OFFICE OF THE PUBLIC ADVOCATE

ANNUAL REPORT 2014

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South Australian Office of the Public Advocate

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Front Cover: Rainbow River Serpent, by Benny Roberts

The Rainbow serpent represents the river, the Coorong and the Murray Mouth. Also included is the dream catcher.

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17 October 2014

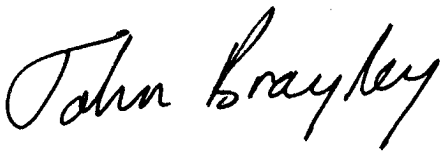
The Hon. John Rau MP
Attorney-General
45 Pirie Street
ADELAIDE SA 5000

Dear Mr Attorney

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

This Report covers the period from 1 July 2013 to 30 June 2014. Part A is an overview of major matters arising during the year, and includes a review of programs, consideration of unmet need, and advocacy positions taken by the Office. Part B provides statistical data on direct client services provided by our Office.

Yours Sincerely



John Brayley

PUBLIC ADVOCATE

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Part A:

General Functions of the Public Advocate

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

Reviewing Programs and Identifying Unmet Need
Disability Services

Guardianship and Administration Act 1993

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

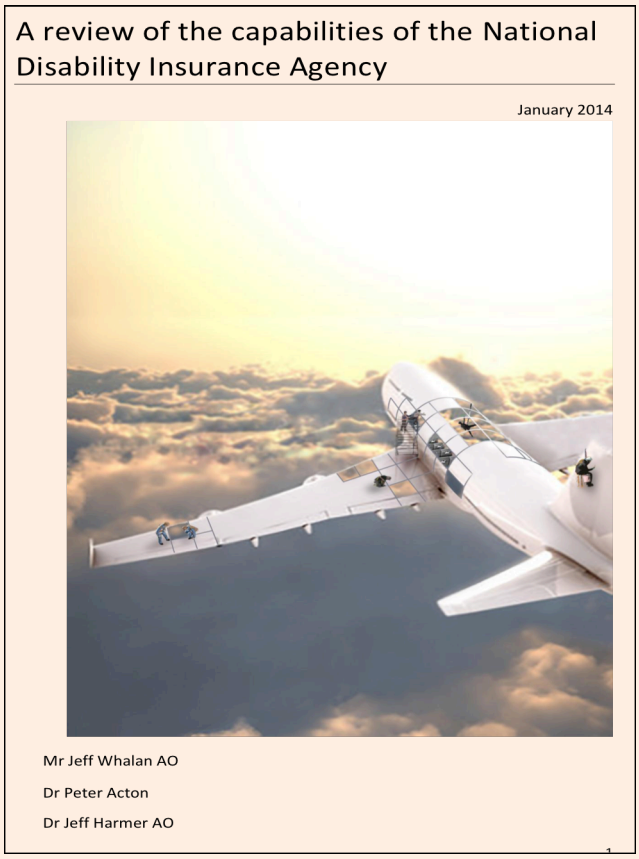
(a) to keep under review, within both the public and the private sector, all programmes designed to meet the needs of mentally incapacitated persons;

(b) to identify any areas of unmet needs, or inappropriately met needs, of mentally incapacitated persons and to recommend to the Minister the development of programmes for meeting those needs or the improvement of existing programmes;

Introduction

This year saw the announcement of further State investment in services to people with disability including $7.4M over two years to the Housing Trust to establish a respite facility in Adelaide, $1.7M over four years to fund disability services to forensic clients in James Nash House and $3.2M over 4 years to fund a disability justice plan (SA Government, 2014). It is expected that SA's disability budget will be $550M in 2014-15 rising to $723M in 2018-19. This will be the state's contribution to the National Disability Insurance Scheme (NDIS).

Last year in our Annual Report we raised concerns about how the National Disability Insurance Scheme (NDIS) and the National Disability Insurance Agency (NDIA) that operates it, might meet the needs of people with complex needs (Office of the Public Advocate Annual Report, 2013 pages 10-11). NDIS trials for adults have proceeded in other states (South Australia's trials are for children), but to our knowledge this significant question about how high needs clients might be engaged has yet to be resolved. A report from the NSW Council of Intellectual Disabilities has noted the need for skilled engagement of people with intellectual disabilities who might not identify as needing help, and the need for the NDIA to be prepared to provide very urgent crisis support to such people even before eligibility has been assessed (Simpson, 2014).



Cover of the report from Whalan, Acton and Harmer (2014), A review of capabilities of the National Disability Insurance Agency.

The review concluded that the agency is like a plane that took off before it had been fully built. Weaknesses include information technology, human resources capability, internal communication, pressured relationships, conflict in planner's jobs as both stewards of sustainability and advocates for a person with disability, and the need to support and resource the actuarial unit to monitor the relationship between support need and resource allocation.

The report was complimentary about the CE, its staff, and the remarkable start to the scheme.

Our concern is that people with high needs who have an intellectual disability, brain injury or autism spectrum disorder, and possibly a co-morbid mental illness, may in many situations need active engagement by providers. They cannot be expected to make "a claim" on an insurance based system unless supported to do so. There is a risk that, unsupported, such people, may, if disability services are not provided, present to hospitals or end up in prison. If the state has handed over its $723M to the NDIA it will not be in a position to offer a service itself, and will need to use its leverage as a funding contributor to the NDIA, and its membership of the NDIA Board to ensure this group gets a service.

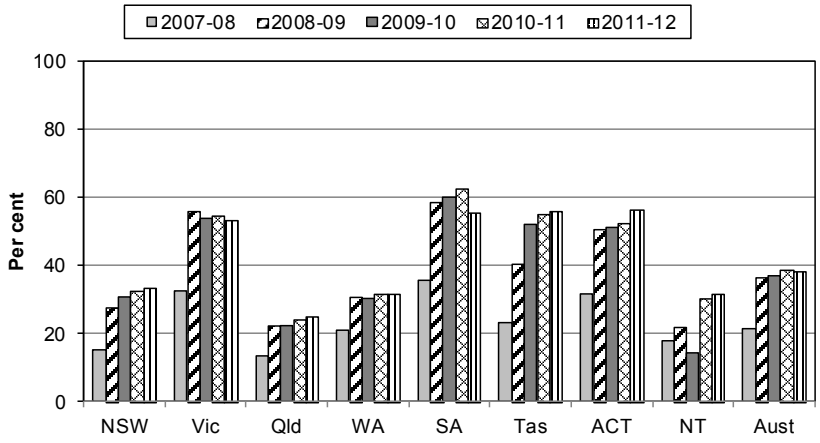
While further modifications and some in flight repairs will be needed as the NDIA trials develop, the overall impression is that NDIS offers hope to participants who have experienced unmet need in underfunded state systems. We hear positive anecdotes about good results for some adults in the Barwon and Hunter Valley trial regions.

Our Office has not been in a position to form a view about the operation of the NDIS South Australian children's services. This local program, until now, has been predominantly for younger children (under 6) who commonly live at home, and need therapy and early intervention services. Our State is yet to see the impact of the NDIS on the needs of people requiring supported accommodation, and how the scheme responds to the needs of people with chronic mental illness.

Update on service use and unmet need

The Productivity Commission's 2014 Report describes services provided under the National Disability Agreement in 2011–2012 (Productivity Commission, 2014). In the previous reporting year South Australia had the highest rate of access to government-funded specialist disability services. This year the rate has slipped and our access to services is comparable to three other states: Victoria, Tasmania and the ACT. It is difficult to draw too many conclusions about the significance of this change.

Figure 14.5 **Users of NDA specialist disability services administered by State and Territory governments as a proportion of the estimated potential population[a, b]**



[a] See section 14.7 for information on how the potential population is defined. [b] Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on data quality issues.

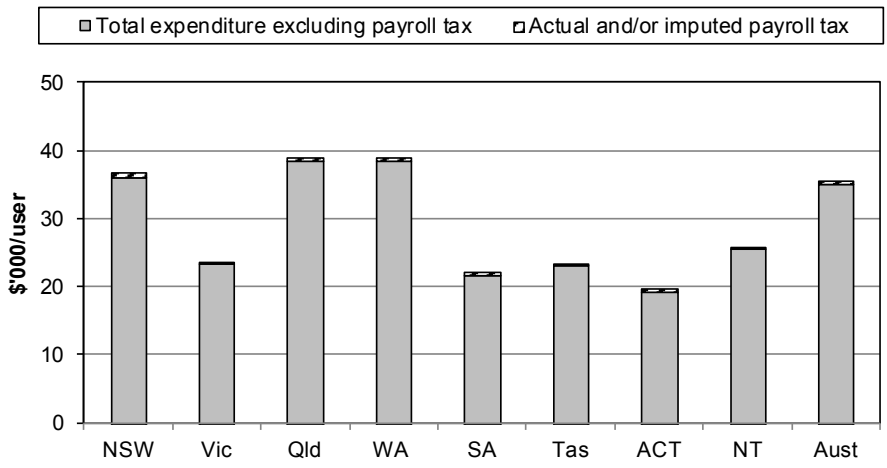
Source: AIHW (unpublished), DS NMDS 2009-10 to 2011-12, CSTDA National Minimum Data Set (NMDS) 2008-09; AIHW analysis of the ABS *Estimated Resident Population June 2008-11, ABS Census of Population and Housing 2006* and the ABS *Survey of Disability, Ageing and Carers 2009*; table 14A.13.

Figure A1: Users of NDA (National Disability Agreement) services as a proportion of the estimated potential population (Reproduction of Figure 14.5, Productivity Commission, 2014).

2011-2012, was also the year that changes to Home and Community Care came into place, with states assuming responsibility for people receiving these services under 65, and the Commonwealth for people aged 65 or over.

Each year, we have looked at what we see as a corollary statistic — the funding allocated per user. As noted before, while South Australia has had a high rate of access to services, government expenditure per user has previously been reported to be lower in South Australia than in other states. This year the statistic was lower for the ACT than for our state.

Figure 14.30 **Estimated annual government expenditure per user of NDA State and Territory administered services, 2011-12[a, b, c, d]**



[a] In some jurisdictions (NSW, Victoria, SA, Queensland, Tasmania and the NT), payroll tax data are actual; in other jurisdictions (WA and ACT), payroll tax data are imputed. [b] Government expenditure per service user for Australia excludes Australian Government expenditure on State and Territory administered services that was not provided as transfer payments. [c] Payroll tax data for Queensland includes paid payroll tax and accrued payroll tax. [d] In the NT, payroll tax relates to government service provision and excludes expenditure for program management and administration.

Source: AIHW (unpublished) *DS NMDS*; State and Territory governments (unpublished); table 14A.80.

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

Unmet need data

South Australia released unmet need data on a six-monthly basis from 2008, increasing to monthly from 2012.

Unmet Need Categories

(used in the following graphs)

Definitions of urgency of need.

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

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

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

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

Service types:

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

As at June 2014, there were 2519 people on the unmet needs list, down from 2809 the year before. The number on Category 1 has increased to 1550 (last year 1384), and on Category 2 has decreased to 622 (last year 908). The definitions of urgency of need are in the textbox at right.

Figure A3 charts unmet need over time for all four categories of service. Figure A4 demonstrates the ongoing increase in the Category 1 unmet needs list. As at June 2014, 517 people are on the Category 1 list waiting for supported accommodation, a slight reduction compared to the 539 clients in this group last year.

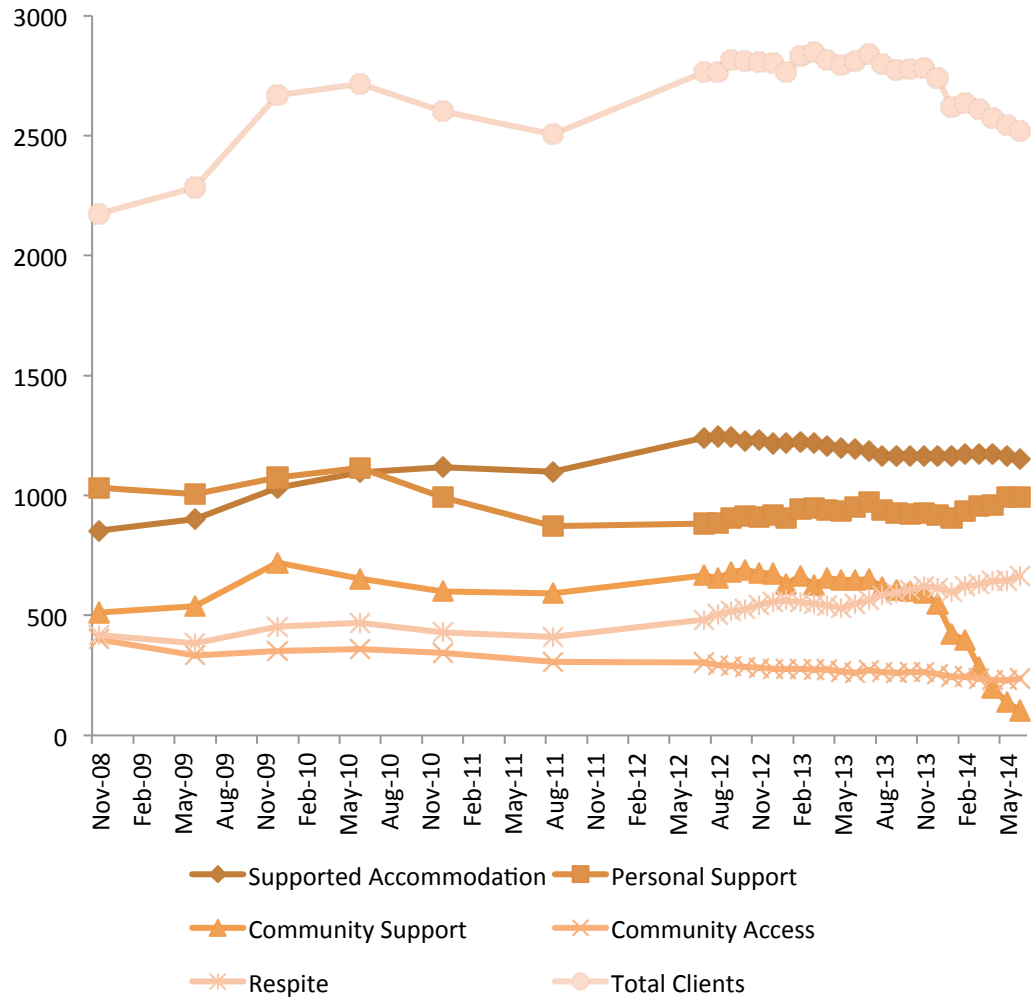


Figure A3. Increase in unmet need list November 2008 to June 2014, for clients in all categories

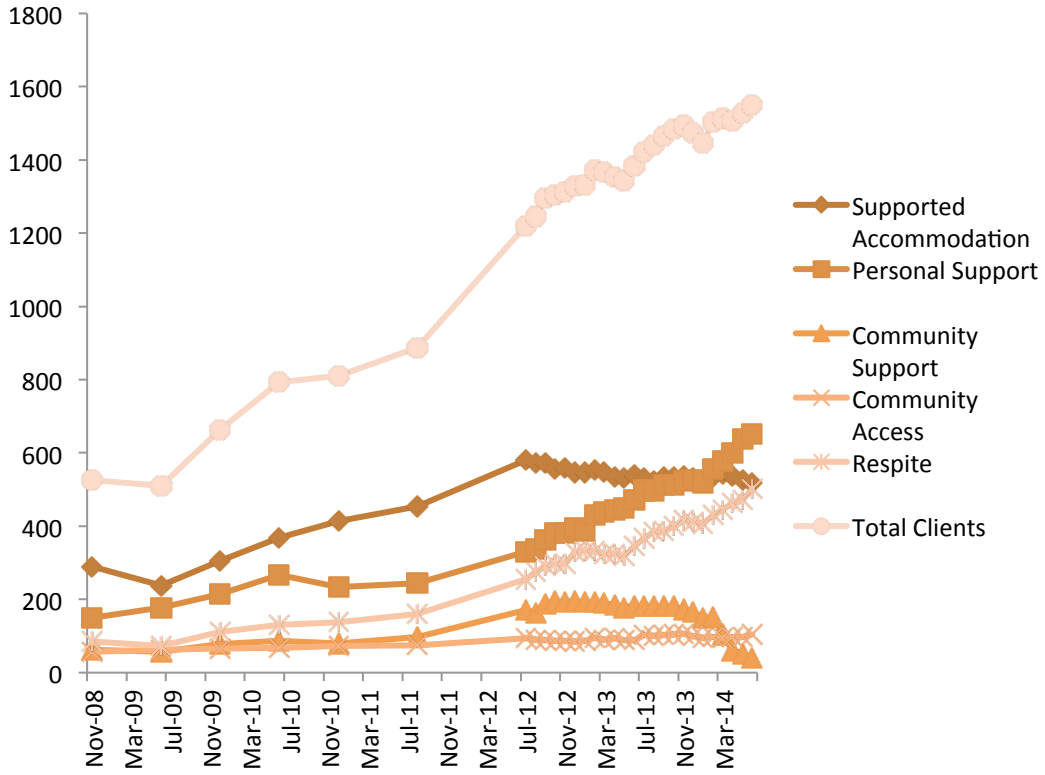


Figure A4. Increase in unmet need list November 2008 to June 2014, for clients in Category 1

The recommendation of the Social Inclusion Board was that the Category 1 and 2 lists need to be funded within one budget cycle (Priority Action Recommendation 2, Social Inclusion Board, 2011). If this had been accepted, the needs of people who have a disability who are at risk of harm to themselves or others, or who are homeless or at risk of homelessness would have been met by June 2013, and there would currently be none or at the very least a minimal number of people waiting on the category 1 and 2 list.

As we have noted in previous Annual Reports the fact that people remain on this list, and in particular in Categories 1 and 2, is a cause of considerable concern. Although adults on this list are likely to receive a service under the NDIS, this will not happen until 2018, and people remain at serious risk in the interim.

Reform to South Australian Legislation

2013 saw the passage of the *Disability Services (Rights, Protection and Inclusion) Amendment Act 2013* to amend the *Disability Services Act 1993.* The amendments included recognition of the UN Convention on the Rights of Persons with Disabilities as a set of best practice principles that should guide policy development, funding decisions and the administration and provision of disability services. Also, that providers of Disability services must have safeguarding policies; examples include policies on management of care concerns, restrictive practices, supported decision making and consent, disclosure of abuse or neglect, and the reporting of critical incidents.

These amendments are positive. However it was also noted at the time that further changes could be considered in future amendments. We wish to canvas the inclusion of restrictive practices provisions in a second tranche of disability legislative reform, as well as considering the potential role of state based disability legislation after the NDIS has assumed full responsibility for disability services in 2018-19. The state will then no longer directly fund services, making the current *Disability Services Act 1993* redundant.

Restrictive Practices and the *Disability Services Act*

Restrictive Practices in Disability Settings were reviewed in our 2010 Annual Report (Office of the Public Advocate, 2010 pp 68-89). Developments in Queensland and Victoria were considered along with the merits of each legislative approach. We preferred the Victorian model, which focussed the responsibility of preventing restrictive practices on the disability system, through provisions in the *Disability Act 2006* (Vic). In contrast the Queensland model had provisions in both *Disability Services Act 2006* (Qld) and *Guardianship and Administration Act 2000* (Qld), creating a role of Guardian for Restrictive Practices. Both states emphasised the need for education, training and research.

We noted that in Victoria there was rapid uptake of positive behaviour support plans, with transparency and quality improved through independent review of these plans by the statutory position of Senior Practitioner. In Queensland providers reported difficulty complying with that state's legislation early on, and there were doubts as to whether it was able to change practices across disability services, or would only provide an approval mechanism for existing practices.

This year further amendments were made to the Queensland legislation, because of concerns that it was not achieving its objectives. The Government in that state introduced new amendments with dual objectives of improving protection for clients, and streamlining processes for service providers.

The amendment, came into operation on 1 July 2014 and included clearer definitions of restrictive practices; reporting requirements; a requirement for service providers to provide a statement about the use of restrictive practices to family members; and a requirement for the Department to publish an "exemplar" positive behaviour support plan, which could be used as a model in the field.

Regardless of the specific details, common themes from both states are the need to specifically regulate the use of restrictive practices in legislation; for parliament to require best practice in the form of positive behaviour support plans; for each form of restrictive practice to be defined, and for external approval for the use of restrictive practices.

In South Australia we now have a Senior Disability Practitioner. This is a welcome addition to Disability Services. It is our view that this position needs to have statutory powers, to report directly to the Chief Executive, and if necessary be able to bring matters directly to the attention of the Minister. We consider that the Senior Practitioner's Office should be modelled on the Victorian Office, and routinely review positive behaviour support plans and approvals given for the administration of restrictive practices by both government operated and government funded disability systems.

Even though such legislation would only operate until the NDIS comes into full operation, these provisions would protect clients of state disability services for the next three years at least, and influence the safeguarding standards that will apply after the NDIS commences.

A State Disability Act from 2018 onwards

The *Disability Services Act 1993* legislates for the funding and provision of disability services. When the state is no longer undertaking these tasks, from 2018-19 onwards, the current Act will be redundant.

However, there will still be a role for state based disability legislation. Such legislation can focus on what a person with a disability can expect to receive from mainstream state government operated services including health, mental health, education, training, housing and justice services.

A state Disability Act framed in this way could provide guidance and set standards for services. Such guidance would be more specific than the general provisions in current anti-discrimination legislation such as the *Equal Opportunity Act 1984* (SA), and the *Disability Discrimination Act 1992* (Cth).

An example of a statutory guidance model is the *Autism Act 2009* (UK). While it is focussed on the needs of adults with autism, the model could be used more generally for people with a disability. Extracts from the Act and statutory guidance model are on the next page.

If such a strategy were followed, a new Disability Act could require statutory or parliamentary guidance to be issued by the relevant Minister or the Governor: in effect mandating the setting of standards for service delivery. Such an approach maintains some flexibility as the requirements spelled out in statutory guidelines can be changed, while retaining the authority of being required by parliament.

A mandatory approach can be justified because many past attempts to increase access to mainstream services for people with a disability on a voluntary basis have not succeeded.

Example of Statutory Guidance. *Autism Act 2009* (UK)

The Act requires Guidance (top), and specifies the content of the guidance (middle). An example of the guidance issued is also reproduced (bottom). This example relates to training of all staff and those who have a direct impact on access to services for people with autism.

In the text (previous page) it is suggested that this approach could be used in South Australia for a future state Disability Act, giving guidance to state government departments on their response to people with disability, post full commencement of the NDIS.

2 Guidance by the Secretary of State

(1) For the purpose of securing the implementation of the autism strategy, the Secretary of State must issue guidance—

(a) to local authorities about the exercise of their social services functions within the meaning of the Local Authority Social Services Act 1970 (c. 42) (see section 1A of that Act), and

(b) to NHS bodies and NHS foundation trusts about the exercise of their functions concerned with the provision of relevant services.

(5) Guidance issued under this section must in particular include guidance about—

(a) the provision of relevant services for the purpose of diagnosing autistic spectrum conditions in adults;

(b) the identification of adults with such conditions;

(c) the assessment of the needs of adults with such conditions for relevant services;

(d) planning in relation to the provision of relevant services to persons with autistic spectrum conditions as they move from being children to adults;

(e) other planning in relation to the provision of relevant services to adults with autistic spectrum conditions;

(f) the training of staff who provide relevant services to adults with such conditions;

(g) local arrangements for leadership in relation to the provision of relevant services to adults with such conditions.

In addition to general autism awareness training for staff, local areas should develop or provide specialist training for those in key roles that have a direct impact on access to services for adults with autism – such as GPs[12] or community care assessors – and those whose career pathways focus on working with adults with autism, such as personal assistants, occupational therapists or residential care workers. The end goal of this specialist training is that, within each area, there are some staff who have clear expertise in autism.

Forensic Disability Services

South Australia does not operate a specific forensic disability service separate from its forensic mental health service. If we had a designated service it would provide disability specific care for people with an intellectual disability, brain injury or autism spectrum disorder who have been found by a court to be not guilty by reason of mental impairment, or unfit to stand trial. Instead, people with disability are placed in the custody of the Minister for Mental Health, and admitted to our forensic mental health facility, James Nash House, where they live with people who have been admitted for mental health treatment.

At any one time up to a quarter of forensic inpatients require a primary disability service rather than mental health inpatient care. It is positive that in its 2014 budget the State Government allocated $1.7M to the Department of Communities and Social Inclusion to fund forensic disability care (corresponding to $400,000 per year over 4 years indexed). However more can be done.

We understand that with these funds it will be possible for people to receive more disability specific care while admitted to the forensic mental health unit, and, that it is intended that people with disabilities will be living together in a 10 bed ward at James Nash House, rather than being scattered through the different forensic wards there as occurs currently.

This is a positive first step. However, ideally, in our view this facility should be physically separate to the mental health facility, and, rather than being operated by a health provider, should be operated by a disability service provider under the governance of disability services, with responsibility resting with the Minister for Disabilities.

While this model creates separation between the two units – mental health and disability – it still enables responding to co-morbidity. When a person with a primary disability needs mental health care, they can receive it in a mental health unit when unwell, and after recovery from an acute episode, can return to a disability unit.

The advantages of operating a separate disability unit are expanded on below.

Increased bed capacity. Operating 10 forensic disability beds in addition to the acute forensic mental health beds (rather than operating the forensic disability beds within the current forensic mental health bed envelope) would improve the capacity of both disability and mental health services to respond to need. The mental health bed number should reflect the need for inpatient mental health care both for patients in custody under Part 8A (Mental Impairment Provisions) of the *Criminal Law Consolidation Act 1935* , and for prisoners who are on remand or have been convicted of a crime.

At the moment it appears that we have 40 forensic mental health beds in this state, but the actual number of beds available for mental health care is, in practice, less because of the need to accommodate forensic disability clients within this allocation. Acute bed numbers will increase by 10 beds to 50 overall in late 2014, but the same issue applies. Ideally all 50 forensic mental health beds should be for designated mental health use, and 10 additional forensic places created for disability care.

Such a proposal could be both practical and economic. It is possible that some large non-government disability providers may be interested in taking on the role of operating such a facility. Expert disability care could be provided, that may be more effective than non-specific

ward care, and potentially cheaper to deliver. The cost structure of providing disability care is different to that used in acute health care. It is likely to be efficient to operate a 10 bed unit staffed by disability staff, whereas usually it is not efficient to operate a stand alone hospital ward of this size.

Ministerial responsibility. The existing legislative arrangements commit a defendant who has a mental impairment to the custody, supervision and care of the Minister who can make directions. The Minister in this case is the Minister of Mental Health. This is very appropriate for people who need mental health care, but it is not logical for people who need disability care to have the Minister for Mental Health (or his delegated authority such as the Chief Executive of Health SA) overseeing directions related to disability matters. This should be the responsibility of the Minister for Disabilities and his or her delegated staff. Disability related decisions would then be informed directly by disability knowledge, and there would be improved continuity of care when a person is discharged from custody to the community, as the same disability service system would be responsible for care in both settings.

Support for prisoners and community corrections clients with a disability: A designated forensic disability service could also offer consultancy, advice and services to prisoners and community correction clients who experience a disability.

This is a significant population. A NSW study recorded that 10% of people appearing before the Magistrates Court in that state had an intellectual disability and a further 20% were in the borderline range of 70-80 (score on the Kaufmen Brief Intelligence Test) (Vanny et al, 2009). This is a similar result to a British study that reported 7.1% of prisoners have an IQ <70 and a further 23.6% to be in the borderline range (Hayes et al, 2007).

There are similar high rates for brain injury. A NSW study of 200 prisoners reported that 65% of prisoners endorsed a history of traumatic brain injury with a loss of consciousness (Schofield, et al, 2006).

Access to disability assessment and advice can assist in planning for immediate therapy, rehabilitation, and, when needed, positive behaviour support to respond to any behaviours of concern. It can also identify people who need ongoing disability supports when released from prison, and advise on the nature of these supports.

A number of high needs clients on licence to the community on a forensic order, or on parole, will receive services from the disability system or the Exceptional Needs Unit operated by the Department for Communities and Social Inclusion. The proposals above do not necessarily require extensive new resources, but instead, the bringing together of existing resources providing positive behaviour support, high level disability support, and exceptional needs care, into a service that has skills and capacity to assess forensic clients, and provide advice and support to disability providers delivering services.

Preparing for the NDIS: It is our view that people found not guilty by reason of mental impairment should continue to be eligible for their NDIS payments to fund therapy, rehabilitation and support. When the NDIS operates for adults in 2018 our Office considers it should fund disability care for forensic patients. Payments should continue when a person is in custody. A parallel is the approach the Commonwealth Government takes to Centrelink payments. A forensic patient will continue to be eligible to receive their Disability Support

Pension in custody. Forensic patients in James Nash House pay rent from their pension. In contrast a prisoner has Centrelink benefits ceased. It could be argued that if there are extra costs associated with custody then this is a state responsibility, however, the disability service should be funded by the universal scheme. Accordingly, we consider that the forensic care of people found not guilty by reason of mental impairment due to a disability should be a disability responsibility now, and should continue to be a disability responsibility after 2018 when the NDIS is in operation for adults in SA. Continuing this as a Health responsibility distorts both practice and funding arrangements, now and into the future.

Reviewing Programs and Identifying Unmet Need

Mental Health

Introduction:

2014 represents a critical point in the development of mental health services in this state. The 2007 "Stepping Up" plan has mostly been implemented, and a 2013 Review by Ernst & Young has identified new priorities to be tackled to address increased emergency demand. The Government has committed to the development of a Mental Health Commission, which will itself need to develop a plan for this state.

Apart from responding quickly to the emergency demand pressures, it is our view that it is time to establish a blueprint of services required to meet population need. This could be a long-term blueprint, for 10 years. Whilst funding may not currently be available to fund necessary service expansion, having such a plan helps to systematically improve services when funding opportunities arise, which they inevitably do from time to time.

More work is needed to plan services across the lifespan. In a draft 2013 model of care Child and Adolescent Mental Health Services (CAMHS) is to focus on the provision of services to children and young people with moderate to severe mental illness as well as providing support to primary care providers. A review by the Women's and Children's Health Network of CAMHS' clinical governance, leadership, supervision, accountability, model of care, consumer focus and other matters is currently underway. A new state plan will need to incorporate these outcomes and develop services. At the same time a decision has been made to auspice services for 16-24 year olds through adult services, and these will need to interface with Commonwealth funded early intervention programs.

Reform of older persons mental health services is well underway with the closure of long term older persons beds. The funding freed up should be used to expand community based older persons mental health services, and top up the funding of care units for people with psychological and behavioural disturbances associated with dementia managed by aged care providers.

A 10 year blueprint for forensic mental health services could outline future expansion in community services, prison in-reach and beds to service both forensic patients found not guilty by reason of mental impairment, and prisoners who have a mental illness. Social impact bonds may offer an innovative funding source in the future for some of these services, and a blueprint could assist developments in this area.

This discussion considers acute bed demand, the 2013 Mental Health Services Review, and future plans to establish a Mental Health Commission.

Mental Health Services Review

An independent review of mental health care, and capacity to respond to demand, by Ernst & Young was released in August 2013. SA Health released its response in October 2013.

So far this report, and the SA Health response to the report, has not led to the hoped for improvements in the ability of mental health services to respond to emergency demand. The report concluded that South Australia had sufficient acute beds. It recommended no further bed closures until the acute and non-acute functions of the system were rebalanced, and said that this should be achieved within 12 months (Ernst & Young, 2013). Since then long waits in emergency departments for mental health beds have been common. At the time of writing this report the Government has announced the opening of 12 extra mental health beds: four at the Lyell McEwin Hospital and eight at Glenside Health Services (SA Government, 2014) amongst other initiatives. One strategy was to bring forward a planned increase in forensic mental health capacity by 10 beds. This will be discussed further in this section.

The Ernst & Young Report was commissioned because demand pressures at the time had led to questions about the validity of the state's Stepping Up mental health plan and its implementation. The reviewers supported the Stepping Up plan, but concluded that there were problems with the way the Stepping Up report had been implemented, leading to a slower than expected change in culture and clinical practice.

The same questions can now be asked about the Ernst & Young report, and its implementation.

The Ernst & Young Report

This report was considered in our Annual Report from last year (Office of the Public Advocate, 2013 pp 22-29). The Ernst & Young Consultants endorsed the Stepping Up report and concluded that South Australia has enough beds. However the methodology used by the review did not consider the issue as to whether the Stepping Up Plan had been followed with respect to the individual steps it required or the impact of forensic mental health overflow into acute mental health beds.

24 hour Supported Accommodation: Ernst & Young had drawn its conclusion about the adequacy of bed and accommodation numbers on national averages. Our 2013 discussion recognised that the Ernst & Young approach was consistent with the national approach to classifying and counting bed types, but that these national definitions do not correspond with the definitions of different forms of care in the Stepping Up report. Also, that there were statistical problems in using national averages as benchmarks, because of the wide range of performance in this area in different states, and it is therefore better to use agreed targets instead.

The consultants benchmarked SA numbers on national averages for "Residential 24/7" accommodation, an analysis which shows SA in a very favourable light, but this benchmark groups together three different levels of care in the Stepped Model (intermediate care, community recovery centres and supported accommodation). If the consultants had benchmarked numbers on the agreed upon targets for the SA plan for each of these different levels of care, it would have become apparent that the target has not been met for the supported accommodation 'step' and the intermediate care 'step'.

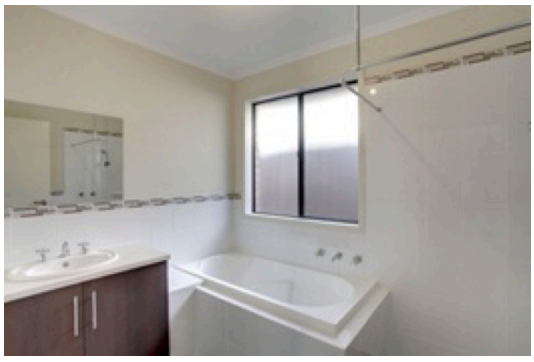
Our 2013 discussion noted that, using the Stepping Up plan targets to measure performance, we are 53 places short for 24 hour supported accommodation, and, that some of the 40 "secure" rehabilitation beds are being used as "open" beds for people who would otherwise benefit from supported accommodation if it were available. The effect of this is that acute beds are in effect closed because of flow on effects. People who should be in supported accommodation can end up staying in 'secure' rehabilitation beds or revolving through acute beds, with the consequence that some people in acute wards who need secure beds cannot be admitted to those beds because they are already occupied by people who require 24 hour supported accommodation.

Intermediate care centres. Another related target is the development of intermediate care beds, the community based alternative to acute beds. The Stepped Model required the development of 90 beds, 60 beds in the metropolitan area in four 15-bed units, and 30 places in the country. So far three of the metropolitan units have been built, in the East, West and South, but no unit has been built in the north of Adelaide.

Ernst & Young reported that the north of Adelaide has no intermediate care beds, and is under-provisioned for residential 24/7 beds. Twelve months later it appears that capital funds to build the Northern Intermediate Care Centre (part of a $18.2M originally allocated for this purpose in 2007) remain unspent.

Intermediate Care Centres have been separately subject to an independent evaluation by Health Outcomes International (2013) who described it as "a new and pivotal component of the South Australian stepped model of care, representing good value on a cost basis costing 58% of the bed day cost of an acute bed". There would seem to be no reason why the 15 northern beds should not be built with the funding available.

Forensic mental health patients admitted to general beds. The Ernst & Young reviewers noted that with the brief time frame for the review, it did not extend to the entire mental health system. It was necessary to examine the impact of forensic mental health service demand on the acute system, but the review did not focus directly on forensic mental health services as such. The review does not explain how the impacts of forensic demand were factored into the conclusions drawn. Our Office has not reviewed data on the number of acute mental health beds occupied by forensic patients, but at times in 2014 we have been aware of forensic patients



Photos of HASP Housing – modern purpose designed dwellings. (Unity Housing, http://www.junctionhousing.org.au/the-hasp-program)

admitted to secure units at Glenside and the Margaret Tobin Centre and open wards. We are aware of there being 5 to 10 patients at a time, often in psychiatric intensive care beds.

To be very clear, forensic patients should be in a hospital and have facilities provided to meet their needs, however sufficient forensic beds should operate to cater for forensic service demand and 'overflow' to community beds should be the exception. Community bed numbers are calculated on community need. Every community bed occupied by a forensic patient can be considered to be a bed that is "closed" for community use. While the number varies over time, up to 10 community acute beds (possibly more) can be closed in this way at a particular time.

The topic of forensic mental health bed numbers is considered later in this section.

Ernst & Young Training Recommendations: Ernst & Young observed that interstate programs have a greater focus on training and development of staff than is the case in South Australia. Workforce capability is considered a "critical success factor". It is not clear to this Office to what extent this training recommendation has been implemented. However, if there has been a lack of training and development opportunities in the mental health sector, then specific resourcing would need to be allocated, even on a one off basis, to increase workforce capacity within a short time period. The report referred to a 12 month time period to achieve change.

Yet such improvements are unlikely to succeed alone in managing bed demand if the model is not fully implemented, because practice improvements alone are unlikely to overcome gaps in an interdependent stepped model.

Implementation of the Ernst & Young Report

In October 2013 SA Health published its response to the Ernst & Young report, including feedback it received. Consumers, carers, advocacy groups and peak bodies were pleased that Stepping Up directions had been confirmed as appropriate and relevant, but in conflict with this, professional groups were critical of the investment in intermediate care and subacute care. Concern was also reported that a lack of supported accommodation options and limited access to rehabilitation and forensic care were ongoing obstacles to efficient bed management (SA Health, 2013).

The SA Health response to the Ernst & Young recommendations was in three areas – resource realignment, clinical redesign and cultural change management. The Department would manage resource realignment, and each local health network would manage clinical redesign and change management.

Cultural change management would include the learning objectives referred to by Ernst & Young. Ernst & Young noted from their interstate experience that Departments provide limited funding, and that training budgets are included in operational budgets for the mental health units.

The SA Health response was that clear delivery targets would be developed to measure local health network performance against the Ernst & Young recommendations, and that funding will be allocated to progress recommendations associated with clinical redesign and cultural change. While funds would be required for these purposes it was considered that no additional funds would be allocated to operate the mental health system (SA Health, 2013).

Our Office is not in a position to objectively assess the implementation process, and have not reviewed the performance indicators or funding allocations for these purposes. Our recent advice to the Minister, based on our overall impression, is that more needs to be done in this area with appropriate allocation of resources to progress the Ernst & Young recommendations.

Yet such activities are unlikely to be effective by themselves if there are obstacles created by gaps in implementation of the bed plan associated with Stepping Up.

Extremely Long Length of Stay in Emergency Departments

All patients should be seen and assessed in an emergency department in 4 hours. A recent American paper on mental health length of stay in emergency departments described a stay of over 24 hours as "extremely long length of stay" abbreviated as EL-LOS. It identified emergency department overcrowding as a threat to patient safety (Stephens et al, 2014). In the American paper the EL-LOS patients had a median length of stay of 33.5 hours, and the people most at risk of these long stays were uninsured people at risk of self-harm (Stephens et al, 2014).

Extra mental health beds were announced in September 2014 to relieve pressures on emergency departments as discussed in this reprot. (Picture RAH www.rah.sa.gov.au)

The South Australian situation has similarities and differences. The similarity is that the presence of EL-LOS patients contributes to ED overcrowding and safety risks. The differences include that in Australia lack of insurance should not be an obstacle to care as it is in the US, and that many patients in South Australia stay longer than 24 hours – at times up to 5-6 days.

The provision of care for EL-LOS clients costs money in security, nursing and medical costs for care delivered in an unsuitable environment. It is reasonable to expect that if the full financial costs of delivering care in this way were to be tallied, these costs would be greater than providing care in more suitable settings.

New funding allocations for Mental Health Services

The recent announcement of more mental health beds to ease pressure on emergency departments is welcomed (SA Government, 2014).

Such announcements generate both relief and concern in the sector. The relief is that people who need beds who will now be more likely to receive them instead of waiting in the unsuitable setting of an emergency department. There is also relief for emergency department staff who will be less likely to be diverted from emergency tasks by taking on "ward" tasks for waiting patients.

The benefits and risks of increasing bed numbers when the system is in crisis

The concern about any opening of beds, is the risk that the money spent on them may not be spent on future expansion of community services if the additional bed capacity is required in the medium to longer term. This is a potential concern at this time, not an intended consequence of the bed announcement. However establishing new acute beds for anything more than a short

term “flex” period will have opportunity costs if money spent on delivering these beds could have been spent instead on the delivery of evidence based community mental health care.

If this fear were to be realised there could be less early intervention, less rehabilitation and therefore more re-admissions, creating a risk that even more acute beds are required in what can become a vicious cycle of increasing need. Community interventions can reduce time spent in hospital: consequently, if there are less resources available for these services, the need for hospital beds will increase. The Cochrane Collaboration has considered the evidence for the benefit of community mental health care. They have reviewed evidence about intensive case management, concluding that it can reduce hospitalisation for people with severe mental illness (Dieterich et . 2010). Also, they find evidence that crisis intervention teams can reduce hospital readmission, in particular by mobile teams supporting patients in their own home (Murphy et al, 2012). There is benefit in properly funding community care that is delivered by clinical services and non-government support services.

Without sufficient community alternatives, demand for beds increases, and the issue becomes the one discussed in our 2012 Annual Report – “When too many beds are not enough” (Annual Report, 2012 pages 47-48). The 2012 discussion quoted Alan Rosen and co-authors from that year noting that with any change process there is inevitably a push to re-institutionalise people, and this regressive influence can cause a loss of momentum in transforming clinical culture (Rosen et al, 2012).

Having said this, there are significant benefits in increasing bed numbers as a short term response so that people who need admission can access care, and the Government’s decision to boost bed access is a positive one. This will assist people, including clients of our office, who have spent time waiting in emergency departments for inpatient care. It should be then possible to reform mental health services, without unacceptable emergency department waits being a consequence.

Mental health bed numbers – forensic beds

In July 2012 the Government announced an expansion in forensic bed numbers from 40 acute beds to 50. Funding had been allocated to build a new 10 bed unit at the James Nash House site at Oakden to replace a 10 bed unit currently operating at Glenside Hospital. The announcement was that 20 beds would be built with these funds instead of the planned 10. (The history of this redevelopment was described in our 2010 report (Office of the Public Advocate, 2010 pages 97-101) and the increase noted in the forensic mental health discussion in our 2012 Annual Report (Office of the Public Advocate, 2012 pages 21-37).)

The Government’s September 2014 bed announcement brings forward the opening of the 10 extra forensic beds, which will now occupy vacant bed space in an old ward building at Glenside Hospital, until the new accommodation is completed in early to mid 2015.

This will benefit forensic patients who will receive care in a dedicated unit. It will also effectively free up mental health beds in acute units, including secure psychiatric intensive care beds that have been not available for their intended use because of this overflow of demand that should be met within forensic services.

There are still critical shortages in forensic mental health capacity. This could be better met if a 10 bed forensic disability unit within James Nash House was operated separately by disability services, with this bed number being additional to the 50 beds designated for forensic mental health use. This has been discussed further in the first section of this report which reviews programs and unmet need for disability services.

A quick comparison with Victoria illustrates the magnitude of the gaps in services for both forensic patients and for prisoners. That state has 116 mental health beds at its standalone forensic hospital, Thomas Embling Hospital. For prisoners it operates 16 beds at an assessment prison that caters for prisoners with a psychiatric illness as well as those who are acutely disturbed and suicidal or who require an assessment; up to 20 beds at a women's prison for women who have a serious mental illness or are at high risk of self-harm (Forensicare, 2014); and it is in the process of building an additional 75 mental health beds for male prisoners as part of a major prison redevelopment (Department of Justice, 2014).

If we were to use the Victorian bed numbers as a target, once their development is complete, i.e. 175 prison based mental health beds in total, and then adjust it to a count for the smaller South Australia population, we should have nearly 50 such beds to meet the mental health needs of our state's prisoners. Currently in South Australia at any one time between 1 to 3 beds are allocated for the use of prisoners at James Nash House. This puts pressure on other staff groups to provide mental health care in prison, and on general mental health wards.

No doubt access to mental health beds for prisoners will improve somewhat with the increase in 10 beds at James Nash House, but even more beds are needed to have enough mental health beds to respond to the needs of the two populations served by forensic mental health services: defendants who have been found not guilty by reason of mental impairment, or unfit to stand trial, and prisoners who need treatment for mental illness.

Mental health bed numbers – older adult beds

Proposed reform in this area has not been as much in the public eye as the reform to adult services, but similar principles were to be applied to older persons mental health services as in Stepping Up: – the development of alternative community services to hospital care by redirecting existing recurrent funds, providing for residential alternatives to long stay hospital care and bolstering the role of non-government providers.

Seventy-two state funded long term psychogeriatric beds were to be closed as part of this plan. Money was to be reallocated to the operation of three 8-bed transitional care units, and five 8-bed intensive care behaviour units which could respond to the needs of people with behavioural and psychological symptoms of dementia. These units were expected to receive Commonwealth aged care funds, as their residents would be eligible for an aged care place, supplemented by state funding to pay for meeting the higher mental health needs not normally managed in residential aged care. Funding from the closure of the long term beds when freed up was to be used to employ approximately 50 additional psychogeriatric staff. While the final bed numbers, and numbers of extra staff were contingent on business planning and negotiations with the Australian Government, this plan, which we described in our 2010 Annual Report was elegant and cost neutral (see Office of the Public Advocate, 2010 page 38).

Currently, the first part of the plan, the closure of long term older persons' mental health beds, has progressed, with considerable recurrent older persons mental health funds freed up. What is needed now is the reinvestment of these funds. The planning and oversight of this task could come through the Mental Health Commission discussed below.

South Australian Mental Health Commission

South Australia is planning for a new Mental Health Commission for this state. Decisions are yet to be made on the purpose of the Commission, and how it will be established.

This Office's 2011 Annual Report reviewed progress in Mental Health Reform to date and considered the possible benefits that a Mental Health Commission could bring (Office of the Public Advocate, 2011 pages 38-43).

A Commission could take over the planning and monitoring tasks currently performed by the Department of Health, offering greater independence, transparency and accountability.

A new state mental health plan is urgently needed to replace the now expired Stepping Up plan, and oversight is needed to steer a steady course in the face of the current emergency bed demand crises. The Mental Health Commission will develop this plan.

In 2011 we reported the work of a NSW taskforce that was established to develop a Commission in that state, which subsequently came into operation in July 2012. The principles to be applied were transparency, integrity, openness, accountability, respectfulness, non-paternalism, consumer-friendliness, and inclusiveness. The SA Commission should have the strategic capacity to identify gaps, be independent, have a whole of government role, and consult with stakeholders (Office of the Public Advocate, 2011 pages 40-43).

The National Mental Health Commission exists but its role is a developing one. It does not have a statutory basis and sees its role as one of "reporting, advising and collaborating". The Commission uses its reports, relationship and influence to give independent advice (National Mental Health Commission, 2014). This year the Australian Government asked the Commission to undertake a Review of Mental Health Services and Programmes across the country. This document is yet to be published, but if it maintains the clarity of thinking and forthright advocacy of the Commission's first two Reports into mental health services, this Review should influence the development of Mental Health services in Australia for years to come.

However while the National Commission has developed its review and advising role, it is a different model to that of a state Commission.

Performance audit

Our 2011 discussion went on to discuss the potential benefit of a Commission in providing accountability for the use of mental health funds and the delivery of policy objectives. We remarked that the Auditor General in South Australia does not have a performance audit role in this state, unlike in some other jurisdictions, making it even more important that a Mental Health Commission has this responsibility.

Legislative basis of a State Commission

The Commissions in Western Australia and New South Wales have different legislative bases, and roles.

The Western Australian Commission is more 'department' like. It funds but does not operate services. The NSW Commission has greater independence in its work and is established by specific legislation. It is responsible for planning and monitoring performance, but does not have control of funding, in the way the WA Commission does.

The WA Commission has been operating as a standalone agency for about 4 years. It was established under section 35 of the *Public Sector Management Act 1994* in that state. The generic provisions under that section allows the Governor, on the recommendation of the Public Sector Commissioner to establish and designate departments. The Mental Health Commissioner acts as the 'Chief Executive' for this purpose. The Commission provides mental health policy and advice to the government, leads the implementation of the mental health Strategic Policy, and provides for grants, transfers and service contract arrangements. The Commission is responsible to the Mental Health Minister, and does not directly administer any legislation.

The NSW Commission was established in July 2012 under its own legislation, the NSW *Mental Health Commission Act 2012*, for the purpose of monitoring, reviewing and improving the mental health system and the mental health and well-being of the people of New South Wales. The Act defines the constitution of the Commission and its community advisory council, and determines that it is under the control of the Minister except in relation to the preparation and contents of a draft strategic plan, or the content of reports. The Principles that the Commission follows in its work are defined in its legislation, as well as its functions: developing a draft strategic plan for submission to the Minister for approval; monitoring and reporting on the implementation of the plan; reviewing, evaluating, reporting and advising on services for people who have a mental illness, as well as mental health promotion, advocacy and education roles.

The NSW legislation requires public sector agencies to work cooperatively with the Commission, and to comply with the Commission's reasonable requests for information.

South Australia will need to determine which model will be best for the needs of this state – and in particular whether or not the Commission should have a role funding services. We also need to consider the small size of our state, and avoid potential duplication in the roles of the Commission and SA Health, if a Commission is to be limited to a planning and accountability role, and not a funding role.

No doubt further research on the performance of the Commissions in different jurisdictions will help determine which is the best model for our state. However, it may be that a Commission could combine the different strengths of both the NSW model and the WA model.

A strength of the NSW model is that the Commission is established in legislation, and allows for both Ministerial control and Ministerial responsibility, but provides independence of the Commissioner in developing a draft plan and providing reports. The Commission engages with the community and services more broadly and is not limited to the mental health sector. Any government agency that works with people with mental illness is expected to cooperate with it.

A potential weakness of the NSW model if applied to South Australia, is that the NSW Commission is not a funder of services, in the way that the WA Commission is. Arguably, if a Commission is involved in monitoring and improving performance, it has greater leverage if it is responsible for contracts made with non-government providers, and for the service agreements used to fund government services, and is not limited to a monitoring role.

There is a risk of duplication of effort if responsibilities are separated, with contract management undertaken by the Department and program review undertaken by the Commission, because similar work is needed to collect and manage the data required for both functions.

Legislation to establish a Mental Health Commission in South Australia could sensibly include the general provisions included in the NSW Act, and also give the Commission authority to fund services, including principles in the administration of this funding, in the same way that the existing South Australian *Disability Services Act 1993* does for services funded through that portfolio.

A future vision for State based commissions

South Australia has one population, but we have two levels of government planning our mental health services: the Australian Government, and the South Australian Government.

This has created duplication and gaps, as each level of government funds programs to solve the same problems - parallel mental health services have developed for young people and adults to meet the same population need.

In the distant past there was a greater delineation between roles, with State Government funding specialist community mental health care, and the Commonwealth Government funding primary care and specialist fee for service practitioners. This has changed progressively over the last fifteen years.

It should be noted that the current situation has benefits for clients of our Office. For example, a person with a mental illness who is not receiving a state based mental health service might access the Commonwealth's Personal Helpers and Mentor Scheme. We seek assistance from the Commonwealth's Partners in Recovery Scheme to bring together services for complex clients. Clients not enrolled in a local state community mental health services might access a mental health worker from the Medicare Local operated Better Outcome scheme. The current levels of unmet need are so great that this overlap provides additional options, but it does create complexity.

Even if existing budget levels were maintained at current levels, greater cohesion and consistency should deliver better outcomes for the population as a whole, compared to the current situation of having services developed and funded by two different sets of government planners.

Any program or clinic operated by the State or Commonwealth with a mental health focus could be brought into one population based plan, with the probable exclusion of Medicare fee for services programs.

In this model a Commission would have two principal stakeholders: the State Government and the Commonwealth Government, and be accountable for developing a population based mental health plan that meets both National and State policy objectives, and where necessary, maintains fidelity to national models in areas such as early intervention for young people. A single Commission operating in this way could then be truly accountable for population outcomes such as suicide prevention, access rates to mental health services, participation in employment, reduction in hospital admissions, reduction in imprisonment, and, ultimately, reducing the prevalence of mental illness in the community through both prevention and delivery of effective services.

Promoting Rights and Interests
Supported Decision Making

Guardianship and Administration Act 1993

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

(c) to speak for and promote the rights and interests of any class of mentally incapacitated persons or of mentally incapacitated persons generally;

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

(e) to give support to and promote the interests of carers of mentally incapacitated persons;

Overview

This year has seen further developments in South Australia, and nationally, in supported decision making practice, and law reform. The Office of the Public Advocate 2012 Annual Report described the outcomes of the first Australian Supported Decision Making trial which was based in our Office and funded by the Julia Farr MS McLeod Benevolent Fund (Office of the Public Advocate, 2012 pages 54-69), and our 2013 Annual Report described a supported decision making model to disseminate practice.

Practical application of supported decision making

In 2013-2014 the South Australian Health and Community Services Complaints Commissioner's Office developed and implemented a supported decision making project. Their project provided training to supported decision making facilitators who work in disability services. The initiative has attracted international interest.

Other supported decision making projects have been undertaken in the ACT, NSW, Victoria, and WA, and a thriving national supported decision making group has developed combining practitioners, academics and Offices of the Public Advocate or Guardians. Initiated by the Victorian Office of the Public Advocate, this group is currently supported by the NSW Office of the Public Guardian.

State based law reform

In 2013 the South Australian Parliament passed two Acts requiring supported decision making to be available. One law relates to disability services, and the other to Advance Care Directives. The *Disability Services (Rights, Protection and Inclusion) Amendment Act 2013* amends the *Disability Services Act 1993,* to require that a prescribed disability provider (a provider that is a government department, agency, or instrumentality or a provider funded under the Act) must have in place appropriate policies and procedures for ensuring the safety and welfare of persons

using their services. The note to this amendment gives as one of its examples a "supported decision making and consent" policy. The need for specific polices will depend on the nature of the services delivered, but it is reasonable to expect, on the basis of this provision, that any organisation that provides services to people who may need support to make some decisions should have a supported decision making and consent policy in place. The Act also recognises the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) as a set of best practice principles that should guide policy development, funding decisions and the administration and provision of disability services. Article 12 of the UNCRPD has been a key driver internationally for supported decision making to be provided.

The *Advance Care Directives Act 2013* has a principle requiring support for decision making. Section 10 (d) requires that a person must be allowed to make their own decisions about their health care, residential and accommodation arrangements and personal affairs to the extent that they are able, and be supported to enable them to make such decisions for as long as they can.

Nationally there have been significant developments in Victoria related to supported decision making with two new Acts, and a Bill currently before the Victorian parliament.

The Victorian *Mental Health Act 2014* has established a supported decision making model in mental health care through a presumption of capacity, the use of advance care plans, the nomination of support persons, and the right to seek a second opinion (Department of Health, 2014). South Australia's Mental Health Act is currently being reviewed. Should it, as we have recommended, be amended to incorporate decision making capacity criteria, this will facilitate a supported decision making model in mental health care in our state also.

At the same time Victoria's parliament is considering the Guardianship and Administration Bill 2014 and has passed the *Powers of Attorney Act 2014* which will come into operation in September 2015. Two new appointments have been developed, those of 'supportive attorney' (in the *Powers of Attorney Act*) and a proposed 'supportive guardian' (in the Guardianship and Administration Bill). The supportive attorney, and if enacted, the supportive guardian will be appointed to help a person gather and consider information, and to communicate and implement their decisions (Attorney General (Vic), 2014).

The proposed scope of the supportive guardian appointment includes both personal and financial matters. This is consistent with a proposed change to the role of guardian in the Bill. Under the Bill private guardians could be appointed to make financial as well as personal decisions, breaking down what at times can be an artificial division between guardianship and administration. The proposed supportive guardian role mirrors this proposed change.

The supportive attorney role can include health and other personal decisions, as well as financial decisions. This appointment is the equivalent of a supported decision making agreement, with statutory recognition.

As we understand the Victorian legislation, it will enable a person to appoint a decision making supporter (the supportive attorney), or if they are unable to do this, the Tribunal will have the power to make such an appointment (a supportive guardian). The Tribunal will have this additional, less restrictive, option to consider and will not have to resort to making a

guardianship appointment with substitute personal or financial decision making powers if that is not necessary.

We welcome the developments in law reform in this area, both in South Australia, and the significant changes to the law in Victoria. Our South Australian Supported Decision Making trial has had some influence – both in raising the need for supported decision making to be available in our own jurisdiction - and , as the first trial of its type in this country, attracting national and international interest. For example, in 2010 we contributed to the Victorian discussion about supported decision making when the Chair and officers of the Victorian Law Reform Commission visited our Office just as our trial was initially getting underway. The new Victorian legislation is likely to form a template for future law reform in other jurisdictions, and ultimately affect South Australian practice, in the same way that Victoria's *Guardianship and Administration Act 1986* influenced the later development of legislation in other Australian states 20 years ago.

National Law Reform

A significant development in 2013-14 has been the inquiry into Equality, Capacity and Disability in Commonwealth Laws by the Australian Law Reform Commission (ALRC).

The ALRC released an issues paper in November 2013, in response to a referral from the former Attorney General Mark Dreyfus QC to examine laws and legal frameworks within the Commonwealth that deny or diminish the equal recognition of people with disability before the law and their ability to exercise legal capacity, and what, if any, changes could be made to Commonwealth laws and legal frameworks to address these matters. The terms of reference asked the ALRC to have regard to how Commonwealth laws and frameworks interact with state and territory laws, and contemporaneous developments and best practice within states and territories (Australian Law Reform Commission, 2013).

The review process has been comprehensive. The South Australian Office of the Public Advocate provided a response to the issues paper from the Commission supporting the development of a nationally consistent approach to defining capacity, as raised by the ALRC. We noted the different rates of guardianship in different jurisdictions and how that could impact on the rights of people with disability receiving NDIS services. The NDIS Nominee Rules appropriately recognise state based appointments, but these vary in their criteria and rate depending on the laws of the jurisdiction and the prevailing practices at the time (Office of the Public Advocate, 2013 pages 6-7). We also raised the need to consider changes to the NDIS nominee rules, to give greater clarity in defining supported decision making and substitute decision making roles of nominees (Office of the Public Advocate, 2013 pages 8-9).

The ALRC subsequently released a discussion paper based on the consultation following its issues paper. The discussion paper proposed the development of National Decision Making Principles, and, amongst many other topics, made recommendations related to the NDIS (Australian Law Reform Commission, 2014). The intention of the proposed National Decision Making Principles is that they should guide reform of Commonwealth, state and territory laws and legal frameworks concerning decision making by persons who may require support in making decisions.

The SA Supported Decision Making Committee (see below) considered the proposed decision making principles and made a number of suggestions, which were incorporated into a combined response to the report prepared by the Office of the Public Advocate (SA) and the Office of the Public Advocate (Vic). This response gave feedback on the principles, considered the role of state based jurisdictions, and the role of guardianship in the NDIS. The submission argued for uniform national principles but supported a significant role for state based tribunals who have been working in the guardianship and administration jurisdiction and have experience in the area. Representatives could continue to be nominated in Commonwealth laws, but when there is a need for a tribunal appointment it should occur within state jurisdictions (Office of the Public Advocate (SA) and Office of the Public Advocate (Vic), 2013).

Supported Decision Making Committee

The South Australian Supported Decision Making Committee has continued to meet since the pilot project, and currently meets quarterly. In the past 12 months it has considered how supported decision making practice can be sustained, developed recommendations for legislative change, and responded to the ALRC inquiry. A protocol for a new project to provide supported decision making for people with dementia was developed, but a suitable funding source for the project has not yet been found.

The membership of the Committee is as follows:

Tiffany Bartlett	
Ian Bidmeade	
John Brayley	*Chair*
Margaret Brown	
Di Chartres	
Ian Cummins	
Helen Mares	
Graham Mylett	
Cher Nicholson	*Health and Community Services Complaints Commission – Supported Decision Making Project*
Elly Nitschke	
Andrew Sarre	
Steve Tully	*Health and Community Services Complaints Commissioner*
Robbi Williams	*Julia Farr Association*
Tiffany Bartlett	

Promoting Rights and Interests
Community Guardianship Planning

Introduction

In most Australian jurisdictions there are two distinct types of adult guardian that can be appointed by a Board or Tribunal– a private guardian and a public, or statutory, guardian. In two jurisdictions, Victoria and Western Australia, there is a third type of guardian, a community guardian. Since the inception of our current *Guardianship and Administration Act 1993* (SA) there has been discussion in the sector about establishing a community guardian scheme in this state.

Private guardians are family members or close friends. The presumption that family, or good friends, be preferred as guardians is obvious and compelling. They will, generally, be most knowledgeable about the person's good, and their previous values and preferences, and most concerned about their good (Buchanan and Brock referring to family guardians, cited in the Office of the Public Advocate (2009)).

Public guardians act as the guardian of last resort, and are appointed when there is no alternative order (appointing a private guardian or guardians,) that the Board or Tribunal can make. In Australia this is the role of Public Advocates and Public Guardians, who are assisted by skilled staff. It is significant to give such responsibility to a non-family member and in our systems public guardians undertake this work in a professional manner. They are expected to apply the requirements of the law, meet established standards, and act independently for the person they represent in making substitute decisions in areas of health care, accommodation and lifestyle arrangements. Decisions are made within professional teams – guardianship practices are discussed and monitored. If there is a dispute about a decision made on behalf of the person, the decision can be reviewed by someone who was not involved in making it. These practices reflect the significant responsibility of substitute decision-making (guardianship).

In the context of the Australian guardianship model, Western Australia and Victoria have established community guardian programs using trained volunteers. They are neither family nor pre-existing friends. While a friendship may develop between the guardian and the person they make decisions for, community guardianship has been established as a subset of public guardianship practice, with similar responsibilities, and accountability.

This year significant discussions have occurred between the Guardianship Board, the Office of the Public Advocate, and SA Health on potential models for a community guardian program in South Australia. Discussions have also occurred with Disability SA and Disability Services within the Department of Communities and Social Inclusion.

Background

Twenty five years ago the Victorian Office of the Public Advocate commenced operation of a volunteer Community Guardianship scheme. In this scheme the Public Advocate delegates the

role of guardianship to community guardians, who are volunteers selected, trained and supported by a Program Coordinator in the Office of the Public Advocate. The community guardians are accountable through record keeping and the provision of reports (Office of the Public Advocate (Victoria), 2009). They receive a yearly stipend to defray costs, similar to that paid to volunteer community visitors, and are indemnified by the scheme. In 2013 in Victoria there were 70 community guardians, and 65 active cases in that state (SA Health, 2013).

An early obstacle to the possible use of community guardians in South Australia was a limitation in the South Australian *Guardianship and Administration Act 1993* which in its first iteration, allowed the Public Advocate to delegate powers only to public sector employees (section 23). The then Public Advocate and President of the Guardianship Board saw the need for section 23 of the Act to be amended so that delegation could occur to volunteers and a Victorian style community guardianship program could operate in this state. In 1999, after legislative review, the Act was amended, to enable the Public Advocate to delegate to non-public sector employees, although this remains subject to the Minister's approval in each case.

In 2005 the Western Australian Office of the Public Advocate commenced its own community guardian scheme aimed to assist older persons in stable accommodation who have needs that are not complex in nature (SA Health, 2013; Whisson and Jones, 2009). In this program volunteer community guardians are appointed as guardians by the State Administrative Tribunal in their own right, rather than having powers delegated by the Public Advocate, and being accountable to that Office. Nevertheless the WA Office of the Public Advocate provides coordinators who deliver training, support, matching of volunteers to clients, and monitoring. The Tribunal in that state helped shape the program, as ultimately it had to be satisfied about the appropriateness of these appointments. Initially it was proposed by the WA Public Advocate that potential community guardians would meet with a client over a 6 month period to develop a relationship and for compatibility to be assessed, before a guardianship appointment was made (during which time the Public Advocate would remain guardian). This period was extended to 12 months to address Tribunal concerns (Whisson and Jones, 2009). Community guardians report regularly to the Public Advocate, and service providers can raise concerns with the Office of the Public Advocate. In 2013 there were 20 community guardians in WA, with 20 people under orders (SA Health, 2013).

South Australian Models and Plans

In late 2008 the South Australian Office of the Public Advocate developed a detailed business plan and budget bid for a program "Supporting Vulnerable Adults Through Volunteering Programs for South Australia". It was a proposal that was consistent with a prominent theme of the Attorney General's Department at that time to engage the community.

This 2008 plan proposed a number of related programs: a community visitors program to inspect mental health, disability and supported residential facilities, a community guardian program based on the Victorian model, a community advocacy program, and a private guardian support program. This work, undertaken at the time by former Assistant Public Advocate Margaret Farr, did not attract funding that year, but the effort was fruitful as the business planning was later used as the foundation for planning the mental health Community Visitors Program some years later. The Community Guardian component was not developed.

In our 2008 planning work, our Office opted for the Victorian model, using the delegation facility of s23 that had been put in place by parliament 9 years previously. Each volunteer community guardian selected and trained for this program would need to be approved by the Attorney General, on the recommendation of the Public Advocate. The Victorian program's manual would have been adapted to reflect SA legislation for use here.

It was our understanding that volunteers attached to our Office would be insured, as would usually be the case for other government volunteer programs. They would be protected from liability to their clients and other third parties by the *Volunteers Protection Act 2001*, and could potentially be personally insured for injuries and loss sustained in their volunteer work, through the Commissioner for Public Employment's Standards that apply to some volunteers in government agencies.

Planning this year

The Guardianship Board has operated a pilot Community Guardianship program since 2011. The program has made a small number of appointments of either Justices of the Peace or a retired Board Member, and was set to expand. This trial was not specifically funded, and perhaps because of this lack of dedicated resources, it did not have the design features incorporated in interstate models. Our Office sees the need for a South Australian model to incorporate selection, training, support, oversight and indemnity along the lines developed interstate.

An across agency working party was convened by SA Health to consider future models if the Board's pilot scheme were to expand. Four models were examined.

Option 1. Justices of the Peace (direct appointment model). The working party considered that JPs would need specific training in the guardianship role. If it were to be coordinated by their association, governance would need to be formalised and a service agreement put in place. It was suggested that if the JPs were appointed in their own right that a 6-12 month period of relationship building occur prior to appointment, and that the JPs be established as volunteers under the relevant Act so that they might be covered for liability.

Option 2. *Guardianship Board coordination (direct appointment model).* This option was not favoured by the working party. This role is not in keeping with the approach of the current Act in separating the appointing role of the Board and the guardian role of the Office of the Public Advocate. There is a clear potential conflict of interest if the Board is both appointing and managing the community guardian scheme. Our view is that the Board as a quasi-judicial body would find it challenging to keep its adjudication and administrative roles completely separate if it had both responsibilities.

Option 3. *Office of the Public Advocate coordination (delegated guardianship model).* The working group considered it would be necessary to increase the capacity of our Office to provide supervision and support, and listed a number of risk mitigation strategies that would need to be in place if we were to operate such a scheme. The Attorney General would need to approve each delegation of powers to a particular community guardian. Our Office sees the Attorney's role in approving delegations as a positive check and balance.

Option 4. *SA Health coordination (direct appointment model).* Multiple risks and conflicts were noted in this option and the working group did not prefer it.

In summary, the working group considered both Option 1 (Justices of the Peace – Direct appointment) and Option 3 (Office of the Public Advocate - Delegation) to be potentially viable options. Both options would require a resource to establish and operate.

In the 2014 Budget, $100,000 has been allocated to the Department of Health and Ageing to develop a Community Guardian Scheme. We look forward to seeing a scheme designed and established.

It should be noted that one option which was not considered by the working party is operating the scheme with the Community Visitor. Community Visitor programs already have an infrastructure to recruit and support volunteers, and a community guardian program can "piggy back" on this infrastructure. Some of the same people who have been interested in the community visitor role in SA may also wish to contribute by becoming a community guardian.

The place of community guardianship

A community guardian scheme can offer a unique service to a person because of the greater availability of a community guardian than a delegated public guardian. A community guardian might have one or two clients, within their general locality, and be able to visit them monthly, whereas a professional delegated guardian (in OPA) will have many more clients, spread across the state, and unless a specific issue arises will visit clients once a year - in keeping with established national standards. We have previously estimated that a manageable caseload of stable less complex clients allocated to a professional guardian could be about 75. In practice at the moment it is over 240 per guardian. Many of these clients might readily move to a community guardian program based on the Victorian model.)

Notwithstanding the benefits that these schemes offer, it is relevant to place the role of community guardian schemes in perspective.

Extent of interstate programs has been limited. The Victorian scheme, with about 80 current clients, has operated for 25 years, and generated significant interest from many jurisdictions. Yet apart from the 20 appointments in WA, it has not been replicated. The programs offer a significant service for people under guardianship but have not become large schemes, and in spite of the ongoing interest in their role, have not been introduced in other Australian jurisdictions.

Alternatives to guardianship. Nationally and internationally, the latest developments in disability rights, aged rights, and adult protection have sought to bolster individuals' rights and provide effective safeguards without any form of guardianship appointment. For example, supported decision making programs, have been a focus in many Australian jurisdictions since Australia's ratification of the UN Convention on the Rights of Persons with Disabilities in 2008. The initial Supported Decision Making trial here in South Australia identified people who wanted decision making support but were isolated and did not have family or friends who could deliver this support. The Victorian OPA has now commenced a trial of offering volunteer supporters to

assist people with decisions. Whereas community guardianship was a focus in the past, with the UNCRPD the new priority has been access to supported decision making.

Defining the problem to be solved. Community guardian programs have been put forward as solutions to a number of problems.

It is critical that problems are carefully defined before solutions are proposed and applied, particularly as guardianship has often been put forward as a solution to a range of systemic problems which should have systemic rather than individual responses. Examples include gaps in services, lack of accommodation and authorisation of the use of restrictive practices. (This was discussed in our 2011 Annual Report (Office of the Public Advocate, 2011 pages 122-132.) There is a risk that community guardianship could be expected to fill similar gaps when the responsibility for solving problems should rest elsewhere.

Social connections for isolated people. Community Guardians can provide this. However there are also other schemes designed to overcome isolation that can provide personal support or advocacy. For example for older people living in residential aged care a Community Visitors Scheme funded and operated by the Commonwealth provides this function. (We note though, that we also consider that the powers of these Visitors could be expanded to better protect aged care residents rights along the lines of a recommendation of the Productivity Commission in 2011 (Productivity Commission, 2011, Volume 2 page 424)).

Adult protection. There are other volunteer programs that offer adult protection or advocacy. For younger people with a disability a state Community Visitor's Scheme operates statutory inspections of disability accommodation. These schemes can potentially benefit large numbers of people by being available to all residents of places visited. Community Visitors have powers in statute or regulation directed towards resolving matters with providers, whereas Community Guardians have substitute decision making powers in relation to a particular individual. A Community Visitors Scheme can be more relevant to adult protection with its powers.

Similarly many people need advocates. The Commonwealth funds a Citizen's Advocacy program that carefully matches volunteer community members with people with disabilities. Although very occasionally a Citizen's Advocate might become a guardian, such advocates generally provide assistance in an advocacy role without needing guardianship powers.

Rapid discharge from hospital. Based on the discussion in the SA Health document, it is unlikely that community guardians per se, will have a role in addressing this issue, as the two options favoured do not have the community guardian meeting a client and then straight away making a major decision – such as a move to residential aged care. This is because the community guardian would either have their powers delegated from the Public Advocate in the Public Advocate option (Option C) or have a 6-12 month period of relationship building if appointed in their own right in the Justices of the Peace model (Option A).

This Office would still be making initial decisions. Although our Office has a waiting list, urgent matters such as decisions about discharge are responded to, usually by one of the senior staff.

The need to independently make hospital discharge decisions is also why the SA Health coordinated model was not favoured. It would be a conflict of interest for SA Health to operate a

scheme that was making decisions in which SA Health had an interest. This is one the reasons the Office of the Public Advocate and the Guardianship Board sit with Attorney General's Departments in most states, although in South Australia both these bodies, now with the Attorney General's Department, were once with the former Department of Human Services before being moved.

Conclusion

The future model of Community Guardianship will be determined by the project now funded within the Department of Health and Ageing.

There is no single right place for the scheme to sit. However our Office, given our role and expertise, would welcome an opportunity to provide training and ongoing support, and to receive reports from community guardians. We still favour the Victorian model in which the scheme operates from the Office of the Public Advocate.

Whichever organisation is funded to provide the scheme, it will need to closely connect to our Office, and fulfil the role of guardianship envisioned in the *Guardianship and Administration Act 1993* and by Parliament. This is relevant with respect to the role of guardianship in the context of other options.

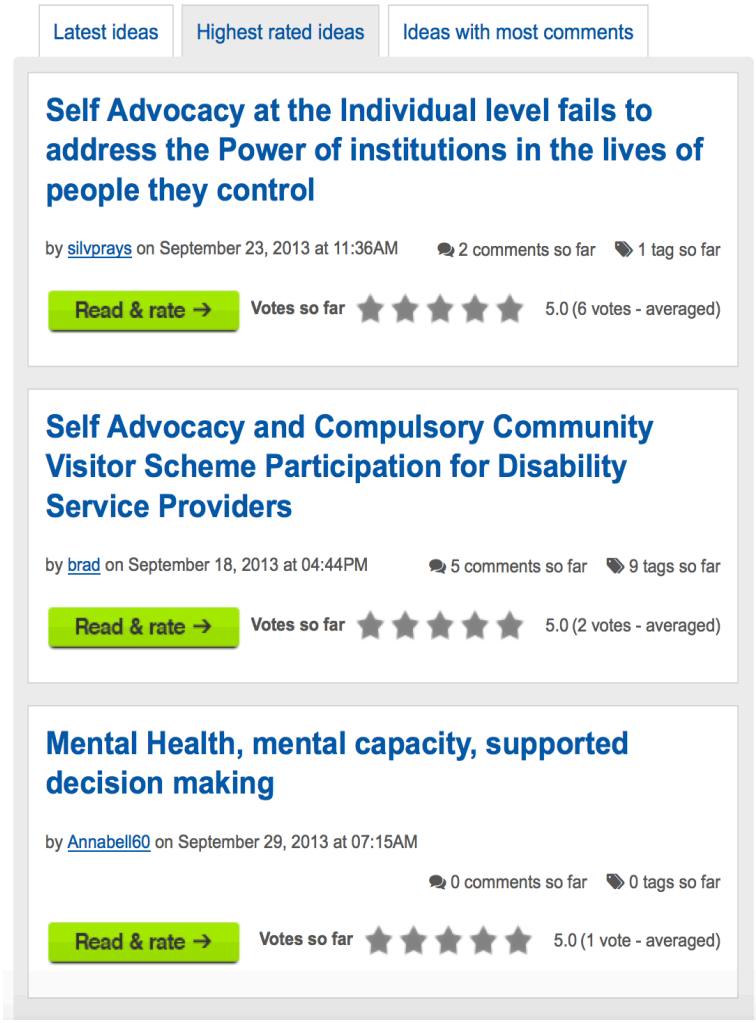
Our state opted in 1993 to set up a Public Advocate model with a broader role than guardian of last resort, rather than establishing a Public Guardian with a more singular legislated focus on adult guardianship. In a Public Advocate model, guardianship is delivered in the context of advocacy and promoting rights for people with decision-making disabilities, and finding alternatives to making orders. Guardianship is a necessary and valuable option but it is part of a model that promotes other options. This affects how delegated public guardians act in their role. A new Community Guardianship scheme will need to be planned in this context of a range of options, and not have a singular focus on guardianship.

The model should also consider the roles of volunteers in providing supported decision making, an intervention that should be tried, or at the very least seriously and properly considered, before implementing substitute decision making.

The above comments are made in the context of the Australian guardianship system as it now operates and the decisions that guardians currently make.

It is possible that the role of public guardian in Australia will change in the future, if adult protection develops further as a distinct function and role, separate from guardianship as it has in other countries (see Office of the Public Advocate, 2009 page 43-49 for an initial overview, and the Office of the Public Advocate and the University of South Australia's Closing the Gaps report of 2011 discussing comparative international practice page 31 – 51). If this were to happen the initial abuse response and prevention work may be done by professionals separate from the guardianship system without needing Board or Tribunal orders. The professional staff in a Public Advocate's Office would then have a more circumscribed role. The Office could provide more support and monitoring and less direct guardianship work – possibly maintaining a panel of potential community guardians to take on these duties. For this to happen there would need to be both adult protection and Guardianship law reform.

Promoting Rights and Interests
Your OPA – Deliberative Democracy Website trial



Introduction

In late 2013 our Office took up an opportunity to trial a deliberative democracy website - to consult with stakeholders who are internet users.

A broad question was posed: "How should OPA promote rights?" We undertook to place the highest rated ideas in our Annual Report.

Website visitors had the opportunity to contribute ideas, and other users could then either vote on ideas or comment on them.

Overall during the period of active operation –approximately two months there were 897 discrete visits to the "Your OPA" website, 422 of which were return visits. Many of the visits were protracted and went onto other pages of our website. There were contributions from people who identified as service users, and others who were professionals. Involvement in rating ideas was limited, with just 14 votes cast to rate different ideas. This may reflect a limitation in this technique when used in this way by an Office such as ours.

However we were pleased with the number of people who went to the consultation site. While it was less than the traffic to our main OPA website, (usually 70 – 100 daily visitors on work days), the consultation site still generated significant interest.

Ideas submitted to Your OPA

The following section brings together ideas from our contributors, using their original words where possible, with further comment from our Office.

Self Advocacy

Arguments were presented for and against the impact of self advocacy for people with a disability.

A contributor supporting the teaching of self advocacy said that it creates a sense of empowerment, and increases self-determination and independence. This contributor was also a supporter of the extension of community visitors schemes to disability services – not just accommodation, but day options, respite and workplaces where people with disability attend.

Presenting a different view another contributor highlighted the pitfalls of self advocacy, and the problems with trials of self advocacy in the past. Clients taught to speak out through service driven self advocacy initiatives 20-30 years ago reported experiencing increased abuse, neglect, discrimination and exploitation.

This respondent noted that service driven self advocacy programs can place all the responsibility to achieve change on the most vulnerable party. One role of advocacy is to challenge institutionalised practice and address the power imbalance between the vulnerable person who is dependent on the service provider. Paid individual, or citizen advocacy, and systemic and legal advocacy fulfil these vital roles, but this respondent was not convinced that self advocacy could do so.

Another respondent commented on the application of self advocacy in the mental health sector. They saw self advocacy as the ideal, but also noted that self advocacy from a person with mental illness can be perceived as a symptom of illness, and a person standing up for themselves can be viewed as difficult, demanding, agitated, requiring extra medication, aggressive, non-compliant and non-cooperative. This respondent did not consider that either systemic or paid advocacy services, including the Office of the Public Advocate, have a real impact in influencing the culture and practice of the Mental Health Services.

OPA Comment: Our Office supports the principles and approach of self advocacy. Inclusion International has summarised self advocacy as being people with intellectual disabilities speaking up for themselves, and making their own decisions. Self advocates also ask for support when they need it.

There is significant overlap between the principles of self advocacy and supported decision making. Our experience in the supported decision making trial was that many people with disability had been taught to let others make decisions for them, and because of this saw a need to develop their own decision making skills and acquire personal confidence in making decisions.

The reports by contributors of the pitfalls, historically, of self advocacy may be not so much an indicator of the limitations of self advocacy per se, but an indication of the problems that can occur in the absence of a range of complementary advocacy strategies, and support for self advocates. Our Office has not reviewed self advocacy as it is practiced in 2014, however we do work with self advocates who are effective both individually and systemically, and know of one program where self advocates are well supported.

Speaking up for carers

A submission was made reflecting on the difficulty carers can have speaking up or knowing who to speak up to. A contributor who had participated in many multidisciplinary meetings around the support, need and funding for the individual in their care, is tired of knock backs and feeling that their voice has not been heard. The contributor noted that it would be beneficial to have someone independent of the family unit that has the professionalism to be non-judgemental and pro-active in assisting families, pointing carers in the right direction and advocating with them.

The OPA comment is that such advocacy is available, but the problem described reflects the limited amount of advocacy accessible, so that a very high threshold exists for carers and families to obtain advocacy assistance. If such assistance was more available it could assist more people in these difficult situations.

Mental Capacity, Supported Decision Making in the Mental Health Act

The consultation occurred at the time of the Chief Psychiatrist's review of the *Mental Health Act 2009*.

A contributor referred to the need to support people make their own decisions in relating to "their life, wants, needs and best interest" as opposed to others making decisions for them.

OPA Comment: This is also the position of the Office of the Public Advocate. This response and others related to the Mental Health Act review were appended to our Office's submission to the Chief Psychiatrist's review.

The Definition of Mental Illness in the SA Mental Health Act

A contributor proposed that the definition of mental illness in the Mental Health Act be expanded to include short term emotional distress. This would recognise that due to life circumstances people can experience short term intense feelings causing severe emotional distress, that can result in a person taking their own life. A person experiencing severe

emotional distress may only need to be kept in a safe environment, have the opportunity to talk about their problems and have a few good nights sleep in order to regain a sense of control.

OPA Comment: The *Mental Health Act 2009* defines mental illness as any illness or disorder of the mind. This is a broad definition, and can encompass distressed and disturbed states, as described above. Nevertheless, the experience of people in crisis being turned away is acknowledged, and at times consumers are told that this is because they do not have a "mental illness".

Community Treatment Order Rates

One contributor voiced concern at the high use of Community Treatment Orders (CTOs) in mental health practice in Australia and South Australia. The contributor noted this has started to look like more a form of social control than the least restrictive medical intervention that it is purported to be. The contributor went on to ask "Is it possible that it's not only the rights of those who are in effect 'legally coerced' into the CTO program that are being eroded, but that growing evidence seems to suggest that in many cases this method of treatment is not only ineffectual but can be seen as detrimental to the recovery process of the individual?".

OPA Comment: The OPA agrees with this concern. We consider there is a role for Community Treatment Orders, but one that is more limited than their current use, which would affect a smaller number of people than are currently receiving treatment under a CTO. An effective, well coordinated mental health system can engage, educate and assertively follow up clients without needing an order authorising coerced medication treatment. A review of the lack of evidence for the effectiveness of Community Treatment Orders can be read in our 2009 Annual Report (Office of the Public Advocate, 2009, pages 49-51).

By way of further update, the lack of evidence for the effectiveness of CTOs led to a randomised control trial of their use by a group based at Oxford University, published last year in the Lancet (Burns et al, 2013). Patients were randomised to either a Community Treatment Order or a control condition called "Section 17" leave. Section 17 refers to a part of the UK Mental Health Act which allows patients to be discharged from hospital, followed up, recalled to hospital if they become unwell, but not given medication without their consent. There was no difference in the readmission rate to hospital between the two groups. It is our view that this study indicates that it is more important that a person receives mental health follow-up, than be subject to a coercive order enforcing medication.

Workforce training

The need for training, and a paradigm shift in provision of mental health services was raised. One contributor said that reducing stigma has to start with the mental health care system where it is most rife. That contributor saw the need for alternative methods, citing a Finnish approach used for the treatment of psychosis. Another saw the need for staff with a broader skill set, with skills in counselling, problem solving, education, knowledge of the law, advocacy skills, social work skills, knowledge of Centrelink, housing, financial management, chronic illness, self management, a focus on promoting physical health and dental health, lifestyle, and how to recover all wrapped in one neat multi-skilled package.

Another contributor noted the need for advocacy to be part of training in human services so that students are grounded in the rights of individuals and able to promote the interests of those who require services.

Communication

A contributor considered that the staff of the OPA need to engage with people. Promoting the Office via a website (referring to the YourOPA consultation website) excludes the very people who in fact require a service. Instead more effort should be put into public education. There was concern that in the past, the Statement of Rights was given to people as a poor photocopy which was difficult to read. People do not know their rights.

Conclusion

Our Office was grateful to those who participated in this consultation exercise that will continue to inform the work of our Office. We trust that this section has done justice to these ideas. As already noted we have used many of our contributors own words to express these ideas, so wish to acknowledge their intellectual input into this section.

We are grateful to Delib Australia for providing access to the web application used in this trial.

Promoting Rights and Interests
Supported Accommodation

Introduction

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), Article 19, defines the right for people with disability to live independently and be included in the community: people with disabilities should have the opportunity to choose their place of residence, and where and with whom they live on an equal basis with others, not be obliged to live in a particular living arrangement, and have access to in home supports.

The need for greater access to supported accommodation has been a consistent theme in past Annual Reports of this Office, particularly in relation to disability accommodation, mental health accommodation and support services. The functions of Supported Residential Facilities (SRFs) overlap the disability and mental health accommodation sectors. These overlaps were discussed in our 2011 Annual Report, which considered the Right to Supported Housing (Office of the Public Advocate, 2011 pages 94-101).

It can seem arbitrary: some people with an intellectual disability, autism spectrum disorder or brain injury are housed in SRFs, while others might be supported within specialised supported housing options funded by disability services. The range of options includes independent units with visiting support, clustered units with onsite support and staffed small group housing.

Similar considerations apply to supported housing for people with mental illness who need 24 hour support. Our 2011 discussion considered the evidence for improved quality of life when mental health consumers have choice and control over accommodation arrangements, the preference of most adults with a mental illness to live independently rather than in a group setting, and the benefit in providing different housing models, ranging from conjugate housing to permanent independent supported housing, because "one size does not fit all" (Office of the Public Advocate, 2011 page 110).

In this context the planning, funding and operation of Supported Residential Facilities (SRFs) should be considered as part of planning for disability and mental health support services more generally. There is hope that the National Disability Insurance Scheme (NDIS) will give many SRF residents more choice and control in their life; if they are eligible for the NDIS and receive a funded package based on their level of disability.

There are leaders within the SRF industry who have sought to develop and implement standards, require minimum standards of training and qualifications of staff, and achieve accreditation for SRFs, using the Department of Communities and Social Inclusion's Service Excellence Framework. This is the same accreditation framework used by many non-government disability providers. These are part of the strategic directions of the SRF Association for 2012-2015 (SRF Association, 2012). The impending arrival of the NDIS, makes further improvement in services financially sustainable, and has encouraged some SRF operators to evolve into disability providers so that they can deliver NDIS funded services.

However, as some operators improve by providing better accommodation and skilled services, the gaps between these leaders and other SRFs that lack financial resources to make such changes becomes more evident. Significant reform is still required in this sector to provide residents with an acceptable quality of life.

To achieve this legislative reform is required, particularly to update the *Supported Residential Facilities Act 1992* so as to protect rights and better reflect the role of SRFs as care providers. The impending roll out of the NDIS is another reason to update this Act. We are pleased to note that the Department of Communities and Social Inclusion has started considering options for future reform of this legislation.

SRF Gaps and Unmet Need

Details of problems within the SRF sector were discussed in our 2010 report (Office of the Public Advocate, 2010, pages 44–60). SRFs are shared accommodation facilities that provide congregate living with meals, medication provision and some level of care. In 2010 we noted a range of problems in the care delivered in this sector that appeared to be driven by financial issues, with consequent variation between providers.

Many residents have to live in shared bedrooms, with two and sometimes three people to a room. To share with a stranger is an unreasonable expectation for an adult, especially as they may be living in these arrangements for many years. Room sharing creates problems for personal privacy and security of belongings.

Other problems described included poor heating and cooling of bedrooms, and variable food nutrition and palatability.

The problem of sharing and lack of personal security continues in the industry, as shared rooms are common, although any new SRF can now only be established with single rooms. Heating and cooling varies, but in winter our staff have noted bedrooms in some facilities can be cold, as current requirements relate to heating and cooling of common areas only, not bedrooms.

Referral to SRFs

In 2010 we described the benefit of a new intake process for SRFs that required assessment and approval by a newly established SRF Intake and Support Team before a subsidy would be paid from the SA Government for a person to live at an SRF (Office of the Public Advocate, 2010, page 46-47). The same service also assesses for provision of extra support services to SRF clients delivered by non-government providers (the SRF Support Services).

The reports provided by the Single Entry Point are comprehensive, covering financial and legal information, general health, mental health, personal care, behaviour, social networks, community living, and community safety. Prospective residents may be determined to be eligible for the subsidy, eligible but with conditions, or ineligible.

People placed under the guardianship of the Public Advocate sometimes have a history of SRF evictions and re-referrals, often following discharge from a mental health inpatient unit. Consequently they may have multiple SRF Single Entry Point assessments over many years. Clients may then be granted conditional eligibility in recognition of a fluctuating condition or remain eligible for only as long as specialist mental health services remain involved. A lack of

alternative accommodation options can lead to requests to our Office to consider SRFs, even when Single Entry Point approval is unlikely. Usually other options can be found with advocacy. This concern has been communicated to relevant services, and is now being monitored.

Our observation was that the SRF Single Entry Point appeared to prevent risky placements. Prior to its establishment we knew of situations where people at significant risk of harming others had been referred to SRF beds, but this practice appeared to cease. However, in 2010 we were aware of another emerging issue: some SRFs with vacancies were prepared to accept people as residents who did not have an SRF Single Entry Point approval, and therefore would not receive a subsidy.

On occasion the Public Advocate has been appointed guardian for accommodation, and has been asked to consent to SRF accommodation: for a client who either object to an SRF or is unlikely to receive Single Entry Point approval because of multiple complex needs or vulnerability. We are also aware that the SRF Single Entry Point team can be asked to assess clients after they commence living in an SRF, rather than always being the gateway for SRF referral.

SRF Accommodation for Women

The safety of vulnerable women in SRFs has been a long-standing concern in the sector. There is no women only SRF in South Australia.

It is possible that work now underway to improve sexual safety in inpatient mental health units could be applied to SRFs. In 2011 we discussed potential elements of a sexual safety policy for inpatient mental health units (Office of the Public Advocate, 2011 pages 90 and 91). Transferring these ideas to the SRF sector, the proposal to establish a women only ward could become a proposal to establish a women only SRF. Suggestions to develop gender specific areas such as women only lounges and wings could also apply to many SRFs, subject to their design. A safety feature in many wards is the ability of patients to lock themselves in their bedroom at night. Staff have an override key, but other patients cannot enter rooms. This can also be a strategy in SRF's, although it is more difficult to apply if people are sharing rooms, as locking one's own room is only practical when each room is allocated to only one person.

A proposal to develop a women only SRF was being developed by the SA Government in 2009, as discussed in our 2010 Annual Report. This morphed into the Women in SRFs sub-program which sought to transfer 12 women from SRFs to independent housing. These were women who were considered vulnerable and at risk in the SRF environment (Supported Residential Facilities Advisory Committee, 2012).

Notwithstanding this positive work, there is much more to be done. Many women live in SRFs – they make up approximately 30% of SRF residents, and referrals of women to the sector continue. The gender balance varies between facilities. There is one men only SRF. The percentage of women living in the remaining facilities ranges from 9% to 60%.

In our view, a range of strategies, as discussed above, is still needed. A sexual safety policy might be implemented for the sector, linked to accreditation and funding. When the Mental Health inpatient sector has published its new policy and associated strategy, it might provide a starting

point for a similar approach across Supported Residential Facilities. While some strategies may be cost free, there will be outlays required for some of the changes.

This year we are pleased to see new work commence in the Department of Communities and Social Inclusion to consider this issue.

Conclusion

Current challenges for upholding Article 19 of the UNCRPD include the significant gaps in supported accommodation in both disability and mental health sectors. These gaps need to be addressed.

Supported Residential Facilities have, for many years, filled some of these supported accommodation gaps. As this sector develops there will be less features to distinguish SRF providers from supported accommodation and services funded under mainstream mental health and disability rehabilitation and support programs.

However, currently, significant problems still need to be addressed in the sector. One is the development and roll out of a strategy to better protect vulnerable women, and to offer women in SRFs more choices. Another related problem is the lack of single room accommodation, which is a requirement for new SRF accommodation, but not for existing SRFs.

Our Office is pleased to note the work in the Department of Communities and Social Inclusion to explore more options for women in SRFs, and the intention to update the *Supported Residential Facilities Act 1992*, to better protect the rights of all residents.

Advance Care Directives Act 2013
Dispute Resolution Service Planning

Introduction

The *Advance Care Directives Act 2013* (ACDA) came into effect on 1 July 2014, significantly updating South Australia's law around making provision for one's future through appointing a substitute decision maker and/or expressing one's wishes around health care, accommodation and lifestyle. The ACDA amended the *Guardianship and Administration Act 1993* (GAA), and the *Consent to Medical Treatment and Palliative Care Act 1993* (Consent Act) and introduced new dispute resolution responsibilities for the Public Advocate. Dispute Resolution is to be provided in relation to disputes about an Advance Care Directive or about a proposed decision about health care for a child or adult considered unable to make that decision themselves. Work was undertaken throughout 2013-2014 to prepare for the changes to the work of the Office of the Public Advocate. A Senior Project Officer was employed to work with internal and external stakeholders to develop a dispute resolution service to meet the needs of the people who will use it. All OPA staff were trained to be aware of and ready to respond to the legislative changes and the new OPA service.

Aim of the Dispute Resolution Service

The aim of the Office of the Public Advocate's Dispute Resolution Service is to enable participants who disagree about an issue regarding an advance care directive or a health consent issue to come together in a collaborative way, in a safe environment, to discuss the issues that are in dispute and develop options to resolve the issues. The Dispute Resolution Service has three components: Preliminary Assistance, Mediation, and Declarations.

Principles underpinning the Mediation Model

The mediation model developed for the OPA Service takes a rights based approach, adhering to the principles of the ACDA, the principles underpinning mediation, the Australian National Mediation Standards, the Charter for Rights for Older People, and the UN Convention on the Rights of Persons with Disabilities. The model is person-centred, placing the person who the decision is about at the centre of the process, and providing support to enable the participation of the person to the fullest extent of their abilities. The model ensures that the thoughts, views and wishes of the person are brought into the mediation even if she/he is not able to take part themselves.

Facilitative Mediation Model

The OPA Dispute Resolution Service mediation model is based on the Facilitative Style of mediation. This style is generally considered to be the most appropriate for mediation with vulnerable people, including those who have impaired decision-making capacity, as it promotes empowerment, self-determination and voluntary participation of the parties. In facilitative mediation the mediator structures a process to assist the parties to come together, state their concerns, share relevant information and acknowledge and understand the views of others. A facilitative mediator assists the parties to find solutions; to test the achievability of the solutions,

reach agreement, and consider how a proposed agreement meets the needs of the participants and of those affected by its outcome.

During the project a document outlining the mediation model, practice guidelines and administrative procedures was developed by the Senior Project Officer, in consultation with internal and external stakeholders, including members of the multi-agency Advance Care Directives Implementation Committee. This document can be viewed on the OPA Website (Office of the Public Advocate, 2014a).

Trial of the Model

During the project, the OPA conducted a trial of the mediation model which produced valuable feedback and practice reflection towards ensuring a best practice model which offers flexibility and can be adapted to suit the complexity of the situation, any special needs of the participants and the urgency of the matter.

The mediations were conducted by the Senior Project Officer who is a qualified mediator, experienced in facilitating mediation where the person who is at the centre of the dispute has impaired decision-making capacity. Data gathered during the trial is outlined below.

Referral Source

During the trial the OPA received 12 applications for mediation. Of these applications eight cases were referred by the OPA Information Service; two cases were referred by the Guardianship Board, and two were referred by hospitals. The focus was on conflict over personal decisions, but some matters involved conflict over finances.

Senior Project Officer: Elly Nitschke delivering training on the new *Advance Care Directives Act 2013*.

Reason for Dispute

Three cases were disputes about where an older person should reside (i.e. either in their own home or in an aged care facility). Of these, one was a dispute amongst family members of the older person and one was a dispute between family members and the treating team in a hospital.

Three cases were disputes about contact with/visiting an older family member. In two cases a family member had been denied access to their older parent. In one case family members wanted a roster to ensure that they visited an older person without having contact with each other.

In two cases there were disputes over the management of finances, one of a younger person with a disability. The other was over the non-payment of accommodation fees for an older person in an aged care facility, which was placing the person's accommodation at risk.

One case was a dispute between service providers and the primary carer (a parent) of a person about appropriate service delivery to the person.

Three cases were disputes about communication in relation to an older relative. Of these, one was about family members being denied information about an older person's health and future accommodation. Another was a dispute about appropriate consultation in relation to the management of an older person's finances. The third was a dispute about the management of an Administration Order for a younger person.

Outcome of dispute resolution process

Four cases were resolved by mediation.

Two cases were referred to the Guardianship Board. Both were about finances. One involved alleged mismanagement of finances under an Administration Order where the most appropriate response was for the Board to review the matter. In the other there were allegations of financial abuse of an older person whose accommodation was in jeopardy due to the non-payment of accommodation fees by their Enduring Power of Attorney.

One case was resolved by the OPA facilitating a case conference where a resolution was reached.

Three cases were resolved by OPA assisting family members by providing information and assisting in the development of options that brought resolution to the situation.

Two matters were not resolved due to a family member/family members not agreeing to participate in mediation.

This experience helped refine the mediation model to be used from 1 July 2014. It was indicative of future practice, although it was not operating under the statutory provisions which from 1 July 2014 require Advance Care Directive disputes to be considered for dispute resolution prior to a matter being determined by the Guardianship Board.

Declarations by the Public Advocate

Under Section 45 of the ACDA, the Public Advocate is authorised to make declarations in regard to an advance care directive, as to:

- the nature and scope of a person's powers or responsibilities under the advance care directive;
- whether or not a particular act or omission is within the powers, or discharges the responsibilities, of a person under the advance care directive;
- whether or not the person who gave the advance care directive has impaired decision-making capacity in relation to a specified decision, and
- any other matter prescribed by regulations under the ACDA.

The Public Advocate can also give any advice considered necessary or desirable in the circumstances of the case.

The OPA is mindful that a presumption of capacity is at the very basis of our human rights and that declaring a person incapable can remove fundamental rights and diminish their personhood. The OPA Declaration Model is designed to uphold the rights of the person who

made the advance care directive and the process will begin with the presumption that the person has decision-making capacity. This presumption will remain unless there is evidence to prove otherwise. This person-centred model aims to include the person who made the advance care directive to the fullest extent of his/her abilities. The Declaration Service Practice Guidelines and Processes document can be found on the OPA Website (Office of the Public Advocate, 2014b).

OPA Staff Training

To ensure that the OPA was fully prepared for the commencement of the ACDA on 1 July 2014, a training program on the legislation and implications for practice was developed and delivered to all OPA staff over a six month period. The staff participated in workshops and assisted to develop written materials to use in their practice.

The work undertaken during the OPA Advance Care Directives Project has ensured that the OPA is prepared to meet the significant additional responsibilities conferred upon the Public Advocate by the ACDA.

Conclusion

The new legislation represents an exciting development in improving the rights of vulnerable people. Key elements of the common law have been included in the new statutes, in particular a presumption of capacity and the decision specific nature of capacity.

The focus on dispute resolution should assist to ensure Advance Care Directives remain in effect, so that the person's wishes as to who they wanted as their substitute decision maker, and their values and preferences in living their lives are upheld despite any impairment of decision making capacity. The Act has given the Public Advocate new dispute resolution powers, and also given the Guardianship Board new powers to make directions without disturbing an Advance Care Directive.

The development period of our dispute resolution service is now complete. The first year of operation will be reported in next year's Annual Report, but at the time of writing this report, the new service has been busy, and the benefits of the dispute resolution service have, in our observation, been demonstrated.

Give advice on legislative powers

Guardianship and Administration Act 1993

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

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

Advice about the Act was provided through:

- The enquiry service
- Education sessions

This work is reported in Part B of this Report.

Raising Matters with the Minister

Guardianship and Administration Act 1993

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

(1) The Public Advocate may, at any time, raise with the Minister and the Attorney-General any concerns he or she may have over any matter arising out of or relating to the performance of his or her functions under this Act or any other Act.

(2) If the Public Advocate so requests, the Attorney-General must cause a report of any matter raised by the Public Advocate under subsection (1) to be laid as soon as practicable before both Houses of Parliament.

(3) The annual report furnished by the Public Advocate under this Act must include a summary of any matters raised by the Public Advocate under subsection (1).

During 2013–14, the Public Advocate met with relevant Ministers and Members of Parliament in an advocacy role.

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

Meetings with Ministers:

Hon. Michael O'Brien MP, Minister for Corrections (until Feb 2014)

Hon. Tony Piccolo MP, Minister for Disabilities

Hon. John Rau MP, Deputy Premier
Attorney-General

Hon. Jack Snelling MP, Minister for Health and Ageing (until Mar 2014)
Minister for Health (April 2014 onwards)
Minister for Mental Health and Substance Abuse

Meetings with Members of Parliament:

Hon Robert Brokenshire, MLC

Hon Susan Close, Parliamentary Secretary to the Minister for the Public Sector

Hon Rob Lucas, MLC, Shadow Minister for Health, Disabilities & Community Services
Shadow Minister for Mental Health & Substance Abuse

Dr Duncan McFetridge, HA, Shadow Minister for Disabilities
Shadow Minister for Mental Health & Substance Abuse

Mr Dan van Holst Pellekaan, HA, Shadow Minister for Police, Community Safety & Correctional Services

Hon. Kelly Vincent, MLC

Hon. Stephen Wade, MLC, Shadow Attorney-General

Section 22 Report

No matters were raised under the formal provision of Section 22 during 2013–14.

Part B:

Direct Services

Provided to the Community by the Office of the Public Advocate

Public Guardian

Guardianship and Administration Act 1993

Section 29 —Guardianship orders

(1) If the Board is satisfied, on an application made under this Division—

(a) that the person the subject of the application has a mental incapacity; and

(b) that the person the subject of the application does not have an enduring guardian; and

(c) that an order under this section should be made in respect of the person, the Board may, by order, place the person under—

(d) the limited guardianship; or

(e) if satisfied that an order under paragraph (d) would not be appropriate, the full guardianship,

of such person or persons as the Board considers, in all the circumstances of the case, to be the most suitable for the purpose.

(4) The Public Advocate may be appointed as the guardian, or one of the guardians, of the person, but only if the Board considers that no other order under this section would be appropriate.

The role of guardian

Guardians are appointed by the Guardianship Board (under section 29 of the *Guardianship and Administration Act 1993* (GAA)) to make decisions on behalf of individuals who are unable to do so for themselves due to mental incapacity. A guardian can make substitute decisions for a person in the areas of health care, accommodation and lifestyle, depending on the scope of the order. If decisions about finances or legal matters are required, an administrator can be appointed by the Guardianship Board. The person under an order is called a protected person.

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

A guardian can use their substitute decision making powers to make a decision if a person does not have capacity to make that specific decision. This 'decision specific' approach was made explicit in sections 58 and 59 of the GAA, which gave specified third parties (including guardians) the responsibility and right to provide substitute consent for medical and dental decisions when the person was unable to give effective consent for that decision. While this decision-specific capacity approach, which limits the decisions a guardian can make, is not explicitly stated for accommodation and lifestyle decisions, it can be inferred from the principles

of the GAA that this approach should be taken. Where a protected person is able to understand the information pertinent to the decision and can be appropriately supported to make their own decision, OPA guardianship staff respect the person's wishes and decision.

Sections 58 and 59 of the GAA, regulating medical and dental consent, operated until 30 June 2014, which were being repealed when new consent provisions came into operation, which are in Part 2A of the *Consent to Medical Treatment and Palliative Care Act 1995* (the Consent Act), as amended from 1 July 2014. The new provisions in the Consent Act include a definition of impaired decision making capacity, which makes it clear that a decision specific approach must be taken to providing substitute consent. The definition stipulates that substitute consent should only be provided when a person is not capable of understanding information related to that particular decision, retaining the information, using the information, or communicating his or her decision. This continues the same policy intent for health consent as expressed in the former section 58 and 59 of the GAA. However, the definition in the new provisions is clearer than the term 'effective consent' and is consistent with our scientific and legal understanding of decision making capacity.

Public Guardianship Activity 2013-14

Overview

Once again there has been a significant increase in demand for public guardianship since the last reporting period, however there has been some slowing from the extreme increases seen in the previous two years. Results for this period include:

- A 12% increase in the total number of people receiving active public guardianship services at some stage during this reporting period compared with 2012–13. This compares with a 25% increase in the previous year, and a 17% increase the year before that.
- A 4% increase in the number of people under public guardianship at the end of 2013–14 compared with the end of 2012-13. This compares with a 28% increase in the previous year, and a 29% increase in the year before that.
- A 20% decrease in the number of new public guardian appointments during this reporting period compared with 2012–13. The previous year was anomalous due to a policy change in Disability Services that resulted in numerous applications for guardianship that would not otherwise have been made. When compared with 2011-2012 the rate of new appointments was a 2% increase.
- A 33% increase in the number of guardianship cases closed during this reporting period compared with 2012-13. This compared with a 10% increase in the previous year, and a 3% decrease in the number of closures in the year before that.

This year public guardianship continued to expand, and the rates remain high in comparison to other states, where comparable statistics are available. It has always been the legislative intention in South Australia that guardianship appointments be a last resort, and other solutions to problems be found where possible. This is important, both in minimising avoidable restriction of a person's rights, and in ensuring that limited guardianship resources can be directed to the needs of people for whom there are no alternatives, rather than being used in

resolving problems that could be addressed in some other way. However, even though there was a further 12% increase in activity compared to recent years, there are indications that the rate of increase is slowing. The rate of new appointments has fallen, and we anticipate this trend will continue in the coming year, because the 1 July 2014 commencement of the *Advance Care Directives Act 2013*, has given both the Public Advocate and the Guardianship Board alternative powers, which we anticipate will reduce the need for orders appointing the Public Advocate.

Data

During 2013-14, the Office of the Public Advocate provided guardianship services under the *Guardianship and Administration Act 1993* on behalf of 1303 people (1162 in 2012–13). This represents a 12% increase over the previous year. In the previous four reporting periods, the increases were (most recent first) 25%, 17%, 6.7%, and 9.6%. The 12% increase this year follows a massive increase during 2012–13 which represented the biggest expansion in the past five years. This was contributed to by policy changes within disability services in 2012-13 which were subsequently reversed.

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

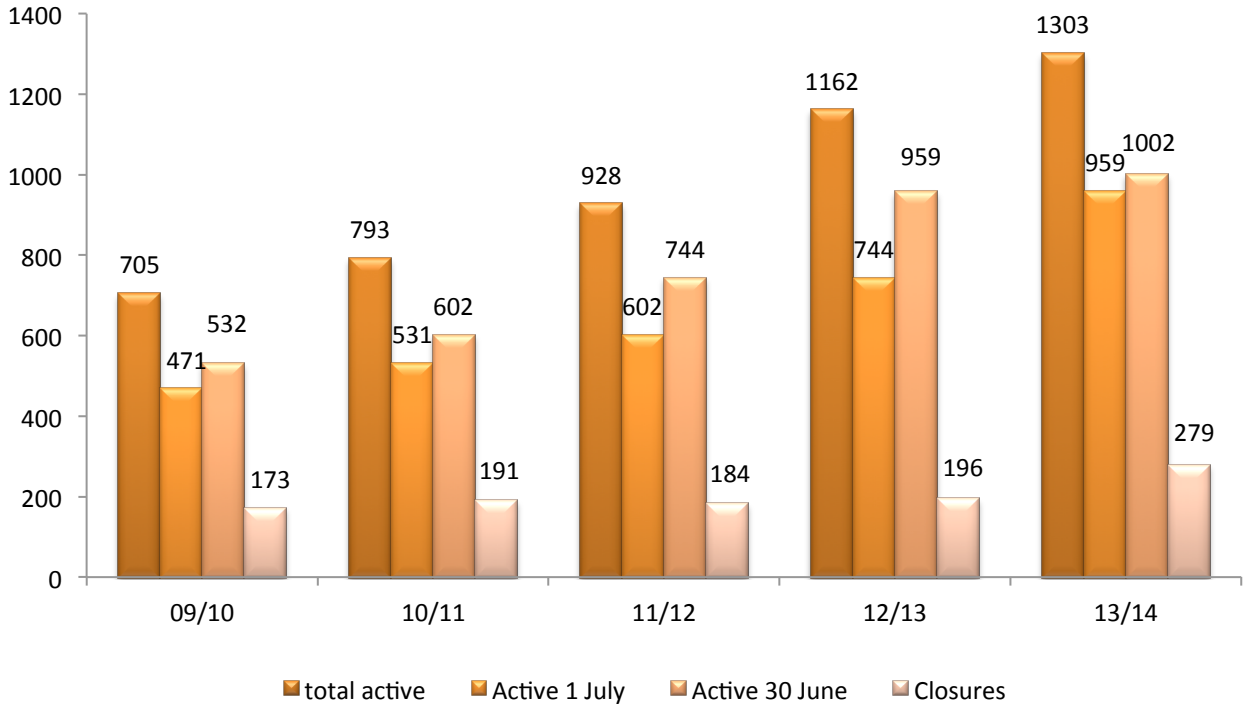


Figure B1: Guardianship Activity 2009–10 to 2013–14 (Total active, Active 1 July 2013, Active 30 June 2014, Revoked)

As at 30 June 2014, there were 1002 active guardianship cases compared with 959 at the beginning of the financial year. This is a 4.5% increase in end-of-year active cases compared with a 28% increase for the previous reporting period.

The growth in active guardianship over the past six years is depicted in Figure B2 (below).

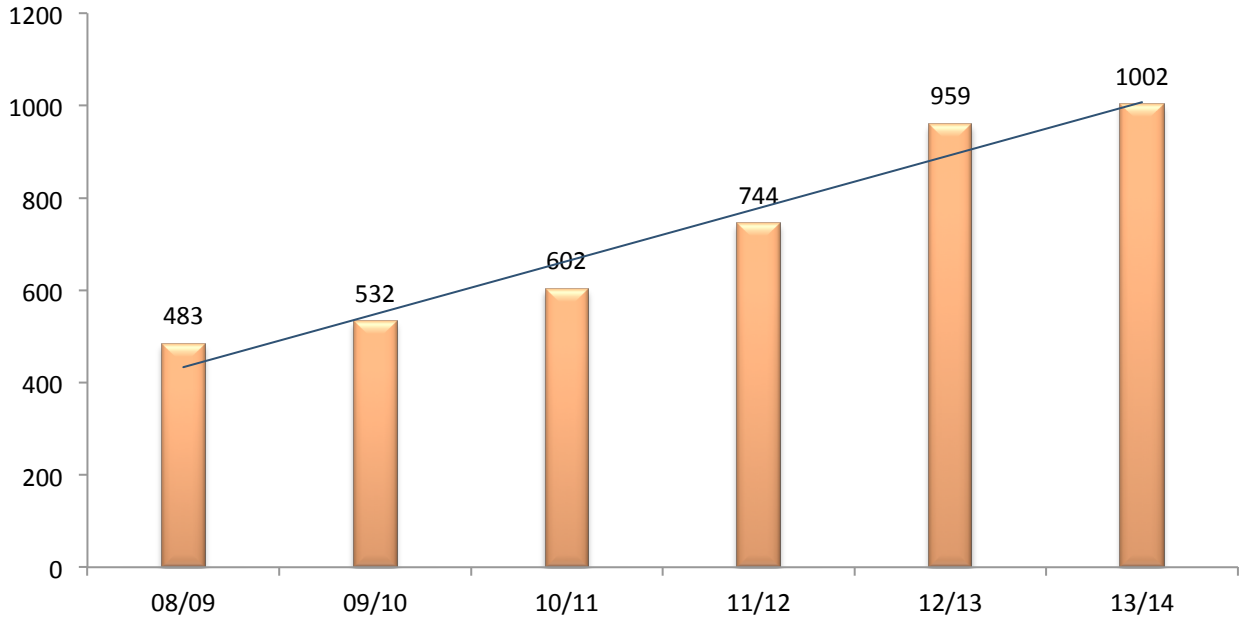


Figure B2: Comparison of Active cases as at year-end 2008–09 to 2013–14

New appointments

This year 334 new Public Advocate guardianship appointments were made, a 19% decrease on last year's figure for new appointments (412).

147 (44%) were females and 187 (56%) males.

Figure B3 illustrates the general upward trend in number of appointments.

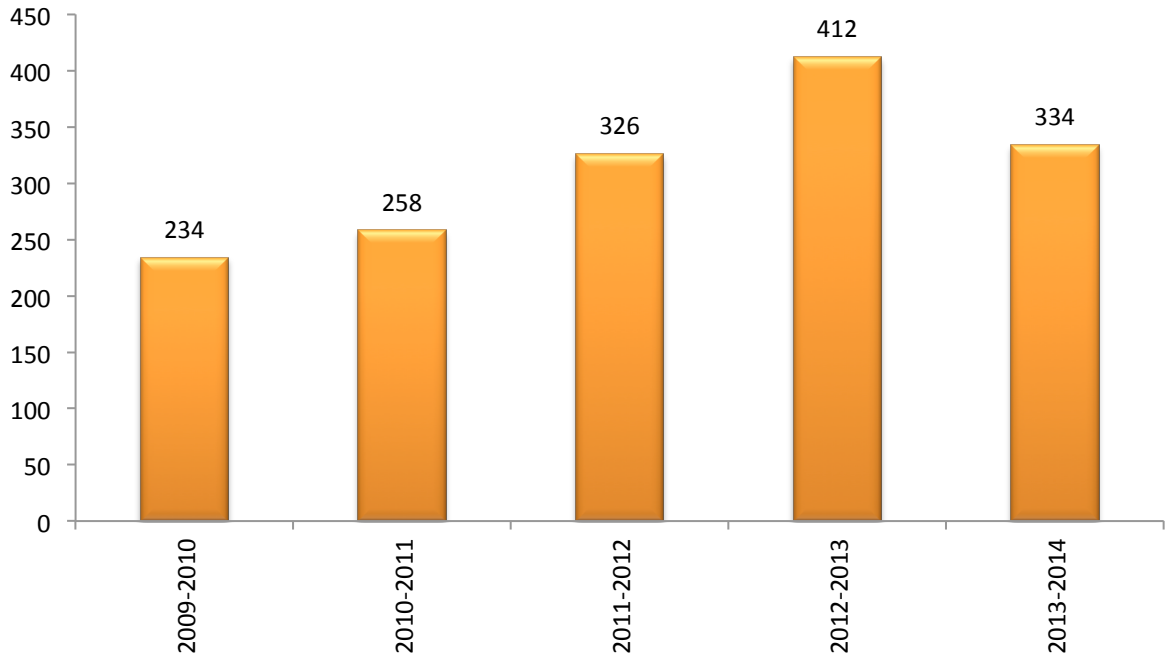


Figure B3: Comparison of new Public Guardianships over the past five years

Joint appointments of the Public Advocate with a Private Guardian

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

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

Interim orders made on an urgent basis

Section 14(7) of the GAA allows the Guardianship Board, if satisfied that an urgent decision is needed on an application before it, to make an order as a matter of urgency, without complying with the usual procedural fairness requirements of hearings. (For example the requirement to give interested parties reasonable notice of the hearing, or the opportunity to give evidence, or examine or cross examine witnesses or make submissions). These orders are described as interim orders and can be in effect for a maximum of 21 days, or of 14 days for orders which authorise placing and/or detaining a person, or the use of force to ensure their treatment and care (see below under special powers).

Sixty six appointments were made on an urgent basis, appointing the Public Advocate as interim guardian, representing 20% of all new appointments, compared to 17% (69 of 412 cases) the previous year, and down from 28% (71 of 258 cases) the year before that.

Special powers to place, detain, or use force

Section 32 of the GAA provides that the Guardianship Board can, on application from a guardian, make an order directing where a protected person lives, or authorise the guardian to make that direction; authorise the detention of the person in that place in which he or she is directed to live, and/or authorise the use of such force as may be reasonably necessary to ensure the proper medical or dental treatment, day-to-day care and well-being of the person. The Board can only make these orders if it is satisfied that health or safety of the protected person or the safety of others would be seriously at risk if the order was not made.

There were 104 cases where orders for special powers were made at the initial hearing or at some stage during this reporting period, for new appointments. This represented 31% of new appointments which is a similar percentage to 2012-13 (28%).

OPA team structure

Since December 2008 the Office has streamed new guardianship matters into two teams; ,the 'short term' and 'long term' teams. Within one team, the Office has a monitoring service to manage a large number of more stable cases identified as not likely to require frequent guardianship work. The short term team tends to be allocated cases where one or two significant decisions are needed quickly, and the long term team is allocated matters where there are multiple or ongoing decisions. In practice the short term team is generally allocated older clients, and works with the aged care sector, and the long term team has younger clients and works with the disability and mental health sectors. Over the past year 52% of the new cases were allocated to the short term team.

In addition in 2012-13 there was a new group of disability clients for whom the Public Advocate was appointed guardian, following a change in policies in disability services related to health consent. The policy was subsequently changed following discussions from our Office. The number of these clients ranged from 64-71 during 2013-14. They are not allocated to a team, as there was not the usual precipitating reason for public guardianship – a decision to be made that cannot be made without a formal guardianship appointment. These clients remain on our waiting list. Many clients have been visited by a Community Visitor working for the Community Visitors Scheme, and an advocate/guardian from our Office was allocated additional time to respond to visit clients and respond to active guardianship matters. Routine consent matters are responded to by our "duty" system.

Waiting list for allocation of an advocate/guardian

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

Waiting for allocation of an advocate/guardian	1st July 2013	30th June 2014
Short Term Team	18	28
Long Term Team	19	29
Awaiting Allocation to a team	7	3
Disability "on hold" group	67	64
TOTAL (excluding disability on hold)	44	60
TOTAL	111	124

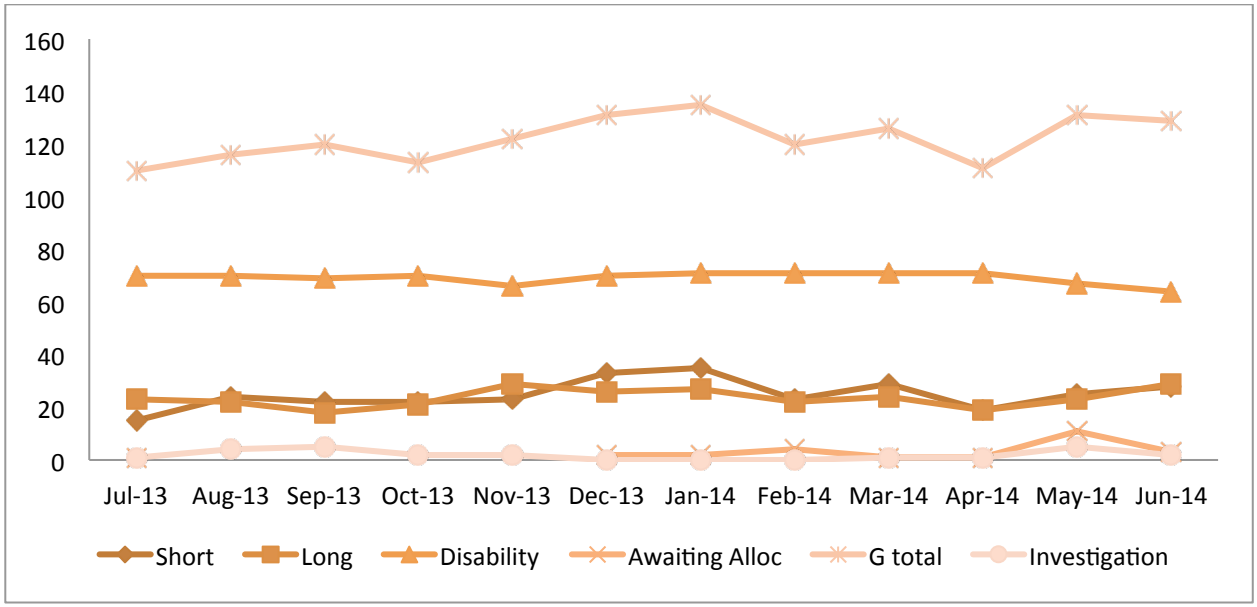


Figure: B4 Waiting list for allocation of new cases July 2013 to June 2014

This waiting list is a serious concern, however it is important to note that it is not a waiting list in the conventional sense – in that the needs of clients on this list are attended to.

Ideally we would wish to allocate an individual advocate/guardian, to meet each client and develop a plan, within a week or two of the guardianship order being made. While this is not possible because of the increase in appointments over recent years, the waiting lists are actively managed by the two Senior Advocate/Guardians, and a service is delivered to those people who are unallocated. Cases are prioritised for allocation using a 4 level priority system. The Senior Advocate/Guardian becomes involved in complex unallocated matters, visiting clients and

attending case conferences if needed. Key decisions can be, and are made, while the person is on the waiting list; for example a decision about accommodation to ensure that a person can leave hospital when ready for discharge.

Our Office maintains a duty worker system, to respond to requests requiring less complex decisions.

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

As indicated in the previous section, those clients in the disability "on hold" group have not been allocated to an individual guardian. Their needs are being met using a different strategy as described in the previous section. For this reason the table describing our waiting list gives two figures – a list including that group and one without.

This situation is not ideal, but does provide a means to manage the sustained increase in demand. One difficulty is that our duty system can become extremely busy, not only responding to calls about allocated clients when an advocate/guardian is away, but also responding to the high number of unallocated matters.

We note that it is our view that this situation is not one that necessarily requires a major change in our approach to guardianship. Even though active cases increased by 12%, this shows a slowing in the rate of increase in appointments, and it is possible in coming years we will see a reduction in public guardianship rates as more alternatives become available that effectively protect rights but provide a more measured intervention. This includes new interventions available to this Office and the Guardianship Board from 1 July 2014, through the provisions of the *Advance Care Directives Act 2013*, and related amendments to the *Consent to Medical Treatment and Palliative Care Act.* We see the consequent potential reduction in guardianship appointments as ethical, and anticipate some consequent reduction in demand pressures. From 1 July 2014 we have resources allocated to a Dispute Resolution Service, which will provide alternatives to, and hence reduce, new guardianship appointments.

Closures of guardianship cases

During 2013–14, 279 cases were closed — a 33% increase when compared to 203 closures in 2012–13. Of the 203 closures, 126 were due to revocation of orders, 114 due to death, 37 due to private guardians being appointed and 2 due to other reasons. Reasons for closure are illustrated below.

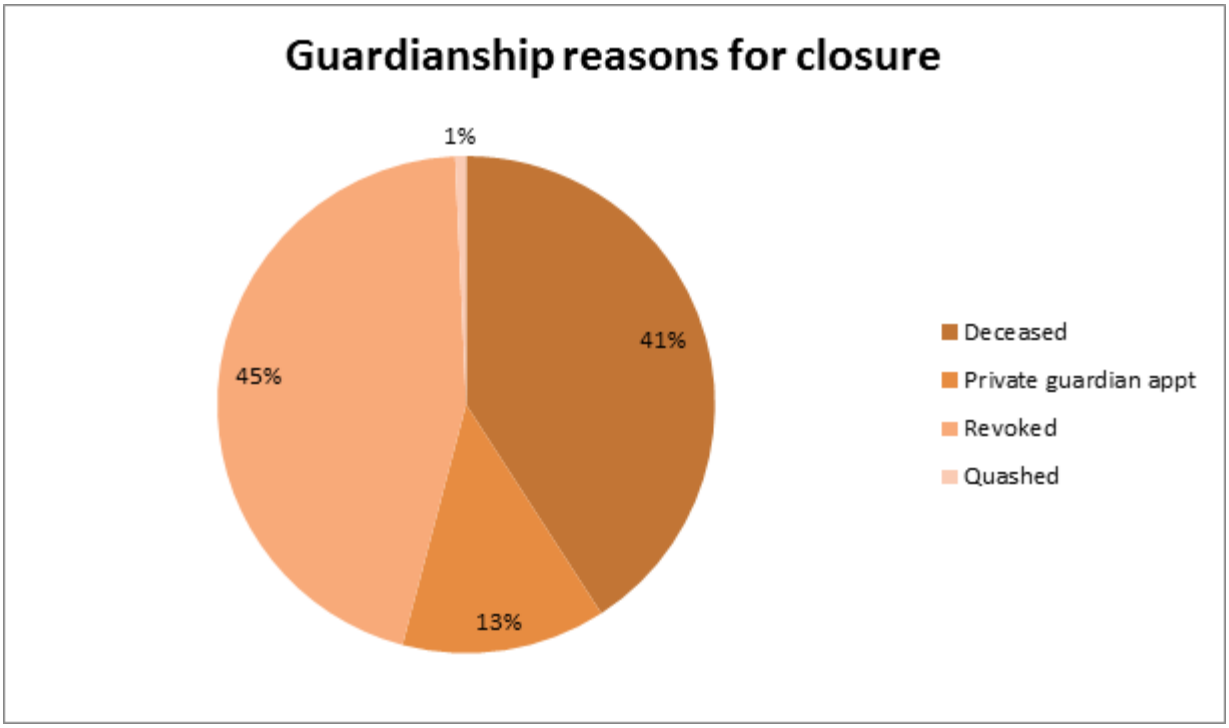


Figure B5: Reasons for closure of guardianship cases 2013–14

The rate of closure in 2013-14 as a percentage of all orders was 21%, up from 17% the previous year, but less than the figures achieved some years back: 24.1% in 2010–11 and 24.5% in 2009–10.

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

Closures as Percentage of Guardianship Services Provided						
	2008/2009	2009/2010	2010/2011	2011/2012	2012/2013	**2013/2014**
Closures	178	173	191	184	203	**279**
Active cases	661	705	793	928	1162	**1303**
%	26.9%	24.5%	24.1%	19.8%	17.5%	**21.4%**

Figure B6: Closures 2008–09 to 2013–14 as percentage of all guardianships

The next graph (Figure B7) compares reasons for closure for a five-year period. Note that in 2010-11 there was a significant decrease in the number of cases closed due to revocation of orders. This reduced rate has largely continued, resulting in a significant decrease in the percentage of orders closed due to revocation when comparing 2009-10 (65%) to 2013-14 (45%).

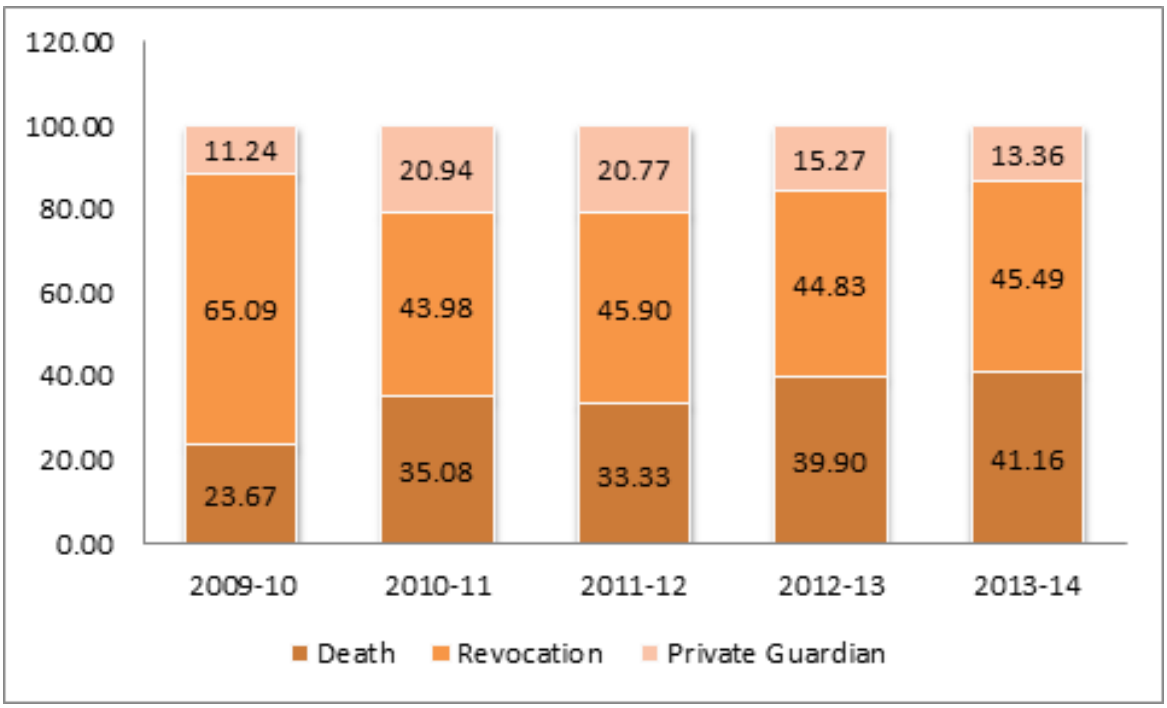


Figure B7: Reasons for closure expressed as a proportion of total closures 2009–10 to 2013–14

Figure B8 below compares the number, rather than percentage (discussed above), of closures in each category over the past ten reporting periods. This graph illustrates the increase in 2013-14 of closures due to revocation, and, to a lesser extent, the appointment of a private guardians.

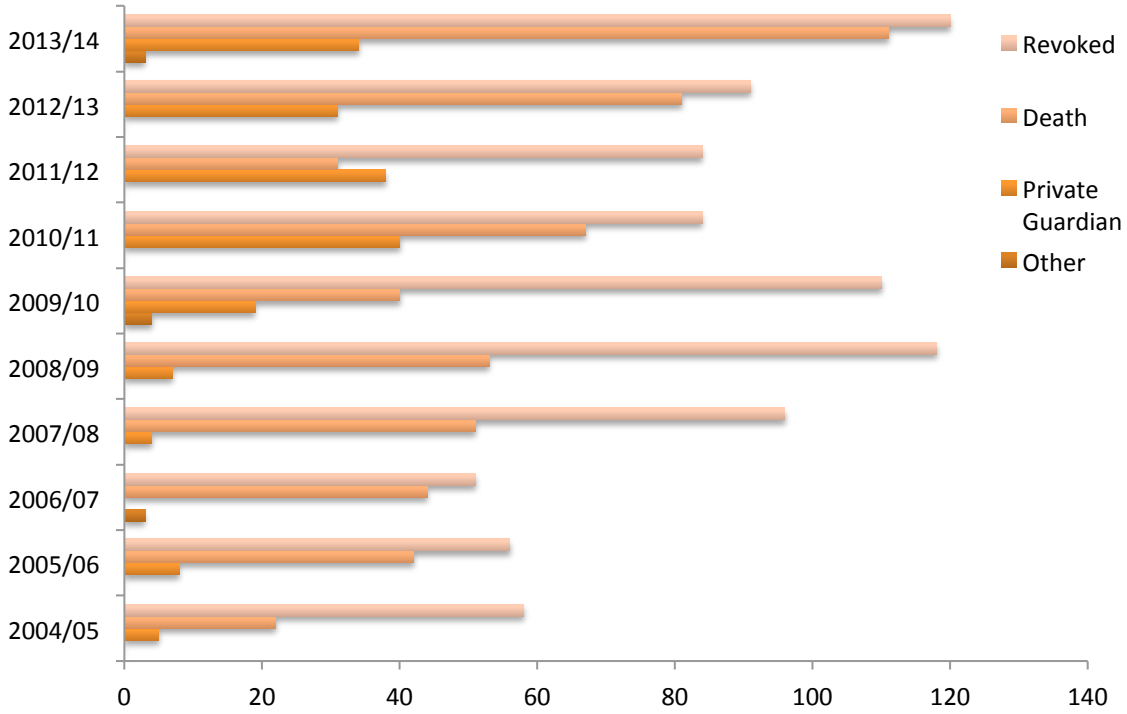


Figure B8: Guardianship numbers by closure type for past ten reporting periods

Average length of guardianship for cases closed in 2013–14 was similar to previous years: 1.9 years (median 1.3 yrs). This compares with an average length of 1.9 and 1.8 years in the previous two reporting periods (median 1.3 and 1.1yrs). We also report on the duration of guardianship related to diagnostic group, with an increase in the duration of guardianship for people with intellectual disability.

Guardianship Cases Closed in 2011–12, 2012-13 and 2013–2014								
Diagnosis and Length (years) of Guardianship								
Diagnosis		Brain Injury	Dementia and degenerative Conditions	Mental Illness	Intellectual Disability	Dual diagnosis	Other	Total
Numbers of clients	2011-12	21	83	29	26	19	9	184
	2012-13	15	84	42	28	20	14	203
	2013-14	21	109	50	49	33	17	279
Average	2011-12	2.2	1.8	1.7	1.6	1.8	0.7	1.7
	2012-13	2.4	1.5	2.2	2.0	3.1	0.6	1.9
	2013-14	1.8	1.6	1.9	2.7	3.5	0.9	1.4
Median	2011-12	1.2	1.1	1.5	1.0	1.2	0.7	1.1
	2012-13	0.3	1.0	1.7	1.0	3.0	0.3	1.1
	2013-14	1.3	1.1	1.3	2.1	2.6	0.4	1.3

Figure B9: Closed guardianships diagnostic profile and length of guardianship

The next graph (Figure B10) compares numbers of active cases as at 30 June, from June 2009 to June 2014 and the length of the orders as at those dates.

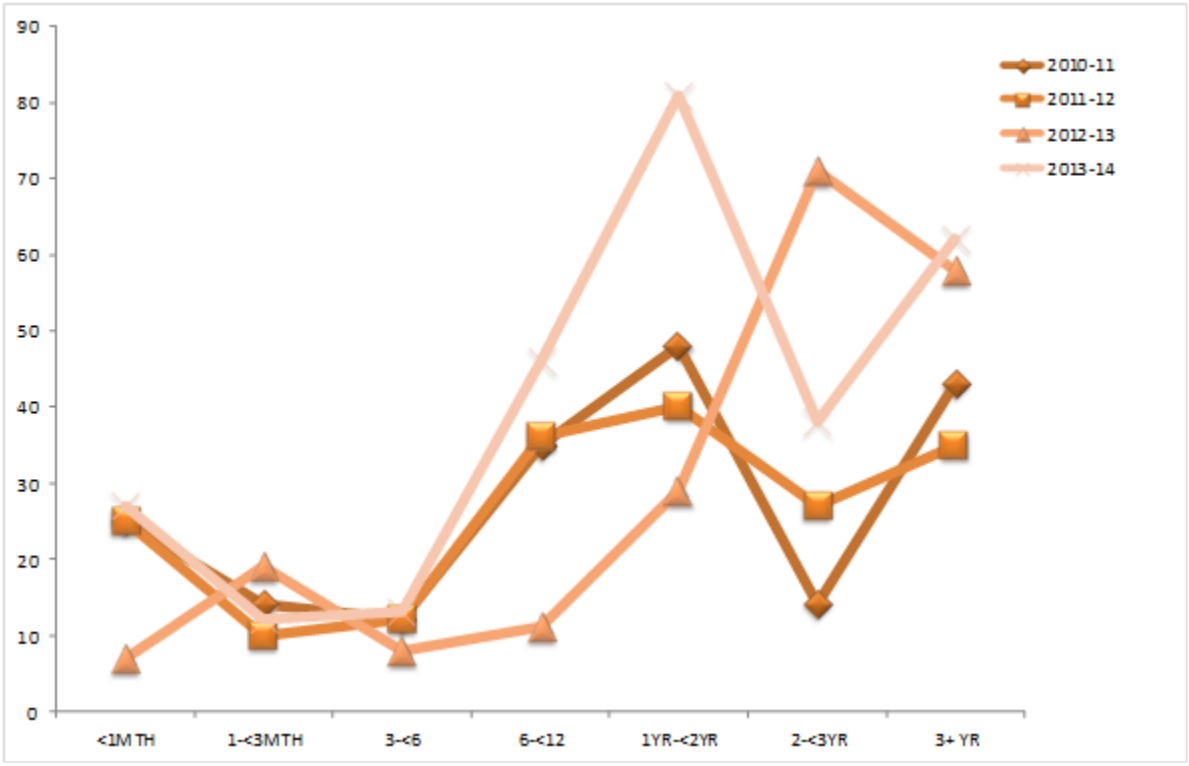


Figure B10: 5-year comparison of length of guardianship for open cases as at 30 June each year.

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

The age profile of active, new and closed guardianship cases as at 30 June is compared in the table below (Figure B11).

Age Profile of Closed, Active and New Cases 2010–11 to 2013–14												
Age	**Closed Cases (age at closure)**				**Active Cases (age at 30 June)**				**New Cases (age at opening)**			
	10-11	11-12	12-13	**13-14**	10-11	11-12	12-13	**13-14**	10-11	11-12	12-13	**13-14**
Age < 41 years	13%	19%	25%	**17%**	28%	30%	27%	**27%**	24%	29%	24%	**20%**
41 to 70 years	30%	37%	29%	**32%**	40%	38%	42%	**44%**	18%	34%	41%	**42%**
> 70 years	57%	45%	46%	**51%**	32%	32%	31%	**29%**	58%	37%	35%	**38%**

Figure B10: Age profile of guardianship clients 2010–2014

Diagnostic profiles of guardianship clients active as at 30 June 2013, and all guardianships active during this reporting period are illustrated in the following table.

Diagnostic Profile of Guardianship Clients				
Diagnosis	Active at 30/06/2014		Active in 2013–2014	
	Number	Percentage	Number	Percentage
Dementia	248	25%	357	28%
Mental Illness	213	21%	263	20%
Intellectual Disability	323	32%	372	29%
Brain Injury	64	7%	85	7%
Dual Diagnosis	123	12%	156	12%
Other	31	3%	48	4%
Total	1002	100%	1281	100%

Figure B12: Diagnostic profile of all active guardianship cases this reporting period

Commentary on activity report

Public Guardianship rates in South Australia remain high in comparison with other states. For example, SA can be compared with NSW, WA, Victoria and Tasmania, using data in a previous year's Annual Report (2012-2013) for each of the Offices. The rate of guardianship per 100,000 total population at the end of that financial year was SA 57, WA 42, Tas 32, NSW 26 and Victoria 14. It should be noted however that some states with a lower rate of active orders at the end of the year may have a higher throughput, with more but shorter orders, during a year.

An example of a rights based approach with higher throughput but lower rate of ongoing guardianship, is that of the Victorian Office of the Public Advocate, which has appointments and revocations made by the Victorian Civil and Administrative Tribunal under that state's legislation. The Victorian OPA commenced 2013-14 with 738 guardianship matters (compared to our Office's 959 cases) and, during that year received 781 new cases, compared to our Office's 334 appointments for a much smaller state. At the end of the year the Victorian Office had 728 ongoing matters, less than it started with, and considerably less than the 1002 for South Australia. The Victorian Office numbers also includes 85 people in their community guardianship program in their Office total (Office of the Public Advocate (Victoria), 2014).

As was discussed in the 2011 Annual Report (Office of the Public Advocate, 2011 page 122 onwards), and reiterated again last year, we do not consider that the South Australian Parliament intended when enacting the GAA, that Public Guardianship would become so substantial in South Australia. More recent legislation such as the *Advance Care Directives Act 2013* is explicitly rights based, reinforcing the rights of individuals, families and friends, and providing for other "one off" interventions by this Office and the Guardianship Board, which are less intrusive and restrictive in resolving matters than making guardianship orders. An increase in guardianship is contrary to the expectations created by the UN Convention on the Rights of

Persons with Disabilities to expand supported decision making rather than substitute decision making.

Nevertheless, sector expansion is slowing, and we hope that we may soon have reached a peak in guardianship, and will see a decline in guardianship rates as new laws and programs take effect, providing effective alternatives to public guardianship, while upholding the rights of individuals and the role of families and friends. Examples include the *Advance Care Directives Act 2013* and amendments to the *Consent to Medical Treatment and Palliative Care Act 1995*, and the associated dispute resolution service which began operating from the OPA from 1 July 2014. Other strategies to improve adult protection have either commenced or are in development – for example community visitors programs, and new strategies to prevent and respond to elder abuse.

In some situations where guardianship is sought, different strategies are needed to protect the rights of individuals. We have previously noted that applications for orders can be made because of the limitations of the mental health and disability systems to provide adequate accommodation and support, rather than an intrinsic need of an individual to have a substitute decision maker (2011 Annual Report, see page 131). Ideally, service incapacity should be addressed at service level, rather than guardianship being used as an intervention to fill service gaps.

A/Senior Advocate Guardian (Short Term Team) Bethany Jordan and Senior Advocate Guardian (Long Term Team) Julie-Anne Harris coordinate case allocation.

Court-related matters — litigation guardianship

In civil legal matters, when a person is unable to manage a matter in Court because of a disability, a Court may appoint a 'litigation guardian' also known as a 'guardian ad litem' to 'stand in the shoes' of the person and conduct the matter on their behalf. Various legislation and rules of Court contain provisions for this situation. For example Rule 19 of the *Youth Court Rules 2012* refers to 'a person who is incapable by reason of disability of adequately conducting proceedings'. The Public Advocate is sometimes requested to take on the role of litigation guardian, and he or his delegate then ensures there is a legal representative, obtains legal advice, discusses the issues with the person concerned, and when necessary, instructs the lawyer, on behalf of that person.

The OPA has in the past two years restricted litigation guardianship work almost entirely to Child Protection matters in the Youth Court. This involves acting on behalf of a parent of a child or children about whom applications have been made to the Youth Court. Applications may be for investigation and assessment orders to investigate concerns about the safety and care of the child, or for orders to remove the child from the parent/s and give responsibility for the child to the Minister for a short or long period. These are very significant proceedings for the individuals concerned.

The Public Advocate is asked to assist when the Youth Court, the parent's lawyer, or another party considers the parent is unable to understand the issues and concerns, accept legal advice or instruct a lawyer. This may be due to intellectual disability, chronic or acute mental illness, brain injury, or, less often, serious physical illness or unconsciousness. This work comes within the overall scope of the advocacy role of the Public Advocate (section 21(1)(d) considered later in this report) although it is not specifically mandated in the GAA. It is significant work, protecting the rights of vulnerable parents, can be time consuming, and is not specifically resourced.

The OPA commenced the reporting period with nine active litigation guardianship matters. A further 21 were opened during 2013–14, and 24 cases closed.

Up until two years ago it was routine to open about 10 such cases each year. The doubling of this figure in the last two years is positive for clients. It shows better recognition of the needs of parents in Youth Court proceedings who are unable to instruct, and the positive effect of revised Court Rules in this area. It has however been a demand for our Office, in the context of increased demand for guardianship more generally, and we will be working to find a more sustainable solution for the provision of litigation guardian services in the coming year.

Investigations

Guardianship and Administration Act 1993

Section **28—Investigations by Public Advocate**

(1) The Public Advocate must, if the Board so directs after an application has been lodged with the Board for an order under this Part, investigate the affairs of the person the subject of the application.

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

(3) The Board may receive the copy of the report in evidence and may have regard to the matters contained in the report.

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

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

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

Number of investigations 2013–2014

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

- 17 were open at the beginning of the reporting period
- 36 were opened during the year and
- 10 remained open as at 30 June 2014

Attendance at initial hearings of applications for guardianship orders

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

During 2013–2014, the OPA staff reviewed 465 applications which nominated the Public Advocate for appointment as guardian. This compares with 506 and 432 such screening matters in the previous two reporting periods.

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

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

Combining the two kinds of investigative activities (participation at initial hearings and formal investigations), the following picture emerges (Figure B12).

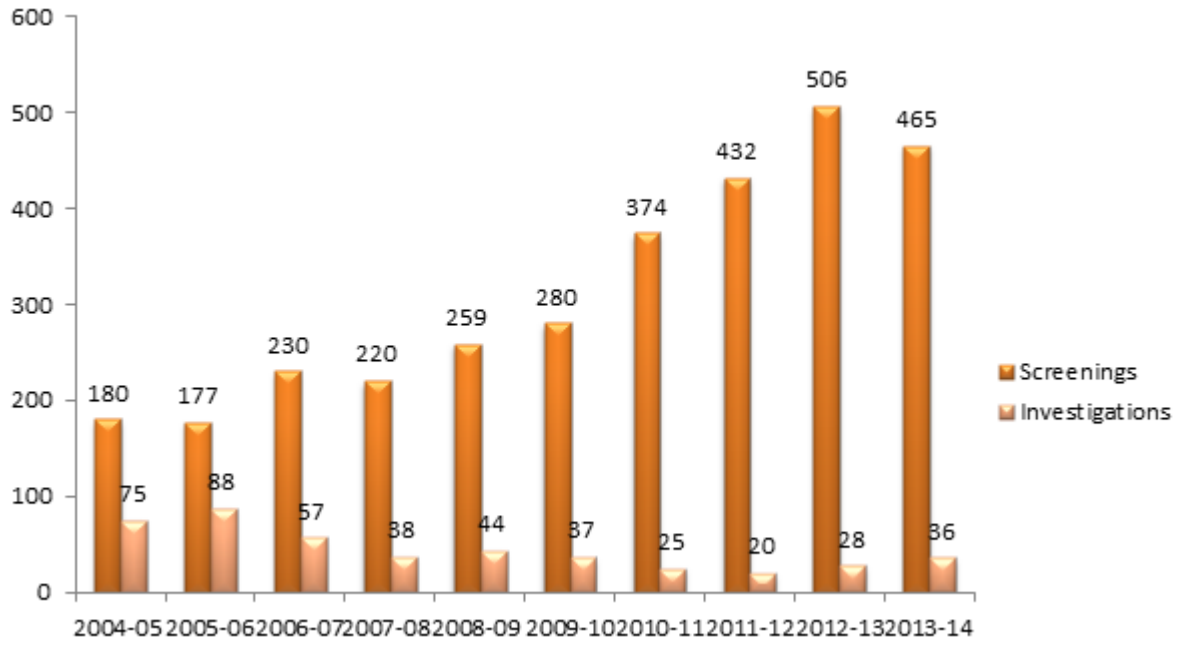


Figure B12: Number of initial guardianship applications screened, & investigations undertaken 2004–05 to 2013–14

Applications for Warrants by the Public Advocate

Guardianship and Administration Regulations 1995

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

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

(a) the number of applications for warrants made during the year;

(b) the age, sex and details of the alleged mental incapacity of the persons to whom the applications related;

(c) the grounds on which the applications were based;

(d) the number of applications withdrawn during the year;

(e) the number of warrants issued during the year;

(f) the number of warrants refused during the year;

(g) in relation to warrants issued—

(i) the age, sex and details of the mental incapacity of the persons to whom the warrants related;

(ii) the grounds on which the warrants were issued;

(iii) the action taken under the warrants.

During 2013–2014, there were no applications for warrants made by the Public Advocate.

Individual Advocacy

Guardianship and Administration Act 1993

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

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

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

There were 47 new advocacy cases opened in 2013–2014. Comparison of the past seven years is featured below (Figure B13).

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

Figure B13: New advocacy clients in each reporting period

Advocacy in matters before the Guardianship Board

Lack of routine access to advocacy services for clients appearing before the Board for both GAA and *Mental Health Act 2009* matters has been raised over the past four reporting periods. Whilst Section 14(9) of the GAA provides that a person can be represented by the Public Advocate or a recognised advocate, this Office is seldom in a position to provide representation and people are referred to other agencies.

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

Education

Information about key legislation, services and systems is provided through the Office of the Public Advocate website which was updated in 2013. During this reporting period there were 13,661 visitors to the site, who read on average 2.57 pages per visit.

The Office of the Public Advocate provides education sessions, usually in response to specific requests from organisations and groups. These include providing written information for displays, acting as panel members or presenters for conferences and workshops, and attending meetings and education sessions for service providers and members of the public.

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

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

The OPA was pleased to have the company of representatives from the National Office for the Empowerment of Persons with Disabilities, Thailand, who joined us in 2013 for a return visit. Their visit, led by Director-General Mrs Napa Setthakorn to South Australia was organised by the non-government sector agency Community Accommodation Respite Agency (CARA). Once again our visitors were particularly interested in the work OPA has undertaken around supported decision making.

From L to R: Ms Elly Nitschke (Senior Project Officer, OPA), Miss Vipadee Viseschart (Social Development Officer), Mr Chaiyaphon Phupharat (Representative from the Council if Disabled People of Thailand), Mrs Supranee Kamtang (Superintended of Nonthaburi Reception Home for Destitute), Mr Prayad Deeong, (Legal Adviser, Ministry of Social Development and Human Security), Mrs Napa Setthakorn, (Director-General, National Office for Empowerment of Persons with Disabilities), Dr John Brayley (Public Advocate, SA), Miss Vijita Rachatanantikul (Director, Bureau of Policy and Technical Support), and Ms Jo Poole (Accommodation Service Officer, CARA).

The Alliance for the Prevention of Elder Abuse

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

Carers Afternoon Tea 2013. Presenters were Pat Sutton, Invited Speaker, and Aileen Vincent from our Office (pictured).

Enquiry and Information Service

The Enquiry and Information Service was coordinated by an Information Officer on a part-time basis in 2013-14. The Information Officer provides practical and factual advice on key legislation in adult protection, and Guardianship Board application processes, or redirects queries to other more appropriate services. Duty advocate guardians provide back-up advice and follow up more complex matters.

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

This year there were 2704 discrete episodes of enquiry. A comparison with previous years is graphed below (Figure B29). The substantial drop in 2006–07 coincides with a change in the database recording system which has improved our ability to link our record of people who call back with additional questions to their previous contact. Callers often raise more than one concern or issue in their contact with the service.

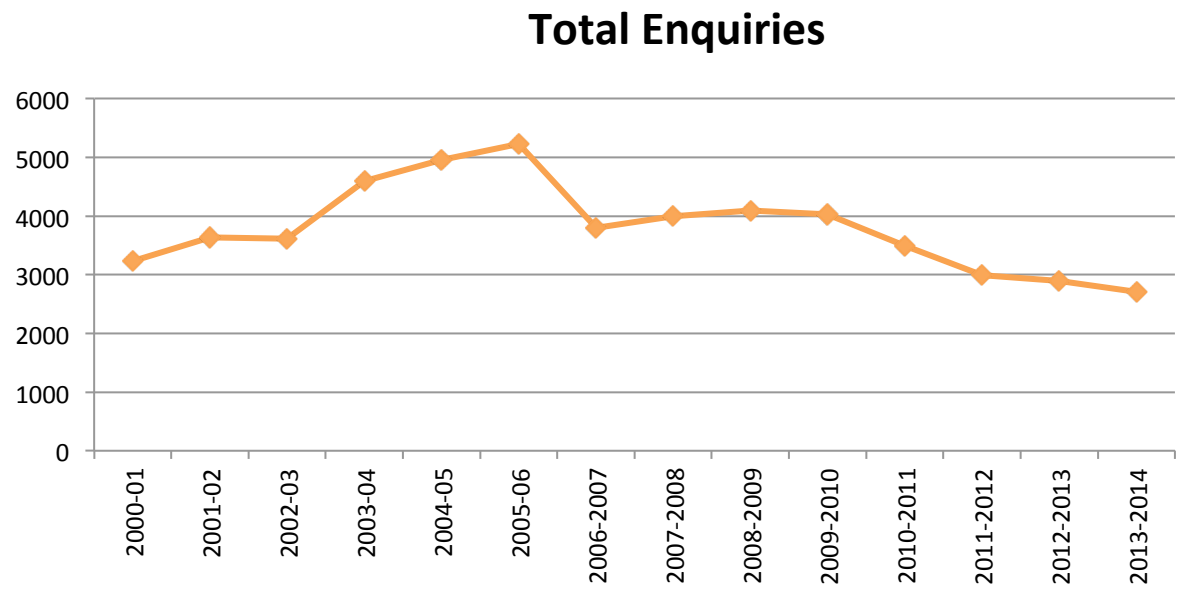


Figure B14: Number of enquiry episodes July 2000 to June 2014

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

Figure B30 below identifies the main issues raised during the last reporting period as advance directives, and guardianship and administration matters.

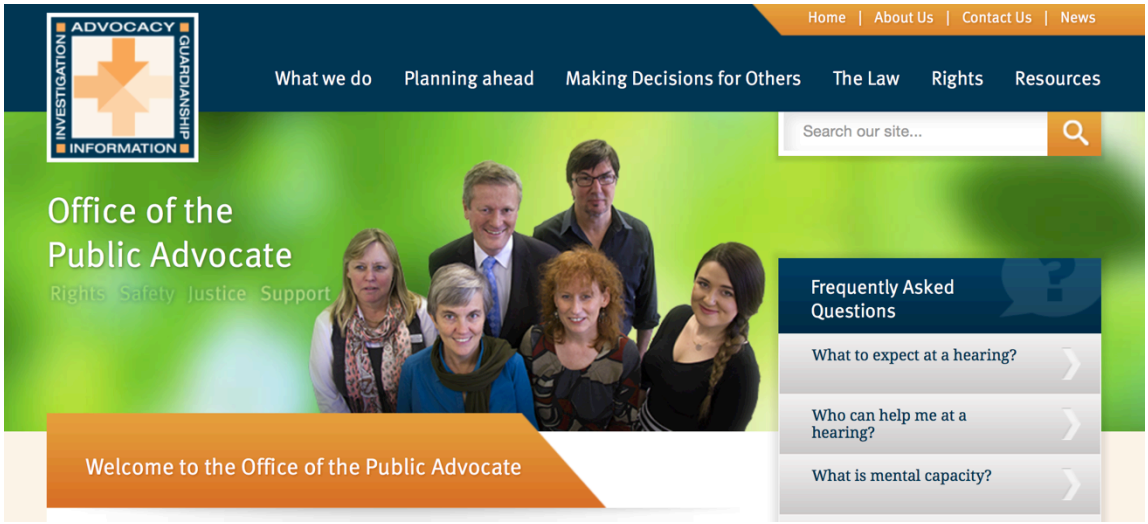
Main Enquiries Issues	2010-11	2011-12	2012-13	2013-14
Mental health issues	370	264	246	187
Guardianship issues	1008	1035	811	697
Administration issues	866	873	604	499
Advance Directives	856	737	656	1052*
Total issues raised	5012	4181	3811	3763
Discrete Episodes	3490	2995	2984	2704

Figure B15: Issues Raised in Enquiries

*The 1052 'Advance Directives' issues includes queries about enduring powers of guardianship, anticipatory directives and the anticipated commencement of the *Advance Care Directives Act 2013*. It includes 393 contacts related to Enduring Powers of Attorney.

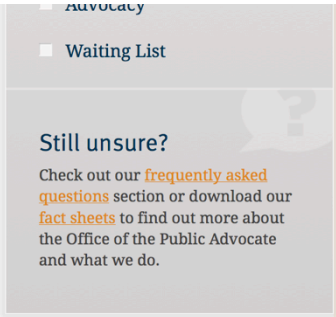
After-hours emergency response

An on-call (telephone) service operates 5:00p.m. to 9:00a.m. on weekdays and 24 hours a day on weekends and public holidays, staffed by rostered OPA senior staff and experienced advocate/guardians. This service acts as the emergency response for existing OPA clients, and an advisory service on the legislation and matters which may require an approach to the Guardianship Board for emergency orders. The President and Deputy Presidents of the Guardianship Board make themselves available to hear urgent applications outside of working hours.



New website developed in 2014:

In early 2014 our new website was completed. Thank you to Cheryl Thomas and Margaret Farr for the planning and development of the new site.



What does a guardian do?

The Guardianship Board defines the decisions for which the guardian is legally responsible.

Part of the preparations involved filming short information clips for the site. Top left and right, Stephen Burns, Advocate/Guardian, films a segment where Michelle Howse, Information Officer, explains the Enquiry Service. Below, Belinda Lake, Advocate/Guardian explains the role of a guardian.

Complaints and Decision Reviews

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

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

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

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

Activity

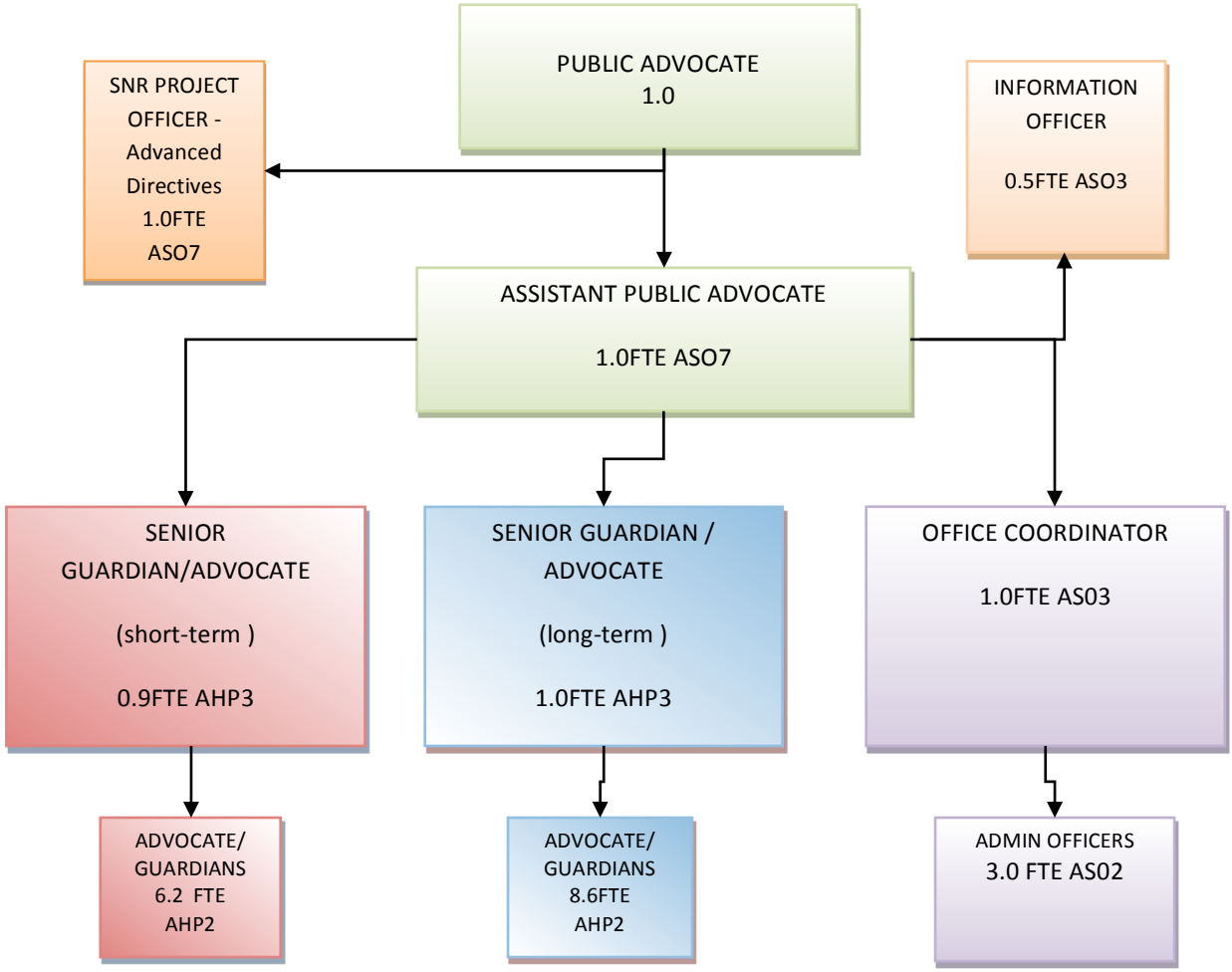
During 2013–14, the OPA acted on 26 separate matters consisting of:

- 16 formal complaints/requests for decision reviews
- 3 Freedom of Information (FOI)applications
- 7 Ministerial and Ombudsman's requests

All matters related to 25 current or past clients of the OPA.

Employment and Human Resources

Deployment of funded positions as at 30 June 2014



Operational: 24.2 FTE as at 30/6/2014

Staff of the OPA 2013–2014

OPA staff 2013-14, in order of their starting date of employment at the OPA (2001to 2013)

Margaret Farr	Assistant Public Advocate (commenced April 2001)
David Cripps	Advocate / Guardian
Elly Nitschke	Senior Project Officer (Advance Directives)
Tarnia White	Advocate / Guardian
Julie-Anne Harris	Senior Advocate/Guardian Long-term Team
Karen Bowden	Advocate / Guardian
Cheryl Thomas	Office Coordinator
Michelle Howse	Administration Officer
	Information Officer (not pictured)
Margaret Thompson	Advocate / Guardian
Andrew Sarre	Advocate / Guardian
Elicia White	Advocate / Guardian
Maria Atkins	Advocate / Guardian
Margi Keville	Advocate / Guardian
John Brayley	Public Advocate
Barbara Robertson	Advocate / Guardian

OPA Staff at a Planning Half Day in late 2013 facilitated by Anne Burgess.

Bethany Jordan	A / Senior Advocate / Guardian Short-term Team
Helen Mares	Assistant Public Advocate
Passant Ibrahim	Advocate / Guardian (not pictured)
Aileen Vincent	Personal Assistant
Rebecca Norman	Advocate / Guardian (not pictured)
Popi Amanatidis	Advocate / Guardian
Susan Goldeband	Advocate / Guardian
Jeannie Thompson	Advocate / Guardian
Belinda Lake	Advocate / Guardian
Stephen Burns	Advocate / Guardian
Ella Nalepa	Advocate / Guardian (not pictured)
Erin Larner	Administration Officer (not pictured)
Amy Martin	Advocate / Guardian
Anna Kleinig	Advocate / Guardian
Timothy Braund	Administration Officer (not pictured, commenced September 2013)

Workplace safety

OPA is guided by the policies and best practice principles of the Attorney-General's Department (AGD) in relation to Workplace Health, Safety and Injury management. Practical assistance is provided by the AGD on request. OPA has an elected, trained WHS representative and First Aid Officer. WHS matters are routinely discussed in OPA staff meetings.

Risk Review Group

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

Incidents have included threats to harm staff members, abusive communications from some interested parties and significant risks to the safety and wellbeing of some clients. Risks for staff are generally not from clients and are more likely to come from family members or associates who are involved in their lives.

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

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

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

Margaret Farr Retirement

A retirement afternoon tea was held for Assistant Public Advocate Margaret Farr on the 28th February 2014, attended by OPA staff current colleagues from the Guardianship Board and Public Trustee, and past colleagues of Margaret's from her work as a social worker before she came to the OPA in 2001.

Margaret delivered a warm inspiring speech, reflecting on her reasons for choosing her vocation.

On behalf of the Office, John Brayley delivered the following words of acknowledgement.

Margaret Farr: social worker, leader, operational manager, strategic planner, policy writer, mediator, complex case conference convenor, definer of professional practice in guardianship, advocate, lecturer, mentor, advisor, team member and guardian.

This is what Margaret does, has done, for the last 13 years. Done with passion, skill, commitment, an innate understanding of human rights, diplomacy and wisdom.

For many years Margaret has set the die in this State for both professional guardianship practice and our office function. She has been the Chief Operating Officer for the Office, a vital cog, sustaining the team, consulting and advising on the most difficult matters. She was the Assistant Public Advocate alone for a long time, then led the service as Acting Public Advocate. Now for many years she and Helen Mares have been effectively job sharing. Each supposedly working just half time!

Margaret has kept us up to date and renewed. Like any good leader, these achievements are team achievements, owned and implemented by many. But ideas, vision and direction just do not happen. The streaming of our Office into a two team structure, and the evolution of our current well received advice service are just two examples of ideas that started with Margaret.

Some of the tasks that many find tedious, Margaret can relish. Well written policies, managing sound finances, keeping spreadsheets, analysing data and making predictions. Her interest in

numbers and administration though is not for its own sake, it is important because of what it means.

And as Margaret moves into her retirement, it is worth reflecting on where we are right now as an Office. We have a richness of talent in our Office. We have the professional and leadership skills. This also reflects Margaret. Think back to what would have happened if Margaret were to have left completely 5 years ago. I think we would have been in a state of panic - where would we get another Margaret? However Margaret has seen her role to guide and support the evolution of the Office. Most recently this involved her proposal of a new leadership structure which will be in place we hope soon.

We will all no doubt keep in contact with Margaret. We will miss her wisdom, judgement and what she has contributed. For a long time Margaret was indispensable and irreplaceable, but she herself has made sure that she now leaves the Office in a state of strength, and even in her absence, I know we will be indebted to her legacy in professional guardian practice and leadership and management

Thank you Margaret Farr. Best wishes on your retirement.

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Financial Information

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

During 2013–2014, the core program expenditure of **the OPA** was as follows:

Income	
Grants	$0
Recoveries:	$483
Total Revenue:	$483
Expenditure:	
Employee entitlements	$2,509,563
Supplies and Services	$440,073
Depreciation	$20,872
Total Expenditure	$ 2,970,508

References

Attorney General (Victoria) 2014 Guardianship and Administration Bill 2014, Second Reading Speech, http://bit.ly/VictoriaAugust2014

Australian Law Reform Commission (2013) Equality, Capacity and Disability in Commonwealth Laws, Issues Paper, Released 15 November 2013, http://www.alrc.gov.au/publications/disability-IP44

Australian Law Reform Commission (2014) Equality, Capacity and Disability in Commonwealth Laws, Discussion Paper, Released 22 May 2014, http://www.alrc.gov.au/publications/disability-dp81

Burns T, Rugkasa J, Molodynski A, Dawson J, Yeeles K, Vazquez-Montes M, Voysey M, Sinclair J and Priebe S (2013) Community treatment orders for patients with psychosis (OCTET): a randomized controlled trial, *Lancet*, 381: 1627-33.

Department of Health (Victoria) (2014) Recovery and supported decision making, Mental Health Act 2014 Handbook, 26 June 2014, http://www.health.vic.gov.au/mentalhealth/mhact2014/recovery/index.htm

Department of Health (2010) Outcomes and proposed next steps: Review of the Access to Allied Psychological Services Component of the Better Outcomes in Mental Health Care Program, http://www.health.gov.au/internet/main/publishing.nsf/Content/2A8C027E06EBA6DACA257BF0001FA175/$File/review.pdf

Ersnst and Young Consultants (2013) Review of the South Australian stepped system of Mental Health care and capacity to respond to emergency demand, http://bit.ly/ErstYoungMentalHealthReview

Department of Health (UK) (2010) Implementing "Fulfilling and rewarding lives" Statutory guidance for local authorities and NHS organizations to support implementation of the autism strategy, Department of Health, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216129/dh_122908.pdf

Department of Justice (Victoria) (2014) Ravenhall Prison Project, http://www.corrections.vic.gov.au/home/prison/ravenhall+prison+project.shtml

Dietrick M, Irving C, Park B and Marshall M (2010) Intensive case management for severe mental illnesses, http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007906.pub2/abstract;jsessionid=945CDBB3B1450BCC1CC2E9F86CD4954C.f03t04

Forensicare (2014) Information on inpatient services operated by Forensicare: Thomas Embling Hospital, http://www.forensicare.vic.gov.au/page.aspx?o=teh#acute ,

Assessment Prison and Womens Prison, http://www.forensicare.vic.gov.au/page.aspx?o=prison#map

Hayes S, Shackell P, Mottram P and Lancaster R (2007) The prevalence of intellectual disability in a major UK prison, *British Journal of Learning Disabilities*, 35:162-167.

Health Outcomes International (2011) Evaluation of the Individual Psychosocial Rehabilitation and Support Services (IPRSS) program Final Report, May 2011, http://www.sahealth.sa.gov.au/wps/wcm/connect/d03c5c004c3ed23d9066b4e408a887aa/IPRSS+Final+Report+-+for+distribution.pdf?MOD=AJPERES

Inclusion International (2014) About Self Advocacy, http://inclusion-international.org/about-self-advocacy/

Murphy S, Irving C, Adams C and Driver R (2012) Crisis intervention for people with severe mental illnesses, Cochrane Collaboration, http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD001087.pub4/abstract

Office of the Public Advocate (2009) Annual Report 2009, http://www.opa.sa.gov.au/files/61_annual_report_2008-2009.pdf

Office of the Public Advocate (2010) Annual Report 2010, http://www.opa.sa.gov.au/files/62_annual_report_2009-2010.pdf

Office of the Public Advocate (2011) Annual Report 2011, http://www.opa.sa.gov.au/files/63_annual_report_2010-2011.pdf

Office of the Public Advocate and the University of South Australia's Human Rights and Security Cluster (2011) Closing the Gaps: Enhancing South Australia's Response to the Abuse of Vulnerable Older People. http://www.opa.sa.gov.au/files/187_closing_the_gaps_final_report_proposed_policy_complete_document.pdf

Office of the Public Advocate (2012) Annual Report 2012, http://www.opa.sa.gov.au/files/64_annual_report_2011-2012.pdf

Office of the Public Advocate (2013) Annual Report 2013, http://www.opa.sa.gov.au/files/188_annual_report_2013_v6_final_as_submitted.pdf

Office of the Public Advocate (2013b) Australian Law Reform Commission: Legal Barriers for People with Disability (Issues Paper Response) http://www.opa.sa.gov.au/files/198_alrc_supported_decision_making_sa_opa_final.pdf

Office of the Public Advocate (2014a) Dispute Resolution Service, Mediation Model, www.opa.sa.gov.au/files/217_model_and_practice_guidelines_june_30_2014.pdf

Office of the Public Advocate (2014b) Dispute Resolution Service, Declaration Service Model, www.opa.sa.gov.au/files/216_declaration_service_june_30.pdf

Office of the Public Advocate (SA) and Office of the Public Advocate (Vic) (2014) Australian Law Reform Commission: Legal Barriers for People with Disability (Discussion Paper Response)

http://www.opa.sa.gov.au/files/212_opa_sa_and_opa_vic_submission_alrc_discussion_paper.pdf

Productivity Commission (2011) Caring for Older Australians, Final Inquiry Report, Canberra, http://www.pc.gov.au/__data/assets/pdf_file/0014/110930/aged-care-volume2.pdf

Productivity Commission (2014) Report of Government Services, Chapter 14, Services for People with a Disability
http://www.pc.gov.au/__data/assets/pdf_file/0017/132362/rogs-2014-volumef-community-services.pdf

Rosen A, Gurr R, Fanning P and Owen A (2012) The future of community-centred health services in Australia: 'When too many beds are not enough', *Australian Health Review*, 36:239-243.

SA Health (2013) SA Health's response to the *Review of the South Australian Stepped System of Mental Health Care and Capacity to Respond to Emergency Demand*, http://bit.ly/ErnstYoungSAHealthResponse

SA Government (2014) Budget Paper 6 Budget Measures Statement, http://servicesa.cdn.on.net/budget201415/docs/budgetp6-201415.pdf

SA Government (2014) News release: More mental health beds- easing pressure on emergency departments, 6 September 2014, http://www.premier.sa.gov.au/images/news_releases/14_09Sep/eds.pdf

Schofield P, Butler T, Hollis S, Smith N, Lee S and Kelso W (2006a) Traumatic brain injury among Australian prisoners: rates, recurrence and sequelae, *Brain Injury*, 20:499-506.

Simpson J (2014) Participants or just policed, Guide to the role of the NDIS with people with intellectual disability who have contact with the criminal justice system, NSW Council for Intellectual Disability, http://www.nswcid.org.au/images/pdfs/participants%20or%20just%20policed%203005514.pdf

Social Inclusion Board (2011) Strong Voices, http://bit.ly/SocialInclusionBoardStrongVoicesReport

Stephens R, White S, Cudnik M and Patterson E (2014) Factors associated with longer length of stay for mental health emergency department patients, *Journal of Emergency Medicine*, electronic pre-publication (available via PubMed)

Supported Residential Facilities Advisory Committee (2013) Annual Report 2011-2012. Tabled in SA Parliament 20 March 2013, http://bit.ly/ZURwil

Supported Residential Facilities Association (2012) Strategic Directions 2012-2015, http://www.srfa.com.au/pages/strategic-directions-2012-2015.php

Vanny K, Levy M, Greenburg D and Hayes S (2009) Mental illness and intellectual disability in Magistrates Courts in New South Wales, Australia, *Journal of Intellectual Disability Research*, 53: 289-297.

Whalan J, Acton P and Harmer J (2014) A review of the capabilities of the National Disability Insurance Agency, http://www.ndis.gov.au/sites/default/files/documents/capability_review_2014_3.pdf