improved transparency and accountability in service provider decision-making for Public Advocate clients. Following a successful trial, its use has been implemented across the OPA for NDIS participants.

Wellbeing Working Group

The OPA Wellbeing Working Group (WWG) was established in early 2024, with member representatives from OPA and the Community Visitor Scheme (CVS). The WWG advises the OPA leadership on wellbeing initiatives.

Its key roles include:

- Gathering staff feedback on wellbeing ideas.
- Recommending and supporting wellbeing activities, including organising social and team-building events.
- Promoting wellbeing resources, including initiatives offered by the AGD.

During 2025–26, the WWG coordinated activities and shared information to support a range of awareness and wellbeing events, including:

- NAIDOC Week
- Women's Health Week
- R U OK? Day
- Harmony Day
- Neurodiversity Awareness Week
- Advance Care Planning Week
- World Homelessness Day
- World Mental Health Day
- International Day of Persons with Disabilities.

Student program

The OPA continues to partner with the Adelaide University to offer fifth-year Bachelor of Laws students a 22-day internship in the Strategy and Advocacy Team. During their placement, students engage in a variety of activities, including visits to the SA Parliamentary Counsel and observing SACAT hearings.

Each student is assigned a legal question relevant to OPA's work and presents their findings to the Public Advocate and Leadership Team at the end of the placement with their paper published on the OPA website. In 2025-26, OPA hosted its 17th, 18th and 19th law students.

Their papers are:

- Part 8A of the *Criminal Law Consolidation Act 1935* (SA): Does it provide Adequate Protection Against Indefinite Detention for People with Mental Incapacity?
- Construction Incapacity: Criminal Law, Consent and the Architecture of Paternalism
- The impact of statutory reform on people with Dementia – Lessons from the *Guardianship and Administration Act 2019* (VIC).

Professional development and training

The OPA offers various professional development opportunities for staff, including training modules from the AGD, guest speakers and guardianship practice sessions. Over the past year, guest speakers and training have included:

- Commonwealth Aged Care Services
- Department for Correctional Services, Female Offender Framework
- DHS RPU
- Yarrow Place - Recognising and responding to disclosures of sexual violence
- Dementia Australia
- Public Trustee.

Over the past year Guardianship practice sessions have covered the following topics.

- National Guardianship Guidelines 2025
- Electro-Convulsive Therapy (ECT)
- Joint Guardianship and working with families
- End of Life decision making
- Attending clinical meetings
- Affidavits and Legal updates
- The new Aged Care Act (Cth)
- Complex Decision-Making
- Appearing before SACAT

- After Hours Service
- Working with the Department for Child Protection
- Youth to adult guardianship management
- Gov Safety
- Restrictive Practices in Aged Care.

Other training included emotionally challenging work workshops and group coaching for leadership and seniors.

Organisational reporting

Additional reporting capability enhancements during 2025-26 include:

- Automated monitoring of incoming correspondence to track the rising demand for guardianship services alongside the increasing number of clients.
- Enhanced NDIS data analyses and understanding of OPA client funding, spending and service provider engagement.
- Analyses of alternative client recording systems to potentially increase efficiency, strengthen information recording and client safeguarding, and improve reporting capabilities.
- Commenced development of a new application for lodging and monitoring notifications to the Public Advocate, to strengthen oversight of serious incident management and responses.

Appendices

Appendix 1: Legislation

The general functions of the Public Advocate are set out in section 21(1) of the GAA:

a) to keep under review, within the public and 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;
c) to speak for and promote the rights 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;
f) to give advice on the powers that may be exercised under the Act in relation to mentally incapacitated persons, on the operation of the Act generally and on appropriate alternatives to taking action under this Act;
g) to monitor the administration of the Act and, if he or she thinks fit, make recommendations to the Minister for legislative change.

The Public Advocate may be appointed as the guardian (or joint guardian) of a person with mental incapacity but only if SACAT considers that no other order would be appropriate.

Other applicable legislation

Advance Care Directives Act 2013 (SA) and Regulations

Aged Care Act 2024 (Cth)

Aged Care and Other Legislative Amendment (Royal Commission Response No. 1) Act 2021 (Cth)

Ageing and Adult Safeguarding Act 1995 (SA)

Children and Young People (Safety) Act 2017 (SA)

Consent to Medical Treatment and Palliative Care Act 1995 (SA) and Regulations

Criminal Law Consolidation Act 1935 (SA)

Criminal Law Consolidation (Mental Competence) Act Amendment Act 2025 (SA)

Disability Inclusion Act 2018 (SA) and Regulations

Disability Inclusion (Restrictive Practices – NDIS) Amendment Act 2021 (SA)

Disability Services Act 1993 (SA)

Freedom of Information (Exempt Agencies) Regulations 2023 (SA)

Guardianship and Administration (Tribunal Proceedings) Amendment Act 2025 (SA)

Mental Health Act 2009 (SA) and Regulations

National Disability Insurance Scheme Act 2013 (Cth)

Powers of Attorney and Agency Act 1984 (SA)

Problem Gambling Family Protection Orders Act 2004 (SA)

Residential Tenancies Act 1995 (SA)

Supported Residential Facilities Act 1992 (SA)

Statutes Amendment (Health and Wellbeing) Act 2025 (SA)

Succession Act 2023 (SA)

Appendix 2: List of acronyms

ACD	Advance Care Directive
AGAC	Australian Guardianship and Administration Council
AGD	Attorney-General's Department (SA)
APTOS	Applied Principles Tables of Support
ART	Administrative Review Tribunal
ASD	Autism spectrum disorder
ASU	Adult Safeguarding Unit (DHS)
BPD	Borderline personality disorder
CALHN	Central Adelaide Local Health Network
CAPS	Care Awaiting Placement South
CHP	Community Housing Provider
CMHS	Community Mental Health Services
CRPD	Convention on the Rights of People with Disabilities
CVS	Community Visitor Scheme
DCP	Department for Child Protection (SA)
DCS	Department of Correctional Services (SA)
DHS	Department of Human Services (SA)
DHUD	Department for Housing and Urban Development
DHW	Department of Health and Wellbeing (SA)
DRC	Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (Disability Royal Commission)

DRS	Dispute Resolution Service
ECT	Electroconvulsive Therapy
ENU	Exceptional Needs Unit
FMH	Forensic Mental Health
FMHS	Forensic Mental Health Service
GAA	*Guardianship and Administration Act 1993* (SA)
ID	Intellectual Disability
ITO	Inpatient Treatment Order
JNH	James Nash House
MAC	My Aged Care
MAPS	Multi Agency Protection Services
MLMW	My Life My Wishes
MOU	Memorandum of Understanding
NAIDOC	National Aborigines and Islanders Day Observance Committee
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
OAW	Office for Ageing Well
OCP	Office of the Chief Psychiatrist
OPA	Office of the Public Advocate
PACE	Participant Communication Environment
PICU	Psychiatric Intensive Care Unit
PTSD	Post Traumatic Stress Disorder

RACF	Residential Aged Care Facility
RAM	Relationship Authorisation Manager
RPU	Restrictive Practices Unit
SAAS	South Australia Ambulance Service
SACAT	South Australian Civil and Administrative Tribunal
SACID	South Australian Council for Intellectual Disability
SAIDHS	SA Intellectual Disability Health Services
SAHT	South Australian Housing Trust
SALHN	Southern Adelaide Local Health Network
SALRI	South Australian Law Reform Institute
SAPOL	South Australian Police
SCCP	Social, Civic and Community Participation
SDA	Specialist Disability Accommodation
SDM	Substitute Decision Maker
SIL	Supported Independent Living
THRIVE	Threat, Harm, Risk Investigation, Vulnerability and Engagement (SAPOL program)
UCLC	Uniting Communities Law Centre
WWG	Wellbeing Working Group



Appendix 3: Compliance with Premier and Cabinet Circular (PC013) on Annual Report Requirements

The following table demonstrates the OPA's compliance with the Department of Premier and Cabinet Circular (PC013) on Annual Report Requirements:

PC013 Statutory Reporting Requirement	
Employment opportunity programs	Refer to the AGD Annual Report 2025-26
Agency performance management and development systems	Refer to the AGD Annual Report 2025-26
Work health, safety and return to work programs of the agency and their effectiveness	Refer to the AGD Annual Report 2025-26
Work health and safety and return to work performance	Refer to the AGD Annual Report 2025-26
Fraud detected in the OPA	Number of instances: 0
Strategies implemented to control and prevent fraud	Refer to the AGD Annual Report 2025-26
Whistle-blowers' disclosure	Refer to the AGD Annual Report 2025-26
Executive employment in the agency	Refer to the AGD Annual Report 2025-26
Summary of complaints by subject (table)	Refer to the AGD Annual Report 2025-26
Complaint outcomes (table)	Refer to the AGD Annual Report 2025-26
Climate Change and Greenhouse Emissions Reduction Act 2007	Refer to the AGD Annual Report 2025-26
Carers Recognition Act 2005 (SA)	The OPA did not have obligations under section 6 of the *Carers Recognition Act 2005* (SA) in 2025-26



Government
of South Australia

Office of the Public Advocate