

OFFICE OF THE PUBLIC ADVOCATE



A N N U A L R E P O R T 2 0 1 1

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

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Annual Report 2011

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5th January 2012

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 seventeenth 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 2010 to 30 June 2011. Part A is an overview of major matters arising during the year, and includes a review of programs, consideration of unmet need, and advocacy positions taken by the Office. Part B provides statistical data on direct client services provided by our Office.

Yours Sincerely

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

John Brayley
PUBLIC ADVOCATE

Office of the Public Advocate Annual Report

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Introduction

The 2011 Annual Report of the Office of the Public Advocate is divided into two parts.

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

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

The past year has seen a significant shift in policy thinking about how our community can best meet the needs of people who are vulnerable. Major reports have been delivered by the Productivity Commission in Aged Care and Disability Service provision, and the Commonwealth has committed to new investments in mental health reform.

This shift has been the recognition of the need to move from a welfare-based to a rights-based approach in the areas of disability service provision, and adult protection. Similar principles can also be applied to the rights-based recovery model used in mental health service provision, and the recognition of autonomy and ‘personhood’ of older people who have dementia.

The traditional welfare-based approach is grounded on giving. A welfare system will respond when it can, amongst its other priorities, and recipients should therefore be grateful for whatever they receive.

In contrast, a rights-based system will respond every time. A rights-based system is concerned about all people in the community who have a particular need — not just those who happen to be in contact with a service¹.

Part A covers a range of topic issues in our role of reviewing programs and promoting rights. However, it is relevant to highlight five key areas that are separate but interrelated: supported decision making; the development of modern, adult protection systems; reforming guardianship; developing deprivation of liberty protections; and providing supported accommodation to people who have high needs.

The Office of the Public Advocate is in a unique position to consider these interrelationships, given its work with individuals receiving services across mental health care, disability support and aged care, in addition to having a mandate to promote rights and review programs.

Improvements in each of these areas can work together to protect rights and deliver results for individuals. They all act to reduce the need to place vulnerable people under guardianship. While guardianship can be essential for some people, and as a guardian of last resort we are proud of the work in the area of guardianship that we do, we are also charged with finding alternatives to guardianship.

¹ This dichotomy of welfare-based vs. rights-based models is summarised by Walsh (2011, p194) as applied to homelessness.

The first of these key strategies is to routinely provide **supported decision-making** assistance. Providing support with decision making is no different to providing support with other life skills. If we do not have a supported decision-making program in the future, then there are likely to be two major negative outcomes. The first is that a person who needs this support but does not get it, may make a decision that they might regret because they have not had help exploring options, considering consequences and avoiding impulsive decisions. The second is that a person without support might then have a guardian unnecessarily appointed to make substitute decisions, as guardianship is generally available but supported decision making is not. Unlike the United Kingdom, we do not have a legislated requirement that practicable steps be taken to support a person to make their own decisions, before it is concluded that a person cannot make a decision. Our Office considers that we should have such a provision in our legislation. Providing this support is not onerous or resource intensive because the actual support does not need to be delivered directly by services. Instead, supported decision-making programs help a person to set up arrangements with chosen family or friends who then provide the decision support.

The move to supported decision making is now driven by the requirements of Article 12 of the UN Convention on the Rights of Persons with Disabilities (UN Enable, 2008) but the values that underpin this are also those that were espoused when the *Guardianship and Administration Act 1993* was debated in parliament nearly 20 years ago — even though ‘supported decision making’ language is new.

In South Australia, the Supported Decision Making Trial has been exploring a practical model of delivering such a service that could be considered for use in this State in the future. The arguments for supported decision making were developed in our 2009 and 2010 annual reports. Now, with actual direct experience of delivering a supported decision-making trial, it is possible to talk more tangibly about how such a service can be delivered, and the very nature of supported decision making. This is described further in the next section of this Report, *Promoting Rights: Supported Decision Making*.

The second rights-protection strategy is the provision of practical, effective, evidence-based **adult protection** models. Just as the disability sector is moving from a welfare model to a rights model, adult protection services should be rights based. In the absence of clear across-government adult protection plans, guardianship can be asked to take on a welfare role beyond substitute decision making. This can have limitations. If a person at risk of abuse or neglect just needs practical social work assistance, and not a substitute decision maker, then it should not be necessary to lose decision-making rights through guardianship in order to get practical help. Adult protection responses link up the existing work of social services, health care, and justice to ensure that this practical help is delivered, and that people seeking help do not need to contact multiple agencies until they find the right one.

Adult protection is everybody’s responsibility and each service can have a defined role. Prompt social work visits, practical help and police assistance are all needed to respond to abuse and neglect. There should also be a single telephone helpline that community members can call for advice for any adult protection matter, whether it involves a younger adult who has a disability or an elderly person who is vulnerable. This single universal approach has advantages over the multiple response systems. Multiple systems that depend on a person’s age, the nature of a disability, and the presence of mental incapacity and can lead to uncertainty and gaps, when

often people need similar forms of practical help to stay safe. Best practice overseas is to focus on the needs of 'vulnerable' adults and 'at risk' adults who are offered help, irrespective of the cause of their vulnerability. A universal system, with clear agreements between local services as to who will do what, can help simplify the system, provide a practical service, and for some people, reduce reliance on guardianship.

The case for such a model has been outlined in previous annual reports, but this year we can present with greater authority. We were fortunate this year to coordinate a 6-month project funded through the Department for Families and Communities that defined the features of a practical rights-based system of protecting at-risk older adults. These recommendations were developed in conjunction with key organisations with input from frontline providers in the sector and are discussed further in the section of this report on *Reviewing Programs: Adult Protection*. We can say that the need for an across-government adult protection model is now widely supported by many in the aged care sector, and similar plans are also likely to be helpful for younger people.

A third strategy that our Office puts forward is the **reform of guardianship legislation**. There is a tension in our current *Guardianship and Administration Act* between rights-based and welfare-based objectives. A rights-based model focuses the role of guardian on decision making. A welfare view promotes a wider, more extensive view of a guardian as protector. Our Office promotes the rights-based model. Protection is important, but this can be provided through an evidence-based adult protection system as described above. Guardianship is a component of this response but one that should not be overused or become the main intervention.

Poorly defined legislation allows swings from narrow to wider welfare-based approaches. A precise definition of a rights-based guardianship service that focuses on decision making can sharpen the role of guardianship.

This suggested reform is consistent with the UN Convention on the Rights of Persons with Disabilities and current policy directions, but as discussed in the section of this Report *Monitoring Legislation: Guardianship and Administration Act 1993*, a rights-based approach also represents a return to common law principles about the decision-specific nature of mental capacity that have been in place for over 60 years. The sentiments about limiting guardianship were expressed in parliament when the current Act was debated in 1993. Because of the current ambiguity about the purpose of guardianship, we consider that the legislation needs to be amended to make clear statements of principle that there is a presumption of mental capacity, and that capacity is decision-specific, based on principles in the common law. Elements of this are already incorporated into the law in New South Wales and in the United Kingdom.

Our Office has proposed such amendments previously, but now is a time of greater momentum for a debate. As can be seen in Part II of this Report, the Office of the Public Advocate is experiencing a significant surge in appointments. While some of this increase in demand is inevitable and reflects our increasing aged population, another factor reflects a swing by the Guardianship Board to a broader protective approach to making guardianship appointments. A broader approach increases the risk of government processes intruding into the autonomy of individuals and the role of families. This is why it is timely to reconsider a narrowing of guardianship but also updating adult protection plans that can provide people with practical

help and minimise the need for guardianship. The *Monitoring Legislation* section presents these arguments in more detail.

The fourth reform is a greater focus on protections against **deprivation of liberty**. In each of the sectors that our Office deals with (disability, mental health and aged care), there are specific issues related to the restriction of the freedom of movement of people receiving treatment or care. In the disability sector, we lack basic protections to prevent and limit the use of restrictive practices, protections that are now part of disability legislation in Victoria and Queensland, a matter reviewed in our 2010 Annual Report. This year, with the Minister for Disabilities announcing a review of the *Disability Services Act 1993*, our State will see new legislation, which is very likely to incorporate restrictive practice protections. More work is needed in aged care so as to provide legislative recognition that some elderly people in secure residential care facilities are in fact detained and therefore require rights protection. This could be provided through new provisions in the *Aged Care Act 1997* without relying on unwieldy and excessive guardianship detention provisions for large numbers of residents. With respect to mental health legislation, this Report reflects more on the threshold for making detention decisions under the *Mental Health Act 2009*, and how people under detention can be involved in decisions about their care. These matters are discussed in the section of this report *Promoting Rights: Deprivation of Liberty*.

The final part of this section considers the provision of **supported accommodation**, particularly for people who have high support needs. This issue might seem conceptually different to the others mentioned above. However, the provision of proper accommodation and support can significantly protect the health and welfare of vulnerable people. The same person in a unit or home visited by a support worker may not need guardianship, yet if in unstable or unsuitable accommodation, it is likely that guardianship could be applied for because the care system does not have the capacity to provide what is required. The section *Promoting Rights: Supported Accommodation* examines issues across different sectors. Often the needs of clients of the Office of the Public Advocate do not fit easily into designated programs, and people can fall through gaps.

The matters considered in this report significantly affect the lives of both service users, and family and friends who act as carers. Current policy and service gaps leave carers to pick up an excessive burden of care which can be unsustainable.

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

In July 2011, The Assistant Treasurer, the Hon. Bill Shorten tabled the Productivity Commission's final report into Disability Care and Support (Productivity Commission 2011).

The report recommended a new scheme, the National Disability Insurance Scheme, to fund long-term high quality care for people with disabilities. A single National Disability Insurance Agency would oversee the scheme. It would provide certainty of funding based on need, and would have common eligibility criteria (Productivity Commission, 2011).

The Commonwealth Government has welcomed the report, and it is expected that Australia could have an operational scheme by 2017.

In this context, South Australia will need to prepare for the scheme's commencement, but also solve problems in the interim.

While there have been some positive developments with increased funding for disability services in South Australia, in 2010–2011 major gaps remained. Many are so fundamental that they need to be addressed now rather than waiting for the insurance scheme to commence over the next five years.

Past observations and recommendations

2009 OPA Annual Report

- **Access block:** The 2009 Commonwealth Government's National Disability Strategy Consultation Report "Shut Out" painted a picture of limited access to services from a disability system that is "...chronically under-funded, under-resourced, crisis driven, struggling against a vast tide of demand."
- **More people receiving services but with less funding:** With just over 40% of the population who might require a specialist disability service receiving one in South Australia, our State performs better at providing access to specialist disability services than any other state except Victoria.

However, South Australia also had the lowest per capita funding. Attempting to serve more users with an average total financial allocation means there is less funding available per service user.

- People who have an **intellectual disability** are often assessed as requiring a service, but there is a gap in the level of service funded compared to what is required.
- People with a **brain injury** can experience delays accessing a service after an injury, with uncertainty in meeting eligibility criteria at times, such as whether a disability is "permanent or likely to be permanent."
- Disability services have struggled to meet the increased demand by children and young adults with **autism spectrum disorder**. The Coroner had recommended the development of a model for service delivery for young people with Asperger's.
- A shift is required from a welfare-based model to a **rights-based model**. This would need law reform of the *Disability Services Act 1993* and the *Guardianship and Administration Act 1993* to meet the requirements of the UN Convention.
- **A new Disability Act** could legislate for individualised funding, eligibility for services, an appeal mechanism and provide for the quality and safety of services including a senior professional role to drive Standards.

2010 OPA Annual Report

- The previous service-access pattern was unchanged. Graphing disability services **unmet need** data demonstrated an ongoing increase in the total number of clients on the unmet need list and on the Category 1 list.
- **New legislation should have detailed and specific provisions.** The role of rights-based disability legislation was further explored (OPA 2010, p. 20). Such legislation should allow parliament to stipulate critical details of service design (rather than leave this to departmental policy, which may not carry the same weight).
- **Ten potential elements of rights-based disability legislation were listed** including: a restatement of rights of disabled persons, a statement on access to services, definition of eligibility, the provision of assessments for people who might be eligible for a service and appeal processes if a person is considered ineligible. For those receiving services, legislation could define a requirement that a support plan is developed for each client and items on that plan are delivered, and require consumer and carer participation in all aspects of care. Legislation would also define safety and quality obligations of service providers, provide a framework for self-managed funding, and define expectations across government departments to ensure the ready availability of the full range of government services for people who have a disability.
- A further detailed review of **restrictive practices**, supported the 2009 recommendation that this should be legislated in the Disability Act, and that an **Office of the Senior Practitioner**, an independent disability professional — most likely a psychologist with specific skills — be charged with preventing the use of restrictive practices where possible.
- **The 2010 merger of state government aged care and disability policy development and service provision was noted:** Our Office was reassured that existing specialist disability and domiciliary care teams will continue to operate, and that only the initial referral response will be merged.
- **Concern regarding the proposed use of the D-START computer-based assessment tools:-** Systems that determine access to services and influence levels of funding should be transparent and open to scrutiny. A high level of vigilance is required in monitoring the scoring systems in such tools, so they do not end up creating de facto policy settings. We all need to know what is ‘under the bonnet’ of critical software.

Update on service use and unmet need

Previous patterns remain unchanged. The Productivity Commission's (2011b) latest report describes services in 2008–2009. That year, South Australia along with Victoria had the highest rate of access to government-funded specialist disability services. Figure A1 demonstrates that 50% of the potential number of users accessed a service. (The potential users are those people who have a severe or profound activity limitation due to their disability).

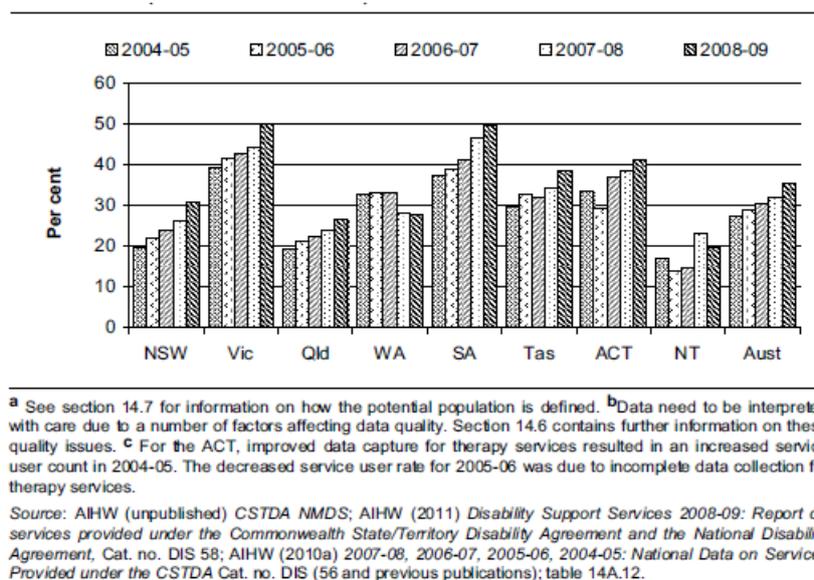


Figure A1: Users of CSTDA funded services as a proportion of the estimated potential population (Reproduction of Figure 14.5, Productivity Commission, 2011b)

The corollary statistic, of less funding per user, is also similar. Government expenditure per user is still reported to be lower in South Australia than in other states.

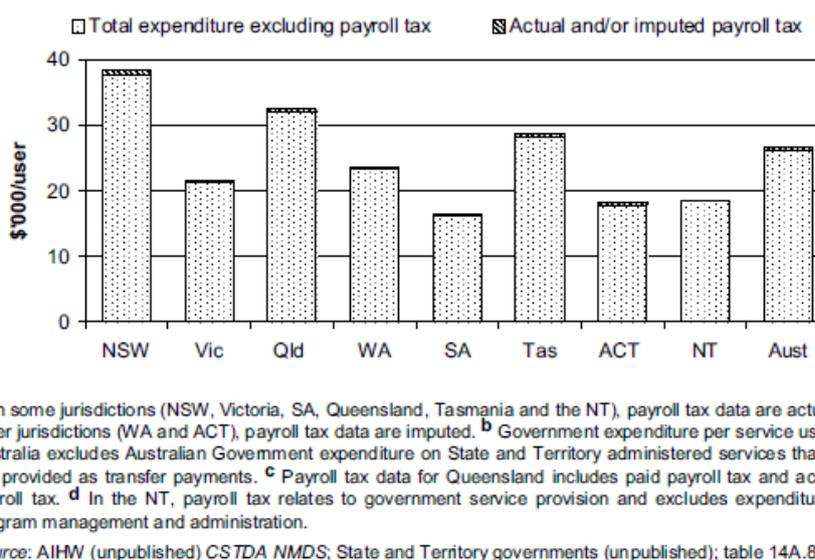


Figure A2. Estimated annual government expenditure per user of CSTDA State and Territory Administered Services (Reproduction of Figure 14.30 of the Productivity Commission (2011))

The 2008–2009 data published this year reported that there were 20,145 people receiving South Australian government-funded or government-provided disability services, an increase from 19,350 people the previous year.

Unmet need data

As a result of requests from community-based disability advocates, South Australia has been releasing unmet need data on a 6-monthly basis.

The Disability Services categorise unmet need according to the type of service required and the urgency of the need.

With respect to urgency, there are four groups. These are:

Category 1 — Critical (homeless/immediate and high risk to 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).

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

Figure A3 charts unmet need over time for all four categories of service. There has been no substantial reduction in overall unmet need, with a total of 2504 clients on the overall unmet need list.

Figure A4 demonstrates a concerning increase in the Category 1 unmet needs list. There are 888 clients on this list, 454 waiting for supported accommodation, up from 368 people the year before. Issues concerning supported accommodation are discussed on the next page.

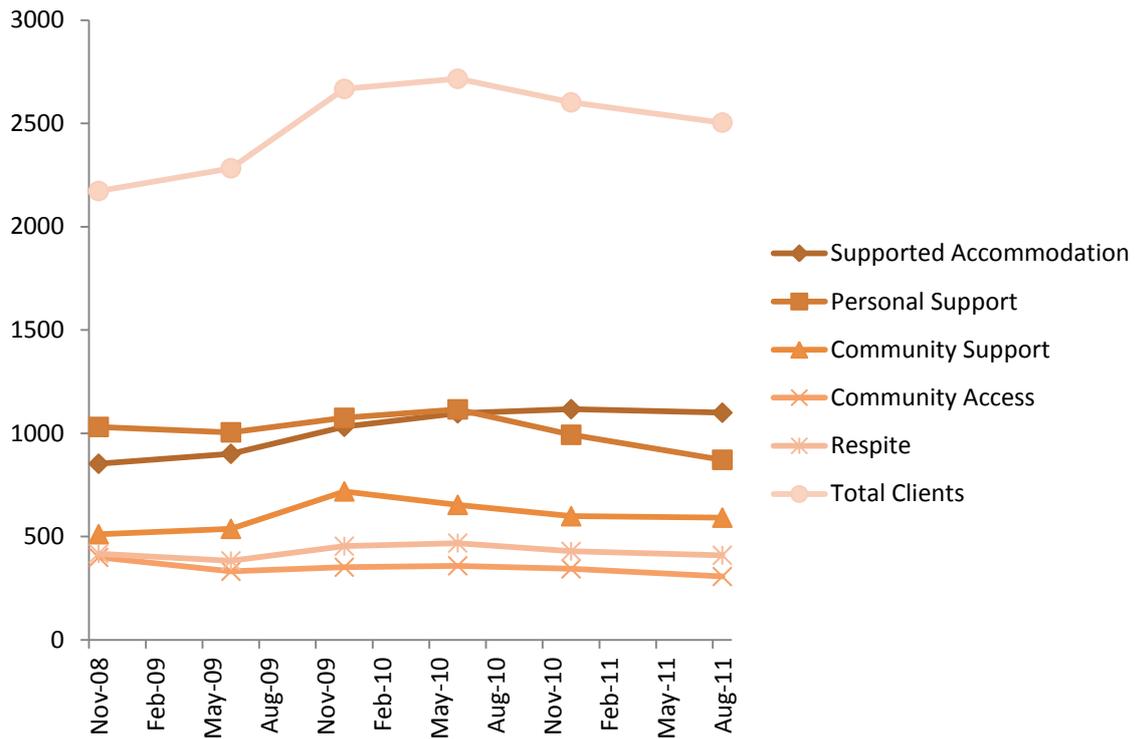


Figure A3. Increase in unmet need list November 2008 to August 2011. For clients in all categories.

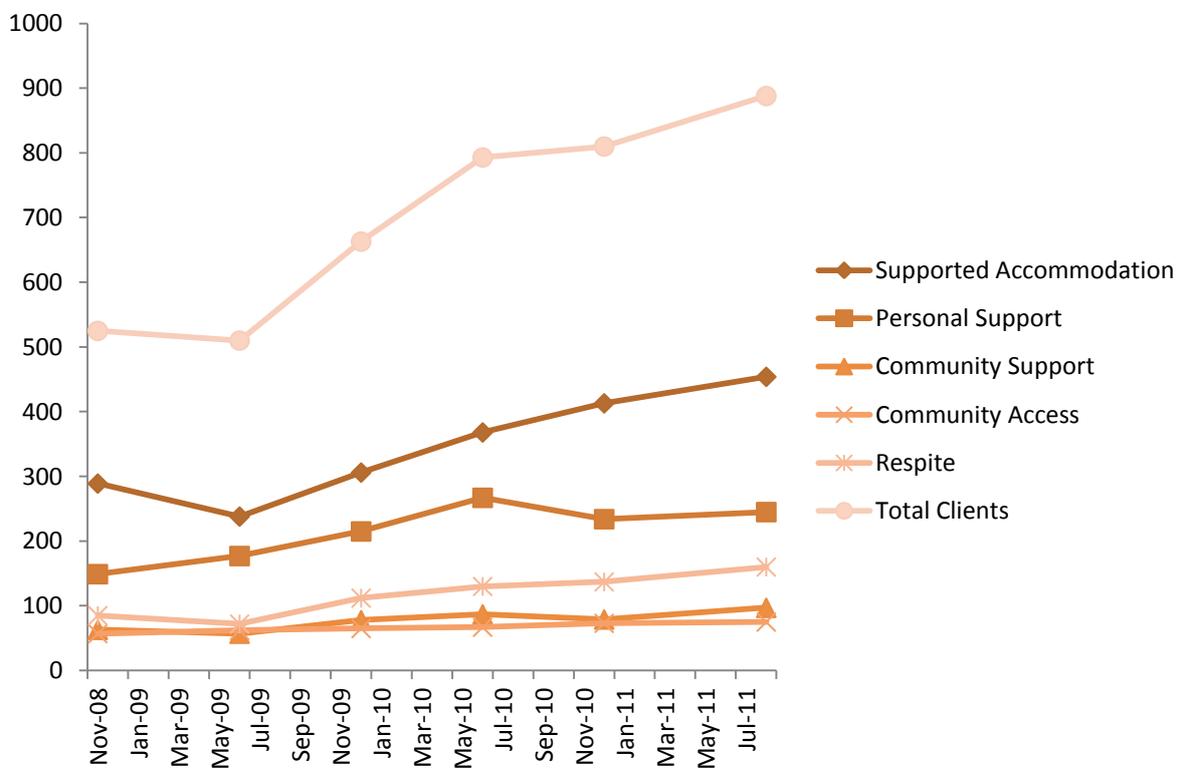


Figure A4. Increase in unmet need list November 2008 to August 2011. For clients in Category 1.

The waiting lists for different services can have a cumulative effect on each other. A person waiting for supported accommodation may sit in a respite place, decreasing the availability of respite. A lack of personal support services and rehabilitation may lead to a person's situation deteriorating, so a higher level of care is needed than may otherwise have been required.

The situation in South Australia, similar to the rest of the country, has become crisis driven.

It is not uncommon for our Office to become involved at these crisis times. Advocacy cases then are presented to disability services. The whole process can set up a pattern of helplessness, as the focus of arguing the case for a service is on a person's problems, personal distress, risk to self (or risk to others) rather than their goals and strengths. While the problems may seem to belong to the person with a disability, they mostly rest with the disability system itself and its inability to respond to the basic needs of clients. If basic needs such as support hours and accommodation are provided for, the issues can quickly move from risk containment to a more productive focus on opportunity and goals.

The well recognised challenge is to respond to the needs of people who are currently in crisis and then refocus service delivery to deal with their future needs before they become more severe. Individualised funding is a key policy solution. Because resources are allocated based on need, the individualised funding mechanism will ensure that there is sufficient support offered when a crisis does arise, but it will also ensure that sufficient assistance is funded at the earliest opportunities, allowing proper early intervention. This should then reduce the potential for future crises.

Increased funding for services in South Australia

When publishing unmet need reports, the Department for Families and Communities also provides a summary of new funding allocations to address this need. Recent measures listed in the December 2010 report included a \$31m boost in funding over four years in 2009 directed at respite and home support, and \$70.9m over four years committed in the 2010–2011 budget (Department for Families and Communities, 2010). The August 2011 report noted a further \$56m over four years allocated in the 2011–2012 state budget to be spent in early intervention, accommodation support, respite and day options, disability equipment, and funding for the Strathmont devolution (Department for Families and Communities, 2011). Government spending on disability was \$261.3m in 2009–2010 (Department for Families and Communities, 2010).

It would seem that without this extra investment, the situation faced in South Australia would be significantly worse. This investment is commended and acknowledged, but the investment has been insufficient to meet the demand by people affected by unmet need.

Tackling the Category 1 Waiting List

It is a positive action that our State transparently reports this list, but as it is released year after year, there is a risk that we will come to accept this figure and to be desensitised to the number of people urgently in need of accommodation.

The relentless growth in unmet need, in particular for those people whose situation is considered critical by virtue of homelessness or risk to self or others, is a major concern. If there were just one or two people on the Category 1 list — people at risk — immediate action would be expected. For example, for those in need of supported accommodation, housing with support would be immediately found. However, because there are 454 people on the list, there is a collective desensitisation to the problem, although the problem is identical but affecting more people. The same issue applies for people on the Category 1 list for other services.

When should the needs of people in Category 1 waiting list be met? The answer is: Tomorrow. Every day that goes on with people on this list in critical need is a day too long. The critical nature of the Category 1 definition itself indicates why there is an urgent need to respond.

In terms of policy, our Office would suggest that it is not appropriate to set a reduction target for the Category 1 list. The only acceptable target is zero. A strategy that plans to leave any person in a critical state of need should not be countenanced.

Without a response to critical need, there is always a cost — both personal and financial.

The personal costs are obvious. The person with disability is deprived of a life worth living, struggling to exist day by day. For those at risk of self-harm or harm to others, the level of their personal distress is self-evident. While therapies and treatments have a role, the simple provision of housing, support, and meaningful activity will calm distress and create safety.

In other situations, the cost is borne by carers — often fatigued, depressed and physically unwell through providing years of personal care services at impossible levels.

The financial cost can be a direct cost to government but on a different department's budget. The examples of people waiting in acute hospital beds are familiar, but people with a disability and problems with behaviour control — the people in the “risk to others” group — may also end up in the criminal justice system, when this might be prevented by the prior provisions of support services and a behaviour management plan. The role of a separate Disability Justice Strategy is discussed elsewhere in this Report, but providing essential support services, assisted by professional assessment and advice, is a strategy in itself to keep people out of trouble.

We need to know more about what happens to people on this waiting list. There are usually more data available for people who are receiving a service than for people waiting for one. For example, an incident management system can be used to track critical incidents for people in receipt of services. We do not have a similar system to report critical incidents for people on the waiting list although it is acknowledged that many people on the Category 1 list will be known to disability services, and will be receiving some type of intervention, but one that is insufficient for their needs.

While more data are needed on the outcomes for people on the waiting list, the best solution is to deliver a service. Given the choice, it is better to provide a basic service, rather than invest resources in monitoring how badly people are doing without a service.

Individualised Funding

South Australia is moving towards individualised funding. The parameters of a new scheme will be critical to its success and to the potential benefits experienced by people using it.

Some of the key advantages of individualised funding include an individual assessment of need, and allocation of funding to meet that need. A person will know exactly how much their care is costing.

Although the differences between individualised and self-managed funding can be debated, the two do not automatically go together. For example, a person may have an individualised budget, but elect not to self-manage it. In South Australia, there has been a self-managed funding trial under way, which is an excellent initiative of Disability Services. The trial will be independently evaluated. Already this Office is aware of many positive stories coming from the trial. This is because people with a disability and their family have a choice as to which services are purchased and from whom. Yet, while this funding is self-managed, it is technically not individualised. The amount that people have been given to self-manage is the historical amount that was allocated to the person in the old system. It is what the person was getting, rather than an amount linked to an assessment of what the person needs. In this Phase I Self-managed Funding Trial, not only is the amount calculated from the historical allocation, the amount provided is only part of the individuals budget because block funded services (such as accommodation services) and case management are not part of the trial. In future phases they will be.

It would be a useful exercise to develop a policy analysis template to rate any proposed individualised funding scheme against the features of a best-practice scheme as described in the literature. At this point, we have not undertaken this exercise. In South Australia, we have ready access to the Julia Farr Association based in Adelaide, which is leading the thinking about individualised funding in this country, and can evaluate the strengths and benefits of proposed schemes.

However, it is still appropriate for our Office to offer a basic list of attributes that might be used as a checklist when the plans for South Australia's next phase of individualised funding are announced. The list of positive attributes includes:

- (1) Allocated funding is matched to need
- (2) Need is assessed transparently
- (3) The scheme supports genuine autonomy and personal decision making
- (4) There is access to consumer protection mechanisms and quality safeguards
- (5) Access to services provided by other government departments that are not part of the individualised funding arrangement, is improved or maximised
- (6) Where possible services delivered by other government departments will be incorporated into the scheme
- (7) There is effective participation of people with a disability and their families in the oversight of the scheme

- (8) The individualised funding permits self-management of the individualised fund if a consumer or carer wishes to do so
- (9) There is effective training and workforce development so that staff are available to be employed by people with disability
- (10) An individualised funding policy allows charities to allocate support on similar principles if they wish to do so
- (11) The scheme has provisions for access to services by Aboriginal and Torres Strait Islander people
- (12) Education about using the scheme is provided to their peers by workers who have a disability or are carers.

A number of these points will be further elaborated on.

A key purpose of individualised funding is to provide sufficient funding to match need. The allocation of funds has to be truly individualised. For example, it might be possible to use financial computing programs to allocate current costs to individual users. Equipment costs, staff salaries and accommodation costs could all be added together, and a financial statement printed. While this may be the *individual's* budget, it is not an *individualised* budget because it is a report of current funding only. It may, however, be useful after a true individualised budget has been determined based on need, to calculate the actual costs incurred using traditional funding. This can be a double check of the accuracy of the need-based calculation.

Access to services funded by other departments needs to be carefully monitored. Ideally, money spent by different departments could be pooled into the individualised funding scheme. For example, a child may receive disability-related services at school through the Education Department and at home, through disability services. Similar types of therapy and rehabilitation may be provided through both sets of funding. If money is pooled, then parents could decide when, where and from whom services are received.

If funding is not pooled across departments, it will be critical that some departments do not expect a person with a disability to use their individualised funds to purchase services that might otherwise have been delivered for free by another department. Allied health services are a good example of this, because at times very similar services can be delivered by health professionals working in either the health or disability sectors. Both Medicare and state services have an obligation to provide health care for all people. In recent years, there has been improved access to allied health services for Medicare. Children and adults with a disability can also receive services from allied health staff at hospitals — from speech pathologists, physiotherapists, occupational therapists, psychologists or social workers. Care needs to be taken to ensure that access to these services remains; otherwise, a disability-funded individualised budget could be used up quickly by incurring extra costs in paying for additional services that were previously provided for free.

Individualised budget holders could be at great risk of cost shifting by other agencies in such situations, particularly as their budget is set.

Care will need to be taken to avoid profiteering. While anecdotal reports from the initial trial show the opposite — people report buying more with the same dollar amount than the

government could — it is also possible that people may be charged a higher cost. For example, many health providers charge a higher fee for service when a compensation authority is paying for services rather than Medicare. It will be important that self-managed disability fund holders are not charged the high rate.

In any program that involves self-management, there will be a need to educate participants, and give advice to people about potential options. Unfortunately, there is a risk that self-managed funding could spawn a new industry for advisers, brokers or consultants, who coordinate packages and help people spend their money.

This is where peer workers as educators and advisers could come in. Already, users of self-managed funding have accumulated significant experience in how to make choices and engage services. There is no reason why people personally experienced in self-managed funding, could not occupy paid positions to advise and assist others. While peer workers would also be trained in the details of individualised and self-managed funding, these workers would deliver an extra benefit because they have experienced self-managed funding, and know first-hand how it can deliver choice and power.

Services for people who are diagnosed with autism spectrum disorders

This year, the Office of the Public Advocate put forward the proposition to the Government that South Australia requires a State Autism Plan to meet the needs of children and adults who are diagnosed with an Autism Spectrum Disorder (ASD). This spectrum includes Autistic Disorder and Asperger's Syndrome. Autistic Disorder presents with impaired social interactions, communication, and restricted or stereotypical patterns of behaviour and interests. It is usually identified before the age of three. However, Asperger's Syndrome may be identified late as early language and cognitive development are preserved and impairments in socialisation and restricted interests are observed later (Volkmar et al., 2009).

Increasingly, young adults are diagnosed for the first time with an Autism Spectrum Disorder, and adult services can lack specific skills to respond. Systems are stretched because of a greater incidence of autism, and better recognition leading to greater service demand. At least 1 in 160 children are likely to experience an ASD (Autism Advisory Board, 2007).

Much of the disability reform work in coming years will be in implementing generic reform to the disability sector as a whole. A State Autism Plan can elaborate on how the specific needs of people who live with autism can be met within a broader disability strategy. An autism plan would sit under the main disability plan. An across- government plan to assist people with Autism Spectrum Disorders could link services in education, disability, health, mental health and justice, and help eliminate current gaps and anomalies.

Why a plan is needed

Children with autism need early diagnosis and then effective interventions, at all ages. Adults similarly need specialist services rather than generic support. The level of service an adult requires is likely to be greater if that person has missed out on early intervention and therapy as a child. A plan can provide for the needs of all age groups, but ensure early intervention, because this is likely to prevent even more problems when a person is older.

There have been positive developments in the expansion of services in recent years, but the sector has developed in a piecemeal way resulting in duplication and gaps. For adults in particular, one-off packages of care are provided, designed for individuals when a predictable service response could be more effective and efficient.

What a plan could address

A key element will be access to education options. Children require skilled input to assist in developing communication skills, social skills and to focus on learning. There is debate in the community about how this can be best achieved through autism-specific vs. mainstream education settings. However, it is reasonable to conclude that children will need access at times to autism-specific education units where staff have the specialist skills to assist with communication, learning, social skills and behaviour, as well as students spending time in mainstream classes where possible. All children with ASD need access to the specific choices for them.

A plan could bring together existing initiatives, ensure that the gaps are recognised, and target new investment to those gaps. It is worthwhile reviewing some of the State and Commonwealth measures currently in place.

Services of school age children who have a diagnosis of an ASD

For school children, the education system is often their key disability service provider. In early 2010, there were 20 special education units for children with a disability, 16 special schools and 110 special classes. The Government announced six additional special education units, two to be autism-specific at The Heights School and Blackwood, an expansion of the Big Buddy Scheme and additional funding for assessment and early intervention.

The Commonwealth has a 'Helping Children with Autism' program that funds autism advisors and early intervention services as well as playgroups and family workshops (Department of Families, Housing, Community Services and Indigenous Affairs, 2011). Through an autism advisor, a family of a child aged up to 6 years who has had a diagnosis of autism, can access \$12,000 of funding for early intervention services.

The Department of Health and Ageing through Medicare will fund specific payment items for paediatricians, psychiatrists, psychologists, speech pathologists, and occupational therapists who see children up to the age of 13 for assessment, individual planning and therapy, although the number of sessions may be limited.

All of these initiatives at a State and Commonwealth level are positive developments; however, in the absence of an overall plan, gaps emerge. The Commonwealth initiatives have great potential as they will assist all people who are eligible and seek the funding. This is a 'rights-based' response. There is no cap on the number of places. However, we hear from providers and parents that the maximum age cut-off creates problems for children with Asperger's Syndrome taking advantage of this funding. While children with an Autistic Disorder are commonly identified before the age of three, and therefore are able to take advantage of the Commonwealth's early intervention package which applies to the age of 6, there are many cases of children with Asperger's Syndrome who are only identified from age 7 onwards — in Grade 1 or 2 — which is after the arbitrary cut-off age for the \$12,000 funding.

However, the State response is limited, particularly in relation to access to autism-specific education places. At school, parents report significant gaps. Children who have autism often require intensive, highly structured intervention so that they can focus on learning. A low student-teacher ratio is essential, and specific teaching and therapy skills are needed to develop children's language and social skills, and to manage behavioural problems.

We hear reports of children with autism grouped with students who have other disabilities and very different learning needs. This can be a problem for a student with an ASD who could miss out on the intensive skilled interventions required, and a problem for other students if behavioural problems are not skilfully managed.

Therapy and support are also required in mainstream settings. Unsupported students may also be subject to bullying, as well as getting into trouble themselves and behavioural outbursts can occur if frustrations are not skilfully managed.

Students with a recognised disability receive additional funding from the Education Department, which may then be used by the school to purchase time for school services officers to work with the students. What we are told is that decisions about how this funding is used are made by the school. The school may have its own strategies to combine funding and to group students together, but if the parents had a choice as to how this additional disability-

linked funding was spent on their child, it is likely that they would be making different choices, focusing on autism-specific interventions.

For example, the parents of a child who receives some community funding through Disability Services, as well as Education Department funding at school, should be able to pool the total funds and spend them where the intervention might be the most effective. A parent might decide to forego some support at home to increase 1:1 hours at school, or may opt to use education dollars to fund extra tuition or rehabilitation outside of school hours.

Limitations extend to the number of specialist skilled staff who visit students diagnosed with an ASD. In early 2011, Autism SA received funding for 15 staff to support 3664 students on their caseload. This limits the number of visits and hours of support that each child can receive.

An autism plan can address the educational requirements for children with autism spectrum disorders. A solution needs to be compatible with both reforms in disability policy, which would emphasise giving parents greater choice and control on how funds are spent, and education policy. Inevitably, autism-specific program places will need to expand as an alternative to placing children with autism in settings with children who have other disabilities and different needs. In mainstream classes, both children and their teachers will need to receive more hours of support from specialist skilled staff.

Services for adults who have a diagnosis of an ASD

For adults, the service gaps have been well documented; in particular, for young adults with autism and behaviour problems. The ongoing need for services for people who have autism are now predictable, although a number of years ago the increasing prevalence of this condition caught health and disability planners by surprise. People who have significant behavioural problems continue to miss out.

In fact, these adults have missed out twice. They missed out the first time when as children, early intervention was not delivered either through lack of diagnosis, or if a diagnosis was made through underservicing. Then as adults with high needs, they can miss out on services until their need is recognised as critical. Our system relies on one-off ad hoc arrangements, which in recent years have been funded through the Exceptional Needs Unit. Although our Office is pleased when clients receive this funding for their care, it would still be preferable if there was a planned response. The needs of this group can no longer be considered exceptional, but rather, are quite predicable.

Coroner Mark Johns (Coroner, 2008) in his inquest findings on the tragic loss of the life of a young man recommended the implementation of a model of intervention for young people with Asperger's. He noted that ad hoc arrangements could be both expensive and unsuccessful, and that with such arrangements it is not possible for staff to build up experience or acquire the specific expertise.

The Government, in responding to these recommendations in 2009, noted the establishment of a new Exceptional Needs Executive Committee, the establishment of a new service model for supported accommodation transition, and examples of the establishment of group homes, amongst other initiatives (Department for Families and Communities, 2009). Some of the work is positive, as we have heard of young people aged less than 18 years with Asperger's Syndrome who will be offered specialist supported accommodation that they will retain when then reach

adulthood. However, even though there are now some limited new opportunities, a system-wide response is not in place. Programs are still developed for individuals with high behavioural needs on an ad hoc basis. An autism plan could ensure that the Coroner's recommendation is addressed.

This Office has been aware of work to further develop responses, but we suggest an autism plan would provide a catalyst to address urgent needs that might otherwise take years to do.

Unsupported adults with Asperger's Syndrome can also end up before the courts. If incarcerated, a young person with an Autism Spectrum Disorder usually has difficulties managing relationships with other prisoners and can be at risk of assault or exploitation.

Learning from the United Kingdom's Autism Act 2009

The Autism Act is the first example in the United Kingdom of legislation specific to a disability. Our Office is not proposing that there should be a new Autism Act for South Australia at this time, as there is already substantial law reform planned for a new Disability Services Act. However, the development of the Autism Act in the UK illustrates the need for a high-level policy solution to meet the needs of people who have autism, whether it be defined by legislation, or an across-government administrative policy as is being suggested for South Australia in this Annual Report. Also, the UK Autism Act focused on gaps in service provision in adult autism only, and did not consider a strategy that includes children and adolescents.

The Autism Act 2009 required the UK Government to develop an Adult Autism Strategy by 1 April 2010, and that the Secretary of State for Health issue statutory guidance for local authorities. The strategy "Fulfilling and rewarding lives: the strategy for adults with autism in England" was released on the 3 March 2010. The vision of the strategy is that:

All adults with autism are able to live fulfilling and rewarding lives within a society that accepts and understands them. They can get a diagnosis and access support if they need it, and they can depend on mainstream public services to treat them fairly as individuals, helping them make the most of their talents (Department of Health, 2010a).

The vision is grounded in an equality and human rights approach. It focuses on five key areas: increasing awareness and understanding of autism; developing a clear and consistent pathway for diagnosis; improving access to the services and support people need to live independently within the community; employment; and enabling local partners to develop relevant services to meet the identified needs and priorities. This was followed shortly afterwards by a publication that described the government's delivery strategy which included the establishment of an Adult Autism Strategy Programme Board, a delivery group, and a range of initiatives to set standards, develop model pathways for diagnosis and personalised needs-assessment, provide training, and undertake research (Department of Health, 2010b).

Statutory guidance released in December 2010 then defined the legal obligations on local councils and health bodies in England to improve the training of staff, the identification and diagnosis of autism in adults, provide the planning of services for people with autism including the transition from child services to adult services, and the development of local leadership (Department of Health, 2010c).

The UK strategy covers a range of providers, who in Australia would be covered by both Commonwealth and state programs. If South Australia were to develop a plan, it could effectively operate by coordinating existing State-funded services, but a further challenge would be to bring into the plan services funded by the Commonwealth such as primary health care, early intervention programs, and vocational programs.

The proposed response — an Autism Plan

In summary: A State Autism Plan could bring together people with autism spectrum disorders, their families and providers to define how specific therapy and care needs will be addressed.

The Plan should be sector-wide, covering education, disability services, child protection, children's health, mental health, and justice. As noted, the Plan should include all age groups.

In schools, the Plan could address the provision of social skills training, communication, behavioural and education needs. Access to specialist learning environments could be provided for, along with support in mainstream classes. A 'pathway' could be defined that addresses government actions to improve the initial recognition of Autism Spectrum Disorder, access to diagnosis and assessment of needs, the provision of services as required to meet those needs, and consider broader community understanding. The response by education, disability and health professionals could then be better coordinated.

Such a plan could lead to better investment decisions. For example, the case for early intervention is stronger when based on economics, when it can be seen as offsetting the high costs of adult care if interventions have not been delivered. For this reason, ideally a State Autism Plan should cover all age groups.

Key generic principles from overarching disability legislation can be implemented through the Plan, which can ensure that necessary skilled assessment, therapy and skills training are available. The application of principles of individualised funding would give parents of children with autism a greater say in how disability funding in schools is spent on their child, and funding from individuals' money could be pooled across departmental boundaries. The Autism Plan could also incorporate the services for young people with Asperger's as recommended by the Coroner, providing a systematic response to this predictable need. This might involve the allocation of specific staff to specialist roles for people who have an ASD, as well as providing more training to a broader group of health and disability professionals who might assist people who have autism.

Disability Services Trust Fund

Introduction

A savings measure that was announced in the 2010 State Budget was the planned closure on 30 June 2011 of the Client Trust Fund operated by the Department for Families and Communities. It was expected that clients whose funds were held in trust would transfer to new arrangements under the Public Trustee.

Later the deadline for transfer was delayed by a further year to 30 June 2012.

The Department has provided a trustee service to Disability Services clients who have been unable to manage their own finances because of their disability. It holds funds on behalf of approximately 600 clients, and as of 30 June 2010, the balance was \$10.3m. During the 2009–2010 financial year, the Fund’s receipts totalled \$12.7m and payments \$12.1m (Auditor-General, 2010). The Client Trust Fund acts as trustee for most of its clients. Approximately 200 of the clients are under the Public Trustee as administrator, and the Trust Fund manages day-to-day transactions for this group.

Our Office was contacted by the families of people who will be affected by this change, concerned about the cessation of the trust fund arrangements.

The operation of the fund

The Department for Families and Communities has provided this service to people who have a disability and who are living in the Department’s supported accommodation. The Minister for Disabilities is the trustee of the Fund. It would seem that the nine staff who have administered this Trust Fund have provided a high level of service to clients and their families. Our Office had heard few complaints about its operation. When a matter did arise related to the Fund in 2010 (described in more detail in this section), this Office found the officials in the Department for Families and Communities to be proactive in dealing with concerns, and transparent in their approach.

The officials managing the Fund make quarterly visits to group homes and institutions to review records and check assets. Four of the nine staff are allocated the task of paying accounts. Families have expressed satisfaction with the regular statements received, and the growth in savings over the years. The Government had not charged for this service.

With respect to the description of clients of the Trust Fund, there are no readily available statistical reports that define the group of clients and the exact mix of financial services that they rely upon.

Bill payment and day-to-day finances, however, is a key role for the Fund. This includes payment of the Department’s own fee for providing supported accommodation. This fee for board and food corresponds to at least 75% of the disability pension, but we have been told by families that with other charges, costs can be higher. Some clients are “partially discharged” and pay 40% of their pension for accommodation but need to pay for food and other costs. The remaining funds that are not paid to the Department are available for clients’ use, so that personal effects can be purchased, and so that people have money in their pocket for day-to-day expenses.

Clients mostly receive the Commonwealth disability pension as income. Some clients have accumulated savings. Families have naturally been keen, when possible, for their family member in accommodation to have some financial security in the future. Residents receive inheritances. Others have assiduously saved money over many years. For example, an elderly mother who herself was on the pension, described to one of our officers how she made sure her son had saved for his future. He now has tens of thousands of dollars in the bank, saved from his and his mother's pension.

Conflict of interest and safeguards

The decision to cease providing this Trust Fund service was made as part of a budget savings strategy that had been considered by the Sustainable Budget Commission. The key driver to this decision was saving funds, not a policy decision. It is expected that as much as \$700,000 would be saved (noted in a letter from Disability Services to families 20 September 2010).

There is, however, a policy argument related to this issue. To avoid conflict of interest and a potential concentration of power related to decision making, it is preferable that service providers not be personal financial decision-makers for clients. Services already wield considerable power over their clients' lives, so to be the substitute decision maker for personal finances as well can be a problem. There are also examples of more direct conflicts that can arise.

Equipment purchases

An example arose in 2010. Ms Monika Baker of the Disability Advocacy and Complaints Service of South Australia (DACSSA) approached the Office of the Public Advocate with concerns that Disability Services clients' funds may be used for equipment purchases that might otherwise be made using government funds. DACSSA and our Office decided to work together on this advocacy matter, jointly meeting the relevant officials in the Department for Families and Communities.

It should be noted that there is nothing intrinsically wrong with using personal funds to purchase equipment. Because of the long waits on the government-funded equipment program, clients often weigh up if they can wait for new or replacement equipment to be provided, or use their own funds. This can be a very individual decision that in many cases is made by clients or family. However, for clients in the Trust Fund, the potential conflict of interest arises because this decision is made on their behalf by the service.

This Office asked for information regarding the number of occasions that client funds had been used by Disability Services to purchase equipment, including a breakdown of these purchases.

The review looked at purchases made on behalf of the 751 clients currently living in supported accommodation. Purchases were made over several years. Fifty-one clients had purchases made on their behalf, which included 32 wheelchairs, 5 commodes, 11 walking frames, 11 electric beds, 11 slings, and 12 purchases noted to be "other".

The Department's review in response to our questions noted the need to: (i) improve asset record-keeping for privately purchased items; (ii) review consent to purchase — the purchase is approved by a service unit manager who is also responsible for budget and facilities; and (iii) a lack of training in the use of new equipment purchased privately. It was not always apparent if the waiting list for the Department's own equipment fund had been checked before private

funds were used. While the long wait for departmental equipment is common knowledge, a number of the private purchases would have been considered “Priority 1” and therefore have a shorter wait. In one case, a private purchase may have been made when the issue to be addressed was staff occupational health and safety.

The Department’s response was both transparent in looking at past issues and proactive in seeking solutions. A new equipment standard would be developed specifically addressing the need for referral to the government-equipment fund, private purchasing, consent for purchase, and the response to occupational health and safety issues. A new reporting tool for new equipment requests was to be developed, and training matters addressed. Following the raising of this matter jointly by OPA and DACSSA, the relevant managers were already intervening when requests for private equipment purchases were made.

A follow-up request from this Office was that refunds be considered to individuals where it was apparent that private funds had been inappropriately used. We were advised that as these purchases had taken place over many years, it would be difficult to identify the instances where a purchase was not reasonable.

The Auditor-General audits the Disability Client Trust Fund. The Public Advocate advised the Auditor-General of this matter, who will give audit consideration to the new equipment policy and procedure to deal with potential conflict of interest.

In the future, there are now both internal and external safeguards in place. There is still uncertainty about some past purchases that have not been identified.

Alternatives to using the Disability Services Client Trust Fund

There was concern expressed by families because the initial announcement following the 2010 Budget was that responsibility for the Client Trust Fund would be “transferred from the Department for Families and Communities to the Public Trustee.”

There are in fact a number of possible alternative arrangements that need to be considered, and a transfer to the Public Trustee is not automatic. Options include: funds managed by the person themselves (in situations where the person has capacity to do so); a family member or friend appointed as a private administrator by the Guardianship Board; or the appointment of a trustee as administrator by the Board, most likely the Public Trustee, but it could also be a private trustee company.

For a family member taking on a private administrator role, some of the tasks can be automated either through the use of automatic deductions from bank accounts, Centrepay (Centrelink’s bill-paying service) or other bill-paying services established in the not-for-profit sector (the Community Business Bureau is an example). Private administrators are required to provide a yearly report to the Public Trustee. The Public Trustee operates education sessions for private administrators.

There have been a number of families who have already taken on the private administrator role. However, while some people have family members who are computer users who can pay bills and e-mail reports, others do not. Many parents are elderly, and even though they can undertake these tasks now, they will not always be there to do so in the future.

For those who might require administration services from the Public Trustee, the concerns have been about the costs of the service and the service quality compared with the departmental service that had been satisfactory.

The Public Trustee charges a capital commission, a commission on income and an estate administration charge.

The capital commission is 4.4% on new estates over \$5000. (This is a maximum rate but the rate reduces for estates over \$200,000). Our Office understands that the reason why a commission is charged on capital is to pay for the costs of setting up a file. Therefore, if a file is to be transferred from one trustee to another, it should not be necessary for such establishment work to be undertaken. For this reason, asking for the capital commission to be waived is a reasonable negotiating request for a family of a person whose finances are to be transferred.

The income commission is 5.5% for income for estates over \$4400. While many people in the community on the disability pension would not have \$4400 in the bank, it is not uncommon to hear of people living in disability accommodation who have managed to save funds over 20 years or longer, with the support of family. Hence, many people are likely to qualify for the income charge, even though their circumstances are straitened and impoverished. A quick calculation on the current disability pension (\$689 per fortnight) indicates that the yearly commission charge would be \$985. Add to this the \$135 estate administration charge and the yearly cost is \$1119.

An inquiry conducted by the Upper House Statutory Authorities Review Committee (SARC) documented concerns of families about the performance of the Public Trustee (Statutory Authorities Review Committee, 2009). There has been considerable activity from the Public Trustee in response to the inquiry recommendation, with new procedures, and an increase in staff numbers. This has been a positive development for all clients of the Personal Estates Division of the Public Trustee. It is easy though to understand the concern of families. The Disability Services Client Trust Fund has delivered a level of service that the Public Trustee has not been able to deliver in the past, even though the latter organisation is now taking positive steps to rebuild itself.

Part of the issue concerns resources and staffing to administer the Trust Fund. Some basic calculations reveal that for 600 clients (the number cited by the Auditor-General), there are nine staff managing the Disability Services Trust Fund. While tasks are not allocated to staff members evenly, overall there are on average 67 clients per staff member. In contrast, using data reported to SARC in 2009, the staffing ratio in the Personal Estate Division corresponded to 113 clients per staff member. This calculation includes all staff up to the team leader level, and is based on the lowest number of clients per staff member for each grade of Personal Estate Officer. For example, the range of client numbers for a Grade 1 Personal Estate Officer is 308 to 333 clients, so the figure used for this comparison is 308. Data are contained in Table 1 of the SARC Report.

Debra Contala, the new Public Trustee appointed in November 2010, has increased staffing in the Personal Estates Division, so this comparison is a historical one, and would need to be recalculated. However, even with all new staff on board, the Public Trustee will not reach the same staffing level as the well-staffed Disability Services Client Trust Fund.

Analysis of issues

The Client Trust Fund matter remains a major issue for those clients and families affected. There are several elements to this topic that go beyond the burden on these individual clients. These include: (1) a general community issue as to where the cost of the global financial crisis is borne; (2) a general issue on the fees for the management of personal estates of vulnerable people; and (3) a specific issue regarding the Disability Services Client Trust Fund and its safeguards.

Protecting the most vulnerable at the time of the global financial crisis (GFC)

The closure of the Client Trust Fund has arisen in the context of the GFC, and recommendations made in response to this crisis by the Sustainable Budget Commission.

Irrespective of the specific rationale for the new charge, the end effect is that many people in this very disadvantaged group will pay a new charge to the government which we calculate to be over \$1000 per year to assist the State's finances. Internationally there is concern about the disproportionate impact of tough economic times on groups who are the least resilient.

The management of personal estates of vulnerable people

The Public Trustee has 3875 clients in their Personal Estates section (Public Trustee, 2010), many of whom would be in a similar situation to those who have been clients of the Disability Client Trust Fund. These clients are already paying a fee. Who should bear the cost of this service?

Our Office considered this issue when preparing for our presentation to the Statutory Authorities Review Committee's Inquiry into the Office of the Public Trustee in 2009. A financial administrator will undertake a range of tasks — some are basic and would usually be undertaken by the client themselves if the client did not have a disability, such as personal budgeting, making decisions on products or services to buy, managing a bank account, paying bills, and ensuring that day-to-day spending money is in the pocket. Other tasks are more complex and require professional input such as accountancy, investment and legal services. When the tasks are divided up this way, our conclusion was that the substitute decision-making services and associated day-to-day account management should be provided free, as these are tasks that a person would normally perform themselves, and now cannot choose to do so, because of a disability. However, it is reasonable to charge for additional professional services, because a person who did not have a disability would need to purchase these services.

This argument applies to most administration tasks under a *Guardianship and Administration Act* appointment. The substitute decision-making tasks should be free, but a charge might still be made for investment, accountancy and legal advice. Charges for people on low income for such services are likely to be minimal.

There are other relevant parallels in supporting the argument for the no-cost provision of administration services by the Public Trustee. These include other parallels: (i) the lack of charges for disability services in general; (ii) the lack of charges for guardianship services; and (iii) the waiving of charges for involuntary mental health treatment. With respect to disability services, conceptually, assisting a person to manage their money is a form of personal support, no different from the provision of a whole range of personal support services to a person who has a disability. Financial administration then is no different to disability services such as

personal care, or work skills training. It is accepted that a person with a disability should not be expected to pay for general support or rehabilitation from personal funds, such services being funded by the government. The same argument can be applied to administration when because of a disability a person is unable to manage their finances.

In Australia, a charge is not made for State guardianship services for similar reasons. A person who has a disability is not choosing to purchase a guardianship or administration service when a State entity is appointed to perform this task under the *Guardianship and Administration Act*. There is an anomaly in that we provide substitute health, accommodation and lifestyle decision-making for free (i.e. guardianship) from the Office of the Public Advocate but the State charges for substitute financial and legal decision making through the Public Trustee (i.e. administration).

Another example of the principle of not charging for an involuntary service is applied commonly in mental health clinics, which traditionally will not bill patients for medication given to them against their will under a Community Treatment Order.

The issue is further complicated because although the Public Trustee charges for involuntary personal estate services, this charge is still insufficient to meet the true cost of providing the service. To manage this, the Public Trustee cross-subsidises its involuntary administration work in its Personal Estates section using the profit from other areas of its operations to subsidise the cost of delivering these services.

This subsidisation is called the community service benefit. “A community service benefit occurs where Public Trustee administers an estate that it would not administer if it were solely focused on profit-making.” (Public Trustee, 2010).

The Public Trustee is “...a government business entity charged with returning dividends and taxation equivalent revenue to the State Government.” (Public Trustee, 2010). The dividend to government from the Public Trustee as a business entity has been substantial. For example, in 2009, \$541,000 was paid to the Government for the year ended 30 June 2008. In the five years prior to 30 June 2007, the Public Trustee paid \$11,730,000 to the Government (Public Trustee, 2008). In recent years the dividend has been reduced, or not paid at all, because of the state of the equity market at home and abroad (Public Trustee, 2008), a loss of rental income on their office building (Public Trustee, 2009) and the global financial crisis (Public Trustee, 2010).

Earlier in this Annual Report, we discussed the differences between a welfare-based model, and a rights-based model for the provision of disability services.. The current structure of Public Trustee was set up in the past when welfare models were the norm. The “community benefit” model has all the hallmarks of a welfare model because of the subsidisation.

For these reasons, the Office of the Public Advocate favours a different structural model for the provision of estate services to people by the Public Trustee. In particular, the “community benefit” services should be funded directly by government, so that the real cost of the service is recognised, along with the responsibility of government to provide this care.

The result of such a change is that without cross-subsidisation, the Public Trustee could then return a greater dividend to government because it is not internally cross-subsidising personal estate work. As a separate transaction, Treasury could pay the Public Trustee for the cost of involuntary personal estate services.

If such a change were put in place, the impost of fees would be determined by government policy rather than an internal decision within Public Trustee.

It is our view that the government should not only pay the current subsidisation rate, but also pay for basic administration services. Ideally, pensioners should not have to pay these fees, although as indicated above, there is justification for charging for professional services such as accountancy, investment advice and legal advice. Overall, the costs to government would still be low because of the relatively small number of people in this group.

The Disability Client Trust Fund matter highlights the need to consider the appropriateness of charging for fees, not just for this group, but for all clients on involuntary administration orders, and in particular those on a pension.

Safeguards for Disability Services Client Trust Fund

Returning to the Disability Services Client Trust Fund: our Office, in developing an advocacy position endeavoured to weigh up a number of issues.

Positive factors about the historical provision of this trust fund service included the satisfaction with the service by clients and families, and also the responsiveness of the management in dealing with the complaint raised in 2010. While there is a potential conflict of interest, the combination of a proactive, transparent management approach amongst those who administer the fund, a legal requirement for the Department in this role to fulfil its trustee obligations, and the auditing role of the Auditor-General, all serve to mitigate against conflict of interest risks.

Hence, there would be little to be gained for a person satisfied with these arrangements to move to an alternative trustee, and for many, to start paying out of their own pocket for what has been a free service.

There are now many people waiting to see what the next step will be in the planned closure of the Disability Services Client Trust Fund. This group of clients should not be disadvantaged, and in any event, it is unlikely that the planned level of savings for government can be achieved irrespective of whether the services continue to operate from the Department or move to the Public Trustee, particularly if it is accepted that fees such as capital commissions be waived, and possibly income commissions as well.

Strathmont Food

Strathmont Centre has progressively contracted over many years. At its peak, 600 people lived there. For most of this year, it has been home for 66 residents. The Centre has reached the end of its serviceable life. In this year's May budget, the Government announced that 32 residents will be funded to move into custom-built housing constructed under the Economic Stimulus Plan (Department of Treasury and Finance, 2011).

Because of the Centre's contracting size, a decision was made to close the on-site kitchen. In September 2008, a new system was implemented, bringing food in from Highgate Park. Hot food is prepared at Highgate, placed in a "Cambro" for travel to Strathmont by van, and then plated on arrival.

This year, our Office became aware of residents' complaints about the quality of food. We asked our guardianship clients directly, and those clients who could express a view were critical of the quality of the hot food. It was also noted that some of the options on the menu could be unappetising and were left uneaten. However, some residents who consumed significant amounts of food because of their disability, would still eat the food, and seek leftovers from surplus food that had arrived in the "Cambro" and not plated.

There were not the same complaints about cold meals such as cold meat and salads. Staff had arranged for a summer menu that offered salads at lunch, so that clients would not eat two hot meals a day. This offered variety, and of course, the cold meals travelled well. Residents would also have opportunities at times to eat out, order takeaway and have barbeques.

The complaints about the poor quality of the hot food related to the transport of food, and the options on the menu. Hot food did not travel well by van. It would become overcooked and mushy on travel, and flavours were affected. In essence, it was 'stewed' in transit.

Initial inquiries confirmed the delay between packing of hot dinners and serving. A hot lunch would be packed at Highgate at 10:40a.m., arrive at Strathmont at 11:30a.m., and then take a further 30 minutes to distribute. A dinner would be packed at Highgate at 3:15p.m., to arrive at Strathmont at 4:10p.m., with once again, a 30-minute distribution time.

Menus were also dated, having been developed in 1995 by a dietician and speech pathologist at Highgate, based on research at the time "Good looking, easy swallowing." While some Strathmont clients can have swallowing difficulties, it is generally less of an issue than at the Highgate site so there is less need for food preparation that does not require chewing.

After the Department for Families and Communities' initial review of the process, a lunch was arranged at Strathmont for the Public Advocate to sample a range of foods served to residents. This lunch, also attended by the Chief Executive of the Department and other staff, confirmed the problem. It should be noted that the problems extended beyond the usual complaints of 'institutional food'. The quality of the hot food had been significantly affected by travel. While the food served at this sampling may have been worse than usual, because it included dishes that had been prepared the previous evening for residents, and then reheated for us at lunch, it was still indicative of the problem.

In response to this confirmation of the issue, the Minister for Disabilities ordered the Department to attend immediately to this matter. This priority response and the Minister's

concern were very appropriate and welcome. It is not necessary to dwell on the significance of food in all our lives, and the need to have enjoyable, nutritious meals to contribute to quality of life.

A senior working group within Disability Services was formed to devise strategy, monitor progress and taste the meals at Strathmont. Vegetables were a particular problem. Cooking times at Highgate were reduced, to recognise the fact that they continue to cook during transit. Food delivery schedules were also revised.

Menu items were reviewed by senior catering, professional and accommodation staff, and a number of items that were deemed not to travel well using the “Cambro” system were removed from the menu.

With these immediate measures taken, internal checks by Disability Services confirmed an improvement in the quality of the food.

A follow-up lunch was attended by the Minister for Disabilities, the Chief Executive, the Public Advocate, the Head of Catering and others. There was a significant improvement in the quality of food, which could now be readily eaten. Staff also reported an improvement on a daily basis. Subsequent checks with some residents confirmed the positive change.

The Department is doing substantial work to modernise the menu, and to replace the hot “Cambro” transit system with a “Cook–chill” system, similar to that used in aged care and health settings.

Ultimately, with the planned closure of Strathmont, the need to provide food will not continue. However, even after the 32 residents due to leave in 2011–2012 have left, the remaining residents will still be at the Strathmont site for a little while yet before it completely closes. The work done in relation to food in the Department will ensure that they receive quality meals during this time.

Reviewing Programs and Identifying Unmet Need

Mental Health Services

Introduction

South Australia is now in the final stage of the Stepping Up Mental Health Action Plan for Mental Health Reform 2007–2012. Implementation has led to extra funding of non-government services, the creation of new residential services as part of a Stepped Model (intermediate care, community recovery centres, and intensive housing support) and the rebuilding of Glenside Hospital.

This year has also seen some welcome developments nationally with new Commonwealth commitments to mental health funding.

Nevertheless, in spite of these developments and plans for the future, the situation remains dire for many people who have a serious mental illness and who are in need of housing, support services, and clinical services.

Mental health reform has had to develop services from a low base, therefore what has been done already can only be seen as the start of more work to create extra services, and transform existing systems.

With the expiry of the Social Inclusion Board Action Plan in 2012, a new Action Plan for the State will be needed in 2012. This will need to be resourced.

The observations made in the 2009 and 2010 annual reports of this Office remain relevant this year.

Past Observations and Recommendations

2009 Annual Report

- The necessary success factors for implementation of the Stepping Up report were listed:
 - The effectiveness of early intervention provided by the system
 - The impact of improved care for people who have chronic and complex needs
 - The reform of community mental health as the driver of the system
 - The effective use of intermediate care facilities

Currently reform is a work in progress.

- Matters of concern
 - The lack of progress addressing the needs of Aboriginal people who experience mental illness requires leadership at the highest level within Health.
 - Transition difficulties because of a lack of access to long-term beds and 24-hour community places. The need to rigorously define what is a '24 hour' place was

described, as opposed to community places where staff visit and offer a lower level of support that are not part of the stepped plan.

- Lack of progress in the development of early psychosis services.
- Forensic mental health
 - James Nash House, the forensic mental health facility, is too small to cope with demand
 - At least 60 beds, possibly 65, are required. Currently only 40 forensic beds are available
 - The current James Nash House has an outdated custodial design, and needs to be replaced with a more therapeutic design (whilst maintaining security) that is used in other states
 - The experience of inpatients in James Nash House was described living in this outdated unit with design limitations.

2010 Annual Report

- Aboriginal and Torres Strait Islander Mental Health
 - The concern of Aboriginal advocates was that Aboriginal people may not benefit from the broad changes in the Social Inclusion Board reform.
 - A key report telling the stories of Aboriginal consumers through data collection in December 2008 had yet to be released.
 - Progress in the area of Aboriginal mental health was described as painstakingly slow.
 - The needs of specific population groups were discussed: in particular, young Aboriginal people who were unable to access a culturally appropriate mental health service, and older people who fall through the gaps created by the artificial divisions between mental health, disability and drug and alcohol services.
 - The components of a policy response based on cultural respect were described. An example was given of a multi-level approach to social justice, community development, family wellbeing, and the provision of culturally appropriate or adapted conventional therapies.
- Early intervention
 - The small Early Psychosis Intervention Service was recognised as a positive development. However, the expectation of the model that one small service through a 'hub and spoke' approach would change the practices of hundreds of practitioners across the state was described as unrealistic and overly optimistic.
 - Commonwealth investment was anticipated but the State should make further investments so that youth, wherever they live, can access mental health workers with early intervention expertise.

- The strategy of providing dedicated services for young people up to the age of 25 needed consideration. The success of such models elsewhere means that any decision not to make this change to dedicated young people's services would also require justification.
- Services for people with complex needs
 - Problems continue for people in need of high-level supported accommodation.
 - Problems identified in SA Health's Community Mental Health Review of 2007 that the potential for consumers to 'fall through the cracks' is very significant and remains current.
 - Circumstances of under-treatment can occur because some consumers receive limited services.
 - SA Health's new Community Model of Care was described as a promising initiative. This is a plan that offers to appoint a care coordinator for all consumers within 24 hours.

Governance and Implementation

As South Australia goes on to develop a new plan to replace the Social Inclusion Board's Action Plan, it is useful to consider the types of governance structures that might be needed in setting an agreed direction and monitoring its implementation.

In Australia, there has been a move to separate mental health governance and accountability from the general health system. The health system is so big, there is a risk in any spheres that decisions to benefit mental health services and their consumers may be affected by the other pressing demands across the health system.

There is now a Mental Health Commission in Western Australia, and planning is in place to establish a similar commission in New South Wales by July 2012. A National Mental Health Commission will be established within the Prime Minister's Portfolio from the start of 2012.

It is worth exploring the reasons for the development of such organisational structures. In New South Wales, it is expected that a commission will develop the state's draft strategic plan and deliver genuine accountability for the use of mental health funds. A taskforce conducted a consultation on how a commission might operate.

The report of the taskforce listed the principles to be applied as: transparency, integrity, openness, accountability, respectfulness, non-paternalism, consumer-friendly, and inclusiveness. The commission should have the strategic capacity to identify gaps, be independent, have a whole of government role, and consult with stakeholders. There was divergence in the New South Wales consultation as to whether the commission should hold the mental health budget. One view was that the commission should have an oversight role to ensure that the mental health budget is dedicated and used for mental health (Taskforce to Establish the NSW Mental Health Commission, 2011). The proposed commission will have some form of community advisory council. A Bill will now be developed for the NSW Parliament to establish a commission.

In Western Australia, the Mental Health Commissioner has a Mental Health Advisory Council that supports the Commission's role developing mental health policy, providing advice to government, articulating key outcomes, and providing ongoing performance monitoring for the state (Mental Health Commission, 2011 (WA))

The Commonwealth's plan is described in this way: "Positioned in the Prime Minister's portfolio the Commission will have a truly whole of government mandate, will provide authoritative advice to the Government and ensure a more transparent and accountable system so that we know we are getting value for our investments" (Department of Health and Ageing, 2011)

In South Australia, we could benefit from this transparency and accountability. We do have some protections but they are not systematic. The Public Advocate has a role reviewing programs and identifying gaps. This Annual Report helps fulfil this function. During "Stepping Up", the Commissioner for Social Inclusion and the Social Inclusion Board had a role monitoring the implementation of its plan. This will not be the case in the future, as mental health services develop their own plan. The Auditor-General might be another official to monitor reform, but unlike some other states, in South Australia the Auditor-General does not have a performance audit role, so cannot take on audits that consider the delivery of policy objectives.

A state Mental Health Commission does not mean more bureaucrats. Current policy-officer positions in mental health in the Department could be reassigned to a commission. Money needs to be spent on actual delivery where possible, and it would not be desirable to establish a new entity if it could not be done by redirecting existing resources.

However, by moving current planning and monitoring tasks to an independent structure, the process of developing plans is likely to be opened up and performance audits could be public, even though the actual work might be done by many of the same people who do it now within SA Health.

Accountability for mental health funds and the delivery of policy objectives

With respect to financial accountability, it is possible to contemplate how a commission might function differently to the current structure using an example of enveloping and protecting funds. Stepping Up Report Recommendation 11 was a key one:

The community mental health service should hold and manage funds that are linked to reform. Transition funding and the reinvestment of funds that can be freed up through implementation of the Plan must be enveloped and managed carefully. The arrangements will require extensive discussion and the development of a detailed model to ensure rigour and accountability.

This particularly refers to the recurrent funds freed up through the closure of Glenside beds. The Public Advocate has been reassured that the enveloping and protecting of these funds occurred, and has no reason to doubt these reassurances. At times, this Office has pondered this question as we have advocated for clients — who have spent hundreds of days in acute wards through lack of readily available high level supported housing or long-term. A Mental Health Commission would have financial auditing expertise on its staff so that it could sign off independently when this has occurred, and mental health funds are then clearly seen to be protected both at a state level, and within the local Health networks that manage day to day budgets.

Retrospectively, it is possible to see how a state-based mental health commission may have helped bring to life Recommendation 9 from the Social Inclusion Board's Plan:

The Chief Executive of the Department of Health should take direct leadership responsibility for ensuring system redesign benefits Aboriginal people. A leadership group will be required who will undertake strategic audits of progress against key measures and report to the Chief Executive on progress and options for improvement.

Driving such reform could be another role for a commission. If the words "Chief Executive of the Department of Health" are replaced with "Mental Health Commission", then this recommendation from nearly five years ago is still relevant today and may work better in a commission structure than a departmental structure.

This recommendation also refers to auditing and accountability. 'Strategic audits' were intended to demonstrate progress towards real outcomes rather than simply describing actions or programs started. Such auditing work would ideally fit within a commission's mandate.

A South Australian Commission could be established at minimal financial cost (by redirecting existing resources from the Department of Health) yet provide independent transparency. The Commissioner could be accountable to a Board, as well as to the minister and parliament. Mental health plans, prior to presentation to the minister would be scrutinised by a board or advisory committee of consumers, carers, practitioners and community members with key areas of expertise. This would replace the current system of scrutiny and sign-off by a portfolio committee of executives in the Health Department who would currently consider such plans.

Consumer and carer participation would be intrinsic to a legislated mental health commission structure. A commission could be designed to give consumers and carers actual power within the decision making structure rather than simply be consulted. South Australia at this time does not have an agreed consumer and carer participation framework for mental health services across the state. Establishing a commission could enable the transparent participation of consumers and carers at the highest levels of policy setting and organisation decision making. An idea from NSW is to make a legal requirement for either the commissioner or one of the deputy commissioners to have had a lived experience of mental illness.

Critically, the commission would have an across government mandate, which is necessary for dealing with the many dimensions to improving the lives of people who experience mental illness.

It is always necessary to be reflective when considering solutions that involve reorganisation. There have been so many reorganisations of our general health system already in recent years that have dubious benefit, so one has to be careful in proposing another for mental health. Braithwaite et al. (2005) have written about the lack of evidence for the perpetual reorganisation of health systems. Arguably, the place of mental health in wider national health reform has been uncertain. Yet with this background, it can still be argued that with a separate mental health commission at a national level it could make sense to have parallel commission structures at a state level.

The Office of the Public Advocate has not as yet formally put these ideas to the Government, but presents this issue in this Report for consideration. This is relevant now more than ever, given that we now need a new South Australian mental health plan.

Within the Department of Health, structures have been undergoing changes. In 2001, the then government created a single position of Director of Mental Health following the Brennan Report. In late 2006, during a reorganisation, the former Chief Executive of the Department of Health split the position into two — creating a Director of Mental Health Policy and Director of Mental Health Operations, each reporting to separate executive directors of different divisions, further enmeshing mental health within the SA Health structure. The current Chief Executive has now created an Executive Director position as a single point of leadership for mental health.

The proposal to create a commission simply extends this process further.

Potential impact of a national commission on state services

Even without a state Commission, it is reasonable to expect that the National Mental Health Commission should provide extra accountability for state-based services. This Office would like to see the National Mental Health Commission set key benchmarks as targets in a blueprint: for example, with respect to gap areas such as number of mental health workers, the number of high-level supported accommodation places, and the number of forensic mental health beds. Once a blueprint target has been agreed upon, it has to be achieved in an agreed timeframe. Currently there are few ways to resolve disputes on what a target should be.

As the national commission is yet to start, it is not possible to say whether it will develop a blueprint for Australia's mental health services or not. If the commission were to set targets, it would be an advance on the existing National Mental Health Report process that has been in place since the National Mental Health Strategy has been managed by the Commonwealth Department of Health and Ageing. The current reports describe performance, but they do not set a benchmark. So, for example, the latest edition of this report published in 2010 tells us that South Australia had mid-range per capita spending in 2007–08 of \$167.25 per person compared to a national average of \$151.63 and that South Australia also has the highest number of clinical staff employed in ambulatory care than any state (52 per 100,000 people vs. a national average of 44). Yet, being average in funding or having more workers than other states, does not help set priorities, particularly when all states could do better.

A National Mental Health Commission would also be in a position to prioritise Aboriginal mental health, set targets and audit progress.

New Commonwealth funding

In March 2011, the following new services were announced by ministers Butler, Roxon and Hill to be funded by the Commonwealth (Department of Health and Ageing, 2011):

- Supported accommodation services in metropolitan and country areas to support people with a mental illness after they leave acute care — 80 bed equivalent
- Mental health sub-acute early intervention care across three crisis respite units in the metropolitan area to ease pressure on families caring for a person with a mental illness — 24 beds for intervention services

- Two new country mental health rehabilitation centres, similar to those already operating in metropolitan Adelaide, at Whyalla and Mount Gambier to provide rehabilitation support closer to people's homes and families — 20 beds across two sites
- Youth sub-acute inpatient services, in either a hospital or community setting, for young people experiencing early psychosis aged 16 to 24 years — 15 bed equivalents
- Mental health forensic sub-acute step-down unit — 10 beds and intensive rehabilitation services
- Mental health sub-acute early intervention home-based services providing around-the-clock assistance in their own homes to people in crisis— 10 bed equivalents

These are excellent initiatives and serve to bolster the Stepped Plan of the Social Inclusion Board.

The provision of round-the-clock crisis assistance to people in their own homes may also be the base for more 24-hour crisis services. Currently, consumers and carers need to present to hospitals after approximately 10p.m. for an emergency service because mobile mental health teams cease to operate at this time. Providing ten 24-hour hospital-at-home beds may allow the services to develop other 24-hour emergency services.

The initiative to provide 10 step-down forensic beds is a positive addition. Until now, forensic consumers have talked about 'step-down' to Glenside prior to discharge to the community. The 10 new purposely-designed beds should be a welcome addition. Having said this, the step-down beds are not a replacement for regular hospital beds, so the expansion of James Nash House described in previous annual reports is still required.

However, the funding creates a dilemma. These Commonwealth funds are allocated to specific projects that have been typically funded by states in the past. To what extent is further expansion in these areas the responsibility of states or Commonwealth? This raises questions for us as an advocacy agency. Any extra funding from the Commonwealth to mental health should be additional to funding that the states would have committed anyway. There should not be service substitution either. Existing state places (such as supported accommodation) should continue to be funded, and Commonwealth places should be in addition to historical state numbers.

It is hoped that the National Mental Health Commission will help clarify the responsibilities of the states and the Commonwealth. Ideally, a funding formula might ensure that funds are available, and then can be systematically incorporated into state mental health strategies. If a blueprint with targets is established, then Commonwealth and state governments could work together to achieve such targets and ensure a common priority for filling gaps.

In May 2011, the Commonwealth announced a substantial new investment in mental health services. These services were described in the Commonwealth Budget Papers and in a detailed statement on National Mental Health Reform by the three relevant Commonwealth ministers — Roxon, Macklin and Butler (Department of Health and Ageing, 2011). The full package will not be discussed here, but the programs funded are listed in the next table. Significantly, once again careful population planning is required to ensure that these initiatives are rolled out based on population need, and are complementary to existing state services.

May 2011 Commonwealth Budget Measure	National Funding over 5 years
Coordinated care and flexible funding for people with severe, persistent mental illness and complex care needs	\$343.8m
Expanding the support for day-to-day living program to meet demand for services	\$19.3m
Expanding community mental health services — more personal helpers and mentors and respite services	\$208.3m
Expansion of ATAPS (Access to Allied Psychological Services) — more services for children and families, Indigenous people and other hard-to-reach populations	\$205.9m
Establishment of a single mental health online portal	\$14.4m
Adjustment to the Better Access Initiative — two-tiered rebate for treatment plan sessions (this affects general practitioners)	-\$405.9m
Cap allied health sessions to 10 from 12	-\$174.6m
Health and wellbeing check for 3-year-olds; and expert group in child mental health	\$11.0m
Family Mental Health Support	\$61.0m
Australian Early Development Index (AEDI) – ongoing national implementation	\$29.7m at no net cost to the budget
Social Engagement and Emotional Development (SEED) survey of children aged 8–14 years	\$1.5m at no net cost to the budget
Headspace — funding to provide additional and sustainable youth mental health centres and reduce waiting times	\$197.3m
Additional Early Psychosis Prevention and Intervention Centres (EPPIC)	\$222.4m
A National Partnership Agreement on Mental Health (money for states for accommodation and assisting people who present to emergency departments)	\$201.3m
Increased employment participation for people with mental illness	\$2.4m plus substantial new investment in Building Australia's Future Workforce package
Establishment of a National Mental Health Commission	\$12.2m
Continuation of Leadership in Mental Health Reform: information and evidence to support national mental health reform and accountability	\$56.8m at no net cost to the budget
Strategic investment in mental health research priorities through the National Health and Medical Research Council (NHMRC)	\$26.2m at no net cost to the budget

Figure A5 Commonwealth Budget Measures

In the context of the Annual Report of our Office which focuses on state services, one item deserves specific mention — the federal ministers' recognition of state shortfalls. They note:

The Australian Government has identified significant service shortfalls, which impact on the ability of Australians with mental illness to receive assistance and recover in the community. An analysis of state data suggests that, nationally, only approximately a quarter of the demand for supported accommodation services is met. Such services are linked to clinical support and help reduce the number of people having to go to hospital emergency departments, particularly for avoidable reasons.

There is also a shortage of clinical specialist mental health services in the community to help people manage their illness and recover in the community. There is only 62 per cent of the estimated number of workers required to deliver services, and inadequate capacity in specialised child and adolescent services and crisis response services, both run through the states and territories. This shortfall is producing a crisis-driven mental health system in which people are turned away from services until they are unwell enough to warrant hospital admission. The acute system is not well equipped to meet both the health and non-health needs of an individual.

Ministers Roxon, Macklin and Butler (Department of Health and Ageing, 2011)

The Commonwealth will provide \$201.3m over five years for a national funding pool for states and territories to bid through a competitive process. Priority areas will be accommodation support, and presentation, admission and discharge planning in emergency departments (Department of Health and Ageing, 2011).

Presumably, on a population basis South Australia might expect to get about 8% of this amount, although because it is a competitive process we may get either more or less than our population share, depending on the quality of our bids for the funds.

This investment, even supplemented with the extra places and services earlier this year, will be insufficient to meet need.

This is why the next South Australian mental health plan will need to be funded. It has now been many years since mental health services had a significant new injection of recurrent funding for new services — a process that began with the work in 2005 of then Minister Lea Stevens in funding extra mental health workers, and making a one-off \$25m commitment to non-government funding that later became the basis for additional recurrent funds.

The priorities for new state investment can be readily identified. Our Office would nominate the following areas: making services culturally safe and accessible for Aboriginal people, expanding supported accommodation, increasing the number of clinical mental health workers, expanding all parts of the forensic mental health services, providing additional services in rural areas for people of all ages but particularly for older people and further developing services for rural young people.

In its 2011 Budget, Victoria announced new state investment in its mental health services. It is now timely for South Australia to do likewise to complement the Commonwealth's investment.

Aboriginal and Torres Strait Islander Mental Health

Our 2010 Annual Report considered the need for urgent action to catch up in our responses to Aboriginal Mental Health.

Some of the recommendations of the Social Inclusion Board relating to Aboriginal mental health have been cited in the previous section. These recommendations were in response to concerns from Aboriginal people that they could miss out on some of the advances from the Plan that the general community would receive. The Board wanted to see “strategic audits” of progress.

We know that there has been work under way from within the Department of Health following the release of the “Summary Report: Statewide Aboriginal Mental Health Consultation” (SA Health, 2010).

In terms of outcomes on the ground, we observe good work that has happened locally. Innovative and well-recognised mental health work is undertaken either within Aboriginal health services, individual mental health clinics, or through partnership arrangements between Aboriginal health and mental health sectors. While the best approaches are most likely to come from practitioners at the coalface working with their local communities, there is still a need to have a strong statewide drive to provide culturally safe services everywhere. This is because service responses are patchy in different regions, and even the exemplar services themselves can be overwhelmed by demand.

Our Office hears from Aboriginal people and families looking for clinical services at a time of need, who cannot readily access the type of service they need.

In the situations that we hear about from families or workers, the reasons why people cannot access services fall into three categories. The first is that the services are simply not there, or are overwhelmed by demand. The second is that the personal needs of the client can cross a number of different service boundaries (e.g. mental health, disability, and drug and alcohol) leading to uncertainty as to which government department is responsible. The third and significant reason is that services are available but are not known by community members to be culturally safe. Cultural safety is needed for communication, understanding, accurate diagnosis and effective therapy.

Every service should take steps to be culturally safe. Steps that are practical and achievable can be taken in conjunction with local Aboriginal people. Best practice examples can be found in our state, and there are also excellent resources available to inform practices, such as a substantial monograph “Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice (Purdie, Dudgeon and Walker, 2010).

While all practitioners should practice within a cultural respect framework, there is a need for Aboriginal people to be in professional roles — trained as doctors, nurses, allied health staff and Aboriginal mental health workers or health workers. The latter professional groups offer a way to train people quickly so that workers can be deployed in clinics and hospitals. Access to Aboriginal mental health worker and Aboriginal health worker expertise can be limited in many places. The workforce needs to expand, and this requires new Aboriginal health worker and mental health worker positions to be created in different regions.

Even when a service is adequately staffed, it is not possible for Aboriginal health workers to be the primary worker for all Aboriginal clients. There are other approaches. For example, an

Aboriginal health worker can use their expertise to provide 'cultural supervision' for other members of the team, using a consultancy model.

There will be opportunities soon to employ more Aboriginal people in mental health services. The newly funded services listed in the previous section will need to employ staff. This can be an opportunity to increase the number of Aboriginal health professionals of all disciplines and in particular take on Aboriginal health workers.

New services can also be placed in areas that can be accessed by Aboriginal communities, and have some of their work directed specifically to those communities. Aboriginal health care organisations can act as a base for some services, and can be preferentially given the contract for some services such as those delivering supported accommodation, rehabilitation, or early intervention services.

Beyond pointing out these broad possibilities, our Office does not seek to put forward specific solutions, although we are in a position to hear about the gaps that need to be filled. The specific solutions need to be determined by communities and services working together. They may have common features, but could also differ from place to place.

At a state-wide level, it is still possible to have specific actions, agreed outcomes, and auditing of results, so that approaches can be properly refined, and progress measured.

At times, our Office has been advised that our concerns regarding Aboriginal mental health will be met in ways other than direct service reform.

For example, the needs of Aboriginal people will be addressed through across-government action to assist communities, and the Health Department can take a lead.

We acknowledge the need for a broad approach. Our 2010 Annual Report cited a model that looked at the need for action at several levels. Acknowledgement of history, a social justice approach and reconciliation can empower communities, overcome disadvantage, and these in turn will prevent illness. However, they do not mitigate the need to deliver culturally safe mental health services for people who need services now, or to have adequate levels of specialist services available in the future.

This is not a case of 'either-or', a community approach vs. providing culturally safe specialist services: it is a case of doing both. The broader society measures would be led by communities and supported by government. However, these measures are not a substitute for providing a basic service.

It is also noted that an Aboriginal mental health response was not funded as part of the Government's response to Stepping Up.

The response of our office to this is twofold. Aboriginal mental health should be part of core business for all services — not just those specifically funded for the purpose. The Social Inclusion Board had wanted a leadership group to oversee this work across the sector.

The second point though, is that if the funding argument is correct, now is the time to inject funds into existing services to improve accessibility, and new services should be specifically commissioned to reach out to Aboriginal people or in some cases be operated by Aboriginal health services.

Finally, it is worth noting that the Government accepted all 41 of the Social Inclusion Board's recommendations, including Recommendation 35 of the report. This was a specific recommendation that would require funding, both for building and for staffing:

Establish a specialist service for Aboriginal people and locate it at Glenside. Co-location with the other specialist services proposed for Glenside—including the drug and alcohol service and the early psychosis service—will benefit Aboriginal people. The specialist service will be supported by a dedicated research effort in Aboriginal mental health care.

There has been no specialist service established. The Rural and Remote Unit at Glenside Hospital does have a highly regarded Aboriginal mental health team; however, this was operating before the Social Inclusion Board report.

This existing team could be the nucleus of a specialist service that supports both metropolitan and rural and remote programs across the state.

The Board also recommended a dedicated research effort. The Board noted New Zealand's investment in Maori mental health research that has allowed New Zealand to apply evidence-based Maori models into practical service delivery (Social Inclusion Board, 2007).

It is possible to imagine a research institute following a research agenda determined by the Aboriginal community. This could be developed closely with services to provide an evidence base to inform practice, and be linked to existing Indigenous health research units at South Australian universities. A successful program would leverage further investment from competitive research funding sources, and might link with national institutes that have successfully brought together Aboriginal organisations, researchers and government agencies.

Services for people with complex needs

In 2009 and 2010, we have included a transition table for Glenside beds. This has been updated below.

Medium- to Long-term mental health beds	Pre-existing prior to reform	30 June 2010	Completion of reform —as per original plan 2007	Completion of reform — current estimate by OPA
Traditional extended care beds	129	40	0	0
New secure extended care	0	0	30	40
Community recovery centre	0	60	60	60
Supported accommodation with 24-hour on-site support (Burnside Housing and Accommodation Support Partnership)	0	20 ("The Glen" ward was used for this purpose)	73	20
Supported accommodation, 1–5 hours support, increased up to 24 hours if required Metropolitan Housing and Accommodation Support Partnership				53 plus
TOTAL (beds or places)	129	120	163	173 If metro HASP counted 120 if metro HASP not counted

Figure A6: Transition in long-term bed numbers related to the redevelopment of Glenside Hospital. Figures for the planned final number of beds obtained from Stepping Up brochures, Government of South Australia, Feb 2007, June 2007, August 2007 and updated brochure April 2008. New Commonwealth-funded places are not included in this table.

This has been modified to reflect the roll-out of supported accommodation. The issues of supported accommodation are discussed in more detail in the section of this Report on *Promoting Rights*.

Perhaps for future auditing purposes, a National Mental Health Commission might set definitions and benchmarks for what constitute different levels of care. At question is whether the care levels provided by the Metropolitan Housing and Accommodation Support Partnership (1–5 hours, increased to 24 hours support with approval) are sufficiently high to allow these places to be included in the replacement Glenside beds in the Stepped model.

This also has implications for how the 80 new Commonwealth-supported accommodation places are counted. While these new packages will certainly offer high levels of support, there is an argument that they be counted with community support packages rather than counting them with the Glenside replacement services. If counted as part of the Stepped Plan, they increase the Supported Accommodation places to 153, and overall bed replacement number from 173 to 253. Once again, the sector could benefit from agreed counting rules so it can be determined where new services are placed within the Stepped model.

Forensic Mental Health

The planned addition of 10 forensic step-down beds, provided through Commonwealth funding is a positive development.

However, the problems of lack of inpatient beds and forensic prison inreach and community services remain.

An urgent solution is needed to increase forensic inpatient capacity, as discussed in the 2009 and 2010 annual reports.

In addition, existing inpatient cell-like beds need to be rebuilt, along with the building of new additional beds.

There is widespread understanding of this gap and the need for action yet currently, no further funding has been allocated to expand and rebuild inpatient services beyond that required to move 10 existing beds from Glenside to Oakden, and undertake some refurbishment and maintenance on the original building but not fundamentally redesign it.

Our Office considers the need for progress in this area critical, along with associated needs to develop a forensic disability service.

Reviewing Programs and Identifying Unmet Need

Justice for People with Disability

Introduction

The development of a Disability Justice Strategy could improve all aspects of the dealings that vulnerable people have with the law.

In 2011, the lack of justice for people with a disability was a significant issue of community concern.

There is no single answer to delivering justice for people of all ages who have a disability. What is needed is a system reform. Our Office becomes involved in situations where people with disabilities are victims of crime, and other situations where people have been accused of committing the crime. We hear the views of people and their families as well as the opinions of professionals working in disability, health and justice, about what our systems currently do and fail to do. There is no doubt that from these conversations, and from reviews in other states and literature publications, work is needed to address each step of the way through the justice system. All parts need to change and work together. The answers are known, and documented in the literature but need a strategy driven across the community to make them happen.

Such a strategy should be inclusive of the needs of all at-risk people who have a disability, including people who have a psychiatric disability. It will have many common features with strategies to give justice to older people, and should work alongside such an elder abuse strategy, developing common approaches to minimise duplication. Similar issues can arise in responding to elder abuse, as occur with the abuse of vulnerable younger adults.

For **victims of crime**, such a strategy can aim to improve the prompt recognition of criminal behaviour, rapid reporting to police, the expert collection of evidence, and the taking of robust statements at the time of a crime that will inform the Court. The latter can be particularly important to victims with a cognitive impairment who can accurately describe events at the time but may be less clear as time goes by. Also recognised as important is the preparation and support of victims in court, a vigorous prosecution of perpetrators, and the recognition of the special needs of victims who have a disability when they attend court and give evidence.

For victims, a disability justice strategy can be part of an overall adult protection strategy that aims to prevent crime and abuse in the first instance (this is discussed in the Rights Protection section of this report). A failure to prosecute perpetrators can mean that the deterrent effect of being caught and punished is minimised, and perpetrators may then prey on vulnerable people in the belief that they will not be caught.

For **people with disability who are accused of committing a crime**, special assistance may be needed when interviewed by the police and then through the court process. There is a risk that for many people with intellectual disability, a desire to please, and to say 'yes' can lead to admissions of guilt for crimes that they did not commit. For others, it is essential that existing options such as the use of the mental impairment defence and court diversion programs are

fully used. Yet, we hear of people with an intellectual disability or brain injury attending court and convicted for offences: even when they may have been found incompetent in similar situations in the past. If the question was fully considered they most likely would be found mentally incompetent.

It is important to note that South Australia is not alone in seeking to improve practice in this area. This is a national and international problem. While there is a need for improvement across the sector, there are also examples of excellent practices in this state. Clients of our Office have valued the work of highly skilled, compassionate officers of the Sexual Crimes Investigation Branch of the South Australian Police who have interviewed them. The staff of Yarrow Place, the rape and sexual assault service, provide a very effective and supportive service at a difficult time, and will work with the needs of a victim who has a disability. The Health and Community Services Complaints Commissioner can give victims and families a chance to follow up allegations, and can conclude that serious abuse has occurred, even when the allegations may not be prosecuted in a criminal court. Yet the ability of such good work can be limited if crimes are not recognised early and promptly reported so that evidence can be gathered, and then taken to court with all relevant evidence considered.

Observations and Recommendations in Previous Annual Reports

Justice related issues have been considered in reviews of adult protection issues in past reports.

2009 Annual Report

- While the topic of abuse of vulnerable people in other states has been a major issue, the lack of public reports of assault, abuse and neglect of vulnerable people in our State is likely to be due to systems issues. We do not have the same strategies in place as other states to ensure that people can safely come forward with their reports, and that incidents are detected and police advised.
- South Australia does not have mandatory reporting to police of sexual assault and serious physical assault, within disability services.
- Mandatory reporting of abuse should occur in government-funded or government-operated disability accommodation, as it occurs in aged care.
- South Australia needs forensic disability services that can provide best practice interventions for people with a disability who might harm others, and therefore reduce the risk to other people with disability who can often be the victims of such crimes.

2010 Annual Report

- Disability Services agreed to develop a single policy on the prevention and response to abuse to apply to both government-operated and government-funded services.
- The Health and Community Services Complaints Commissioner and the Office of the Public Advocate worked together on individual client matters concerning abuse and assault of vulnerable people who are under the guardianship of the Public Advocate.
- As a result of investigations, the Health and Community Services Complaints Commissioner had concluded in individual matters that serious sexual or physical abuse by a staff member did occur, although the police may not have been able to lay charges.

Background on disability justice issues

This topic has been widely reviewed by law reform commissions, expert bodies and academics. There have been a number of similar interventions recommended.

The Australian Institute of Family Studies published a significant review on sexual assault and adults with disability in 2008. This report by Murray and Powell (2008) identified best practice to enable recognition, disclosure and a just response.

Research consistently finds that people with disability are victims of sexual assault at a higher rate than the general population. It cites three main groups of offenders against women with intellectual disabilities: (i) for women in residential settings, male residents; (ii) family members, including intimate partners, ex partners, fathers and step fathers; and (iii) staff of residential care facilities or disability support services (Murray & Powell, 2008). This is consistent with the experience of both male and female clients of our Office who have been the victims of an assault.

Murray and Powell (2008) describe barriers to reporting at a societal, organisational and individual level. They cite Keilty and Connelly who found that “two myths, in particular, emerged consistently: women with intellectual disability are promiscuous and the complainant’s story is not a credible account (Murray & Powell, 2008 p. 5).” It is not uncommon now to see these myths applied to both women with disability and mental illness who have alleged assault in a residential facility. A further gap is the lack of sexual education provided to both men and women with disabilities so that it is possible to understand and then talk about what has happened.

Gaps can occur in policies. Effective policies can ensure that there is appropriate early assistance sought from sexual assault referral services, which in 2011 has not always occurred in our State. Similarly, employment policies must ensure that there are appropriate screening checks of staff who work with vulnerable adults (Murray & Powell, 2008). While police record checking occurs in South Australia, checking for other unresolved disciplinary matters that may be relevant is variable.

With respect to the inadequacies of the criminal justice system, an American review states that “the literature seems to confirm that criminal convictions can be won in cases in which the victim is cognitively disabled, but it takes specialised training and may involve additional investigative and prosecutorial resources” (Petersilia, 2001). There is no reason why such training and extra resources should not be applied. Petersilia (2001) also noted the need for “special accommodations” given in court to include the use of an advocate to help a victim understand what is being asked during investigation and options of clearing courts and using videotaped evidence.

The next table summarises a range of practical procedural and educational strategies that might improve justice for people with disability who have been the victims of a sexual assault, once again collated by Murray and Powell (2008)

Summary of Key Policy Recommendations for the Criminal Justice System

Made by the Victorian Law Reform Commission Sexual Offences reports, NSW Committee on Intellectual Disability and the Criminal Justice System, plus several other research reports.

Collated by Murray and Powell (2008)

- Ensure responding police have had training or expertise specifically in identifying and interviewing people with differing functional needs due to disability
- Consistent use of video- and audio-taped evidence
- Coordination between police, sexual assault support workers, intellectual disability rights services and other relevant disability support workers
- Additional training for independent third persons (ITPs) specifically regarding sexual assault
- Systematic monitoring of matters which are not investigated, or where a report is made but a statement is not taken, and the reasons for this
- Flexibility in taking the statement to accommodate the person's impairments, such as limited concentration, memory impairments or need for communication aids

Court preparation

- Planning and preparation to ensure that the victim feels prepared, including a visit to a court to familiarise them with the environment and procedures
- Coordination and pre-trial conferences between sexual assault support workers, witness support staff at the Office of the Director of Public Prosecutions (DPP)
- Expert witness reports to the DPP on the victim's abilities and disabilities to identify the victim's additional needs or difficulties that they may experience in being a witness

Supporting victim/survivors in court

- Inclusion of expert witness reports early in the court process to explain to judges and/or juries the person's abilities and disabilities that may affect their giving evidence
- A clear mandate, rather than discretion, for the Courts to attend to special needs of a victim/ survivor with a disability such as: "frequent breaks in giving evidence to ensure optimum concentration, support person sitting with the witness, physical modifications such as wheelchair accessibility, use of speech therapists to assist communication, willingness of the court to use plain language and short sentences, use of special provisions such as closed circuit television and screens, closed court when giving evidence ..."

Figure A7: Summary of Key Policy Recommendations for the Criminal Justice System

Law Reform — making sexual abuse of vulnerable clients by staff a crime

In NSW, it is a criminal offence for disability staff to have sexual intercourse with a person in their care who has a cognitive impairment. This is punishable by up to 10 years' imprisonment.

The offence is created by the NSW *Crimes Act 1900* section 66F. It is an offence to have sexual intercourse with a person where the accused is responsible for that person's care (either generally or at the time of the offence). This can be in the course of a program at a facility or at home (Judicial Commission of NSW, 2011).

Originally, the provisions of the NSW *Crimes Act 1900* applied only to persons with an intellectual disability. Following the NSW *Crimes Amendment (Cognitive Impairment — Sexual Offences) Act 2008*, the term "intellectual disability" was replaced with "cognitive impairment",

and the provisions now apply to people who experience an intellectual disability, developmental disorder (including autism spectrum disorder), a neurological disorder, dementia, severe mental illness or a brain injury.

South Australia does not have such a statute.

The operation of this statute in NSW would need careful review, if it were to be replicated in South Australia.

It would seem, however, that it could act as deterrence to perpetrators who choose to take up employment and other positions of trust with vulnerable people, for the purpose of committing sexual abuse and assault. Such a statute would have been of assistance to some clients of our Office who have wanted justice, and may have helped prevent the crimes if it had been in place.

Section 66F of the *NSW Crimes Act* has a second component that makes it an offence to have sexual intercourse with a person who has a cognitive impairment, with the intention of taking advantage of that person's cognitive impairment (Judicial Commission of NSW, 2011).

This is similar to an existing provision in the South Australian *Criminal Law Consolidation Act (CLCA)*, 1935. Section 49 (6) provides that:

A person who, knowing that another is by reason of intellectual disability unable to understand the nature or consequences of sexual intercourse, has sexual intercourse with that other person is guilty of an offence. Maximum penalty: Imprisonment for 10 years.

However, this provision, which can apply to a broader range of people, not just people in authority, does not in itself offer the same potential deterrence to staff as the extra NSW provision we do not have.

Indeed, *CLCA* s49 (6) may be of limited benefit. In 2004, Ian Bidmeade made the following observation referring to *CLCA* s 49(6) in a handbook prepared for the then Intellectual Disability Services Council:

This section is worth debate. It is really a lesser offence alternative to a charge of rape. It aims to cover the situation of defective consent, rather than no consent, although, arguably, consent without understanding is no consent at all. In a sense, it protects the exploiter from a rape charge, if it does anything at all. It would seem not to provide any special protection for the person with disability and it may encourage some to prevent people with intellectual disability from expressing their sexuality. It also tends to assume that such persons are not capable of understanding the sex act.

In summary: South Australia could benefit from a review of the existing provision, as well as the addition of an unequivocal criminal offence to cover the actions of disability and other staff in a position of authority.

A review of s 49 (6) could ensure that it does properly protect vulnerable people, does not unintentionally assist exploiters avoid a rape charge, or limit expression of sexuality in non-exploitative relationships.

Specific issues related to people with disability who have been the victim of an assault

During 2010–2011, there was significant contact between the Department for Families and Communities, the Health and Community Services Complaints Commissioner’s Office, Lorna Hallahan, Chair of the Minister’s Disability Advisory Council and our Office on this topic, which has contributed to the development of a new policy for use by disability services.

Matters have also been raised with mental health authorities, and the suggestion put to them that South Australia needs a sexual safety policy to prevent and respond to assault and exploitation in mental health facilities. Male and female clients of supported residential facilities can also be fearful for their safety in a shared environment.

The following are some of the issues that have emerged in a small number of individual matters for both advocacy and guardianship clients. As suggested in past reports, we consider that the true frequency of abuse in South Australia remains unknown, as there is a need to improve systems for identifying and reporting abuse.

Contacting the police to discuss a matter vs. formal reporting. Petersilia has described how crimes against people with disabilities can be truly invisible. Crimes can be defined as abuse or neglect and followed up through administrative channels rather than police investigations. Crimes are labelled “incidents” in these scenarios (Petersilia, 2001).

A lack of a formal report has prevented a timely analysis of some events by local police, as well as consideration by the specialist officers of the Sexual Crimes Investigations Branch who automatically review reports of alleged sex crimes. It can also mean that forensic evidence may not be collected.

A decision as to whether a crime has been committed may require further police investigation and sometimes, professional advice about a person’s ability to consent. This cannot occur if the matter is not formally reported, so any possibility of charging a person for rape or an offence under the *CLCA s 49 (6)* (having sexual intercourse with a person who has a disability knowing that they may not understand the consequences) might be lost.

It should be made clear that in the instances we are aware of, involving both disability and mental health services there has been ‘contact’ with police as opposed to ‘reporting’ to police. Generally, a senior administrative or professional person has phoned police to discuss whether a matter might be a criminal act for the police to manage, or a matter of unprofessional conduct to be dealt with by the organisation. As a result of these discussions, it has been concluded in these instances that matters are not criminal and a police report is not made.

What should occur is that a formal police report be made so that the question of criminality can be carefully and formally considered as described.

In contrast, the Commonwealth *Aged Care Act 1997* has a requirement for mandatory reporting. Even when consent issues are unclear, the nursing homes will make a report because of this requirement, rather than try to reach their own conclusion about what has happened. As a result of this, we have seen prompt reports to the police made by nursing homes on specific matters regarding both sexual and physical abuse in aged care. Immediate police investigation can be valuable, and information uncovered has assisted not only with police action, but enabled our Office as guardian to take immediate steps to protect individuals.

There is no doubt a mandatory reporting requirement has assisted to remove ambiguity in these first critical steps for people in nursing homes, and should have similar benefits if applied to disability services, to inpatient mental health services and mental health supported accommodation.

The Health and Community Services Commissioner has outlined expectations to disability services management that formal police reports are lodged, and how the details of the report are recorded. The Adelaide Mental Health Services have also taken similar action.

Education of disability workers. Disability workers receive some education regarding abuse and neglect, including the risk of abuse of vulnerable people by workers, as a part of the Disability Certificate III or IV training. The need for more education in this area has been raised following incidents.

More education, as part of training and continuing education can assist workers to take action to prevent, identify and report abuse in accordance with new policies in this area.

Preventing reemployment with another service when allegations are unresolved. When an allegation is raised, an alleged perpetrator facing investigation may resign and leave before the process is concluded. If the person seeks reemployment in another organisation, as there has been no charge and no criminal conviction, police checks will be clear.

As a result of work to develop a new policy (discussed below), a specific role emerged for the Special Investigations Unit (SIU) within the Department for Families and Communities. The Unit receives reports of “serious care concerns” involving a staff member. If a staff member leaves, and a matter has not been resolved, the SIU will be aware of this. A prospective employer in the sector can contact the Unit to see if there are any outstanding matters that have not been resolved.

Ideally, given the high levels of responsibility for vulnerable people borne by disability workers, a registration system should be in place, so that it is possible for employers to know that a worker is in “good standing”. In the absence of a registration system, checking with the Special Investigation Unit will provide ready answers at least for people who have been employed in South Australia.

Policy development

This work fed into a new policy that was developed by the Department for Families and Communities, with combined input from the Health and Community Services Complaints Commissioner's Office, the Minister's Disability Advisory Council and the Office of the Public Advocate.

A significant amount of good work was undertaken by Disability Services staff to develop a new policy, although it was disappointing that having advocated for a single policy to apply across all government-operated and funded services, there are now two different policies: one used by government disability services staff, and the other by non-government organisations (NGOs) providing disability services funded by government.

It was the policy for government-operated services that received our input. It is the opinion of this Office that of the two policies, the disability services document is the more comprehensive and potentially effective.

The new disability services policy for government-operated services is called "Management of Care Concerns Procedure" and considers assault and abuse as part of other care concerns, which may relate to poor performance by workers, as well as deliberate antisocial behaviour. Care concerns are classified as minor, moderate or serious. Assault and abuse are serious care concerns. The policy defines key responsibilities of staff to identify and report abuse, with specific examples, and flowcharts. The flowcharts of the overall process are reproduced on the next page.

Key features of this policy include:

- Definitions of abuse, and "care concerns"
- Police reporting of all serious incidents (i.e. rape, sexual intercourse between staff member and client, indecent assault, client injury)
- Incorporating procedural fairness for those whose interests will be adversely affected by the implementation of the policy
- Defining the role of the Special Investigation Unit to undertake independent assessments of allegations of harm and abuse by a staff member.

The flowchart (figure A8) on the following page describes the procedure for disability services. While the document provides a response when a staff member is the alleged perpetrator of abuse, it does not give guidance when the perpetrator is someone else, such as another client or visitor.

The policy developed for the non-government sector, which this Office understands to have been developed in consultation with the sector itself, is called "Guideline. Reporting of Incidents to SA Police by Non-government Organisations." This document does provide a response irrespective of whether the perpetrator is a staff member, another client or someone else. The policy incorporates:

- Requirements for police reporting similar to the government-operated disability services policy

- A requirement to report to the Department matters that have been reported to the police
- A requirement that the Special Investigation Unit or other delegate may undertake an investigation.

The effect of these two policies is to create, at a policy level in this State, mandatory police reporting for clients of disability services who are victims of abuse.

The two policies, while having similarities also have differences. For example, the government services policy requires the SIU to be informed of serious care concerns, even when the threshold for police reporting is not met. The NGO policy requires the Department (and hence the SIU) to be informed only if a police report is made. This could reduce the amount of information that the SIU will have on hand about employees seeking to change jobs in some circumstances.

There is still a need to have a consistent sector-wide policy or legislation regarding police reporting, as well as providing information about incidents to the Department, so that pre-employment screening of individuals who have left a previous employer with unresolved matters can effectively occur.

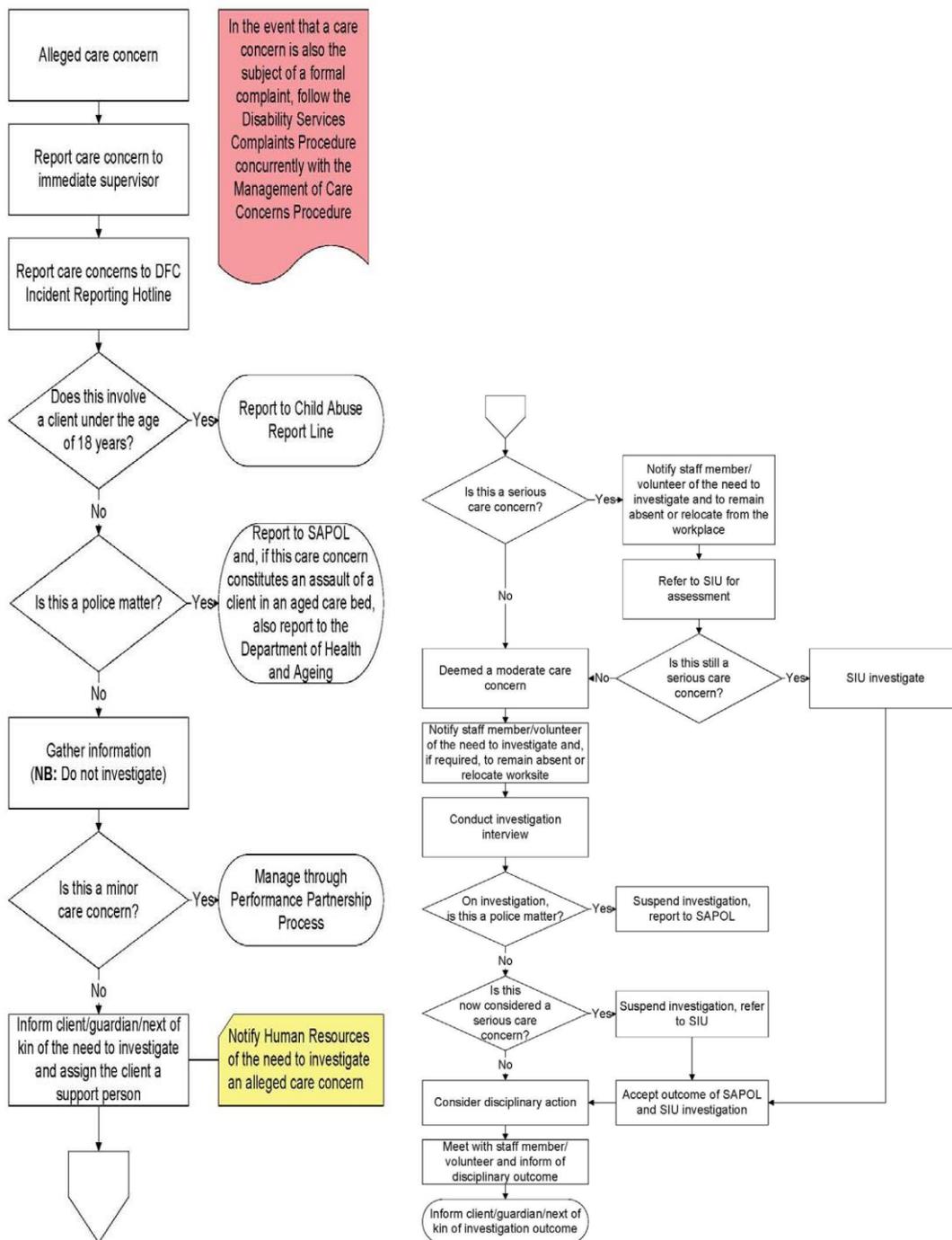


Figure A8 Flowchart describing Disability Services response to a care concern (Disability Services, 2011)

People with disability who are suspected of committing a crime

Many of the issues that apply to communicating with victims who have a disability also apply to alleged offenders who have a disability.

It is recognised that people who have a disability can be overrepresented in our justice system. Although there are mechanisms such as the Court Diversion Program, and the use of the mental impairment defence, some people are found guilty of crimes despite technically lacking the competence to commit the offences.

Recognition of a disability or a psychiatric disability may not always be straightforward. Some people who have a mild intellectual disability will not disclose this fact, or draw attention to what they do not understand, through shame or stigma. Certain communication patterns for some people — as noted earlier such as a desire to please and a wish to agree — can put people at risk of agreeing to propositions put to them that are not true.

In Victoria, the Office of the Public Advocate operates a volunteer Independent Third Person scheme (ITP). Trained volunteers sit in on interviews with people who have a cognitive disability or mental illness. The ITP provides support, and monitors the communication process — helping the person contact a lawyer, understand their rights, asking for police questions to be rephrased if difficult to understand, and requesting breaks if a person is distressed or unable to concentrate. The need for such a service in South Australia should be considered as part of the development of a justice strategy.

The interview of a vulnerable adult suspect can require extra skills, and well developed procedures. This year, the Australian Institute of Criminology reviewed processes used in police interviews around Australia (Bartels, 2011). Legislative guidelines and police general orders were considered. Both the law and police rules in this area would appear to be more developed in other jurisdictions than in South Australia.

The report cites provisions of the South Australian *Summary Procedures Act 1921*, which provides that where a witness is a “person who is illiterate or suffers from an intellectual handicap” their statement may be taken as a written statement or video or audio tape. In contrast, other states have better developed systems. New South Wales has the most extensive provisions for vulnerable people that include obligations to help the vulnerable person, the involvement of support persons, to meet care needs, and an obligation to put details of a person’s vulnerability on any application for a detention warrant (Bartels, 2011).

Similar comparisons apply to police orders, which appear to be limited in South Australia compared with the more detailed requirements in the NSW Police Code of Practice, and the use of Guidelines for Interviewing a Person with a Disability (Bartels, 2011). The review also notes the lead of the United Kingdom in this area.

A South Australian disability justice strategy could lead to the development of a range of special measures, required by both legislation and police orders, which would ensure that the needs of vulnerable people are addressed when being interviewed.

Elder Abuse and the Criminal Justice System

Myths and Prosecuting Decisions

In 2011, the Aged Rights Advocacy Service invited Paul Greenwood, Deputy District Attorney, San Diego County to present to the World Elder Abuse Awareness Day Conference held in Adelaide. Paul was originally a British lawyer who has worked on both sides of the Atlantic. He argued that victims of elder abuse and neglect deserve our utmost response, but that some victims are overlooked, ignored, disbelieved and abandoned. The result is that elder abuse is a crime that has gone unpunished, as was the case of child abuse and domestic violence 30 years ago.

Paul Greenwood is an example of a prosecutor who has developed specialised skills in the area of elder abuse and vulnerable witnesses. He has described myths in the prosecution of elder abuse. These are summarised in the table on the next page. See figure A9

Many of these myths relate specifically to financial matters, as money can be a driver of the abuse of elders. Some are similar to the myths that apply to younger persons as witnesses.

Conclusion

A Disability Justice Strategy gives rights to people with a disability, but this should not be seen to be at the expense of other parties. There is no suggestion that standards of evidence should change. Instead, specific and sustained effort is required to obtain evidence that might otherwise have been dismissed in the past.

By accommodating people's needs in our justice system, they will better understand what they are asked, and give more meaningful answers. More effort is made to ensure that important information is not overlooked.

This is a form of 'reasonable accommodation'. Reasonable accommodation occurs when we make modifications so that a person with a disability can exercise their rights as anyone else might. The common examples are modification of buildings so that people with a disability can access them, or the modification of transport systems. These are rights that are well accepted. A disability justice strategy is simply a set of accommodations to our justice system, so that people with a disability can have access to justice to the same extent as other citizens in our State.

Myths that can Stop the Prosecution of the Perpetrators of Elder Abuse

(from Greenwood, 2009)

MYTH	FACT/SOLUTION
1. Elderly people make terrible witnesses	Do not stereotype seniors as forgetful, senile, longwinded, grumpy, fragile
2. If an elderly victim refuses to provide information, there is nothing that can be done	A case can still be built by talking to other key witnesses. Start on the outside and work your way to the middle. It is up to the prosecutor to figure out a way to break through a victim's wall of silence A lesson from domestic violence is that self-determination is not the answer. Prosecutions need to proceed
3. If an elderly victim gives the money to a perpetrator, it is not a crime	Apparent voluntariness is diluted by fraud, undue influence or by exploiting the mental limitations of the victim
4. If the financial institution reimburses the elderly victim and then declines to seek prosecution, we have no victim	Restitution can never remove the stigma of being the victim of a crime Prosecution is still required
5. If the victim is deceased before we discover the theft, we cannot prosecute	Treat such a case as if it were a murder. There are some situations in which we do not need the victim for a prosecution
6. Any case where the elderly victim is involved in a home repair and there is a dispute over money, this is always a civil matter	Need to consider if there are other victims, was money paid up front, what services were promised, and what were delivered
7. Suspects of elder abuse crimes NEVER call 000	Wrong. Ambulance dispatchers need training, as do paramedics in identifying and responding to elder abuse
8. There is no point in reporting this incident to local law enforcement; they will not do anything about it	In San Diego, prosecutors have worked with police to identify elder abuse crime, and will expect to be advised of reported crime
9. Elderly people die from natural causes	A critical system function is to have an elder death review team. Need to pick up cases such as Dr Harold Shipman (UK)
10. There are more important cases out there that are taking up my time	Need a collaborative approach

Figure A9: Myths that can stop Perpetrators

Promoting Rights and Interests

Deprivation of Liberty

Guardianship and Administration Act 1993

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

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

Introduction

Promoting the prevention and avoidance of unnecessary deprivation of liberty of vulnerable people is a significant role for this Office. When deprivation of liberty does occur, it must be in compliance with the statutory provisions of the law — which in most instances is either the *Guardianship and Administration Act 1993*, or the *Mental Health Act 2009*.

This discussion concerns the deprivation of liberty of people in aged care, disability services, mental health services and health services, focusing on issues that emerged in 2010–11.

Observations and Recommendations of Previous Annual Reports

2009 Annual Report

- The position of a Senior Practitioner in Disability Services should be established to oversee the use of restrictive practices in disability settings.
- The formal recording and reporting of the use of restraint, seclusion and detention should extend across both government and non-government disability services.
- The recognition of chemical restraint in disability settings in South Australia is limited.
- Strategies are required in disability services to reduce and eliminate the use of restraint (similar to the national strategy in mental health services, which has a similar objective).

2010 Annual Report

- A new Disability Services Act should have new specific provisions regarding the prevention of restrictive practices, as well as their authorisation.
- These provisions should also support education and research in the area of the prevention of restrictive practices.
- Consistent with the 2009 report, a Senior Practitioner position should be established to consider compliance with the Act, as well as the technical and professional adequacy of positive behaviour support plans, aimed at preventing the use of a restrictive practice.
- The final consent for restrictive practices should rest with a suitable guardian appointed by the Guardianship Board for this purpose.

Restrictive Practices in Disability Settings

In the absence of detailed legislation aimed at preventing and regulating the use of various restrictive practices, the Office of the Public Advocate set about developing a policy, based on work undertaken in Queensland and South Australia. The background research that informed this policy is described in the detailed review of restrictive practices in our 2010 Annual Report.

This policy sets expectations that are beyond the requirements of the law, as restrictive practices are not addressed in the current *Disability Services Act 1993*, and protections in the *Guardianship and Administration Act 1993* with respect to restrictive practices are partial and limited. A feature of the OPA Policy, which is consistent with new laws interstate, is that restrictive practices are defined — in particular, detention, seclusion, physical restraint, mechanical restraint and chemical restraint, and the requirement for assessments and positive behaviour support plans made clear.

Without a broader government strategy that includes new disability legislation and specific funding for training, extra clinical services, and setting standards (by creating a Senior Practitioner role) a single organisational policy, such as that at the OPA policy will be limited in what it can achieve. However, it has been met with enthusiasm from the disability sector that wishes to improve its own practices.

For the OPA policy to work, it requires provider organisation to have in place their own restrictive practice policy, so that it is clear a person has an assessment, a positive behavioural support plan and that necessary professional advice and manager approval has been obtained.

The positive behaviour support plan should identify the function of the problem behaviour for the person concerned, recognise environmental factors that contribute to it, and support both environmental change, and new alternative 'positive' behaviours. These behaviours should then be reinforced, and if necessary, strategies put in place to respond to a recurrence of the problem behaviours. All this involves effective communication amongst stakeholders. It should be noted that positive behaviour support is a key feature of the Queensland and Victorian responses to restrictive practices.

Definitions

The policy established the following definitions (Office of the Public Advocate, 2011):

Restrictive practices are detention, seclusion, chemical restraint, physical restraint and mechanical restraint as defined below.

Detention means a situation where a person is unable physically to leave the place where he or she receives disability services. The means of detention may include locked doors, windows or gates, and the constant supervision and escorting of a person to prevent the person from exercising freedom of movement. 'Detain' and 'detained' have corresponding meanings.

Seclusion means the confinement of a person with a disability at any hour of the day or night in any room or area in the premises in which that person is detained.

Chemical restraint. If the primary purpose of administering medication is to subdue or control the behaviour of a person with a disability, then the use of the medication is a chemical restraint. Likewise, the use of medication when needed (i.e., PRN), for the primary purpose of controlling behaviour, is a restraint. If information regarding the primary purpose of administering the medication is not available, the intervention should be considered a chemical restraint. If the medication is used to treat a person's illness (psychiatric or physical), then it is not viewed as a restraint but as a treatment.

Physical restraint means the use of any part of another person's body to restrict the free movement of a person with a disability with the aim of controlling that person's behaviour.

Mechanical restraint means the use of a device to restrict the free movement of a person with a disability to prevent or reduce self-injurious behaviour. It does not include the use of devices for therapeutic purposes or to enable the safe transportation of that person.

It is worth noting the *Guardianship and Administration Act* refers to detention but does not define it. When it has been necessary to consider the meaning of detention, the practice has been to use common dictionary definitions. The above definition of detention is consistent with dictionary definitions.

The Board, under the *Guardianship and Administration Act* s 32 (1) (b) can authorise the provider to detain a person in the place in which he or she will reside. A guardian applies for these powers, which the Board can grant if it is satisfied that the health or safety of the person or other people would be seriously at risk. There is no separate definition of seclusion to distinguish this practice from detention. The new policy of the Office of the Public Advocate makes it clear that additional consent for the use of seclusion is required from a guardian, even though it is not separately considered in the Act.

The *Guardianship and Administration Act* does not specifically refer to either physical restraint or mechanical restraint. However, the Board under s.32(1)(c) can authorise the provider of care to use such force as may be reasonably necessary for the purpose of ensuring the proper medical or dental treatment, day-to-day care and wellbeing of the person. The use of physical restraint and mechanical restraint needs separate and specific consent in this policy.

The definition that has required the most discussion is that of chemical restraint. This is not defined in the *Guardianship and Administration Act*. Historically, chemical restraint has not been well recognised. It has been generally assumed to have applied in emergency situations

when a person's behaviour is out of control, and they are required or coerced to take medication orally or intramuscularly. As indicated in this definition, chemical restraint can include the administration of any psychotropic medication, given to control behaviour rather than required for the treatment of an underlying mental illness or physical illness. Such sedating medication may be provided as part of regular medication, at morning and night, and a person who has a mental incapacity may be unaware of the nature of the medication that they have received.

The policy considers who has made the recommendation of the use of a restrictive practice based on an organisation's own guidelines, and who has the authority to provide consent, based on our existing legislation. The complete table is available for view on our website (Office of the Public Advocate, 2011). On the next page (figure A10) is an extract that describes the recommendation and authorisation for the use of chemical restraint.

Extract from Restrictive Practices Policy (Office of the Public Advocate, 2011)

Form of restrictive intervention	Practitioner's Recommendation (Disability Services Guideline as example)	Manager's Recommendation (Disability Services Guideline as example)	Consent
<p>Chemical Restraint (of behaviour <u>not</u> due to a mental illness)</p> <p><i>Not requiring the use of force to administer medication.</i></p>	Medical officer, GP or psychiatrist	Senior Manager	<p>Medical agent appointed under a Medical Power of Attorney (<i>Consent to Medical Treatment and Palliative Care Act 1995</i> s.8, subject to any conditions and directions (s.8(7))</p> <p>Enduring Guardian appointed under the GAA, s.25, subject to any conditions, limitations or exclusions (s.25(5))</p> <p>Guardian for health care appointed under the GAA, s.29, subject to any conditions or limitations (s.29(6))</p> <p>Where none of the above have been appointed then:</p> <p>A relative of the person (<i>GAA, s.59(2)(b)(i)</i>)</p> <p>[OPA policy position: consent to chemical restraint should not be given by a staff member defined as a relative pursuant to s.3(1) of the <i>GAA</i> (see para (c) of the definition of 'relative').]</p> <p>Guardianship Board (<i>GAA s.59(2)(b)(ii)</i>)</p>

Form of restrictive intervention	Practitioner's Recommendation (Disability Services Guideline as example)	Manager's Recommendation (Disability Services Guideline as example)	Consent
Chemical Restraint (of behaviour <u>not</u> due to a mental illness) <i>Requiring the use of force to administer medication.</i>	Medical officer, GP or psychiatrist	Senior Manager of persons involved in the care of the protected person, expressly authorised by the Board under s.32(1)(c) to use such force as may be reasonably necessary for the purpose of ensuring the proper medical or dental treatment, day-to-day care and wellbeing of the person but only to the extent authorised by the Board	Medical agent appointed under a Medical Power of Attorney (<i>Consent to Medical Treatment and Palliative Care Act 1995</i> s.8, subject to any conditions and directions (s.8(7)) Enduring Guardian appointed under the GAA, s.25, subject to any conditions, limitations or exclusions (s.25(5)) Guardian for health care appointed under the GAA, s.29, subject to any conditions or limitations (s.29(6)).
Psychiatric treatment (medication prescribed for treatment of a mental illness)	Medical practitioner, authorised health professional, Guardianship Board (<i>Mental Health Act 2009</i>)	Not applicable	Not applicable

Figure A10: OPA Authorisation of Chemical Restraint

Consent for Chemical Restraint

The consent for the use of chemical restraint in the table is divided in two sections — those instances where force is not required to administer the medication, and those instances where it is. The former describes the situation where a person has not objected to receiving sedating drugs – usually delivered in their regular morning and evening medication with a range of other tablets. In many situations, people who have a disability have been receiving medication this way for years.

Our policy only applies when a person has the Public Advocate as guardian; however, the table describes who can consent to chemical restraint when a guardian is not appointed, as well as the powers needed by enduring guardians or private guardians.

An enduring guardian or guardian can seek special powers from the Guardianship Board under the provision of s 32 (1) (c) which authorises the service provider to use such force as may be reasonably necessary to ensure proper medical treatment (e.g. administer the medication).

If a person takes medication willingly, then s 32 (1) (c) powers are not required and the table lists the people who can give consent to medical and health treatment — a medical power of attorney, enduring guardian, guardian with health powers and relatives.

The provisions with respect to relatives are defined by the *Guardian and Administration Act s59 (2) (b) (i)*. The Act does not distinguish between different types of medication so the consent by a relative for a drug given as chemical restraint is no different to the consent by a relative for a drug given to treat other conditions such as high blood pressure or diabetes. This of course only applies when a person willingly takes the medication and enforcement powers are not needed.

On the one hand, relatives' consent arrangements may seem very lax given the significance of chemical restraint. If we had new legislation, chemical restraint would be seen differently to consent to other medication, as it should be.

On the other hand, these relatives' provisions may be adequate if there were other protections in place. If South Australia also had a Senior Practitioner; then, a relative contacted by a provider could be confident that the recommendation to sedate a person has been through external scrutiny before being presented to a relative for consent. There is no such external scrutiny currently in place in South Australia.

Family members who act as "relative" under the Act take on a significant responsibility. Our Office would suggest that disability service providers only seek "relative" consent for a restrictive practice from family members who are closely involved with the person.

Care provider consent and conflict of interest

The *Guardianship and Administration Act*, in defining a relative, as well as listing family also defines as a relative a person who is "...charged with overseeing the ongoing day-to-day supervision, care and wellbeing of the person."

This would almost certainly be a conflict of interest. Problem behaviours can be addressed by increasing staffing levels, and reducing crowding in facilities. In such a situation, if an accommodation manager were to act as "relative" under the Act, the same person would be acting as the decision maker in consenting for sedative medication on the one hand, while managing staffing and budget on the other.

The Restrictive Practices Policy of the Office of the Public Advocate makes it clear that a disability provider should not act as a relative under this provision of the Act, when the issue in question is consent to chemical restraint.

A further question for policy consideration is whether such consents should be limited only to medical agents, enduring guardians or guardians only, and a relative who does not have such an appointment should not be asked to give consent.

The argument is that such decisions are so significant that only a person with a formal substitute decision-making appointment should make the decision. That person is more likely to be aware of their obligations under their appointment, and to be taking an ongoing interest in the person for whom they make decisions. A policy requirement for a guardian to make such decisions would be consistent with the situation in Queensland, where decisions about chemical restraint are made by a “guardian for restrictive practices” who has been specifically appointed for this role by a tribunal (Disability and Community Care Services, 2011).

As noted, this question would be less critical if decisions about chemical restraint were also subject to external review by a Senior Practitioner, as we hope might occur in the future. Then, an involved relative’s consent might be appropriate, as any plan to commence chemical restraint would already be subject to independent scrutiny from a Senior Practitioner’s Office.

Our Office is yet to reach a policy conclusion on this topic. As noted above, in the interim our view is that providers should seek consent from engaged and involved relatives only.

Initial implementation of the policy of the Office of the Public Advocate

The work on implementing this policy has had both positive benefits and also highlighted problems.

The benefit has been the opportunity to work with industry in developing the policy, and discussing its implementation. There has been an enormous amount of interest in improving performance in this area. Both government and non-government providers have enthusiastically welcomed any new initiative to do with limiting the use of restrictive practices, and sought to combine the OPA initiative with their own work in the area. This applies to frontline staff, as well as executives. In 2010–2011, there have been meetings with relevant committees of the NGO peak body, the National Disability Services, executives of some providers who deliver services for people with behavioural problems, and seminars presented to disability staff groups.

The process has also highlighted problems with the lack of resources in this area to drive a reform in practice. This would be anticipated, as a policy response is not accompanied by the resourcing that would be expected with new legislation. As noted in our 2010 Annual Report, the policy proposal of our Office is only an interim measure that will require a legislated response. Resourcing is needed to ensure that frontline providers have access to necessary skilled staff who can undertake specialist assessments and support front line workers. Legislation can also be used to create a Senior Practitioner role — the single point of professional leadership in disability services across the government and non-government sector is needed to define best practice.

Lack of organisational policies. The OPA policy requires that disability practitioners comply with their own organisation’s policies with respect to gaining necessary approvals for the use of restrictive practices. This led to one organisation that had no policy quickly developing one, so that it could comply with this requirement. It is possible that other organisations that might only administer a restrictive practice from time to time will discover policy gaps in how they handle such matters in the future.

Access to assessments. Access to psychologists and psychiatrists with the necessary skills in this area has been limited. Some organisations have psychologists and disability educators on

staff with the necessary skills to undertake a behavioural assessment, and to prepare a behaviour support plan, whereas other organisations, particularly smaller ones, have needed to employ an external practitioner. Greater access to psychology and other behaviour support services is needed across the sector.

Crisis plans vs. positive behaviour support plans. Consistent with the current literature, the OPA policy requires a positive-behaviour support plan that seeks to prevent episodes of aggression, by identifying underlying issues, and finding alternative activities that are enjoyable and meet a person's needs.

The plans prepared in many situations are crisis response plans, either to the early warning signs of impending aggression, or to actual aggressive behaviour. Such plans would not be considered adequate in other settings that have restrictive practices legislation.

The South Australian OPA policy expects the same best practice elements that are required in Victoria. Our initial requests for the first few plans found that these elements were not generally met. There is a professional debate to be had. On the one hand, many of the existing plans that are characterised by their brevity and simplicity may in fact be serving a useful role, even though not all information is recorded.

On the other hand, it is also likely that many of the South Australian plans may be suitable only if understood in the context of the current limitations in the training and resourcing of services. However, with increased training and support of the frontline workers who will implement them, plans that are more comprehensive might then be expected. There would also need to be more psychologist time available to oversee the development of the plans. So the current limitations on what can be achieved from a support plan should be overcome in the future.

For these reasons, it is not surprising that we should find initial resistance in asking for plans. What we have sometimes received are crisis response plans, that tell staff what to do when a person's behaviour is escalating, or is already out of control: they do not describe key quality elements of a behaviour support plan, such as identification of the function of the behaviour, identification of environmental factors, and the introduction of new 'positive' behaviours and environmental change.

This is where a Senior Practitioner's Office could play a critical role, because every plan can be individually reviewed, and a professional judgement made as to its adequacy. If we had a Senior Practitioner now, there would be few support plans that would be approved. The type of crisis response plan in particular would not meet the current standard.

Also, a full positive-behaviour support plan allows systemic problems to be identified and be responded to. Positive behaviour support planning is also likely to identify inadequate care environments, and the need in some instances for increased staffing.

Key Quality Elements of a Behaviour Support Plan

1. Plan identifies the function of the problem behaviour
2. Environmental factors that support the problem behaviour are identified
3. The plan introduces both environmental change and supports new behaviour
4. Reinforcement of new behaviours is identified
5. Response to recurrence of problem behaviours is described
6. Plan contains strategy to communicate between stakeholders

Based on work of Browning Wright cited by Webber et al. (2011)

It is also important to note that South Australia is not unique in needing to improve behaviour support plans. Webber et al. (2011), in summarising studies undertaken on behaviour support plans in Victoria, noted results of previous studies that showed that behaviour support plans did not include critical criteria, and that best practice criteria were inadequately addressed. This has led to the use of standardised assessments of the quality of behaviour support plans such as the Behaviour Support Plan Quality Evaluation Guide II, which has been shown to have acceptable reliability and validity. Webber et al. (2011) used this tool and noted that the quality of Victorian behaviour support plans was poor, and that the majority failed to include key components.

While this may be the case in Victoria, the Senior Practitioners Office provides a method to improve plans that are all routinely checked. This does not happen at all in our State.

Access to specialist practitioners and specialised environments. As well as access to assessments and planning by psychologists, there is also a need for access to psychiatrists, and medical practitioners with training and experience in caring for people who have a disability, to review the prescription of sedating medication.

Accommodation choices that have better environmental options for caring for people with disturbed behaviour can be difficult to find. Space, proximity to other clients and staffing can be key variables. Residential options that have more open space, and behavioural support are available but limited. Some people have successfully been cared for in semi-rural environments.

There have been instances where people who can be both verbally aggressive and at times physically violent have been cared for in suburban houses, in close proximity to other neighbours. During a difficult period of behavioural escalation, there are no readily available respite options for people to move, except a hospital emergency department. What tends to happen is that chemical restraint can then be relied on to sedate a person.

“Clinical Governance” in the use of restrictive practices. When a person is managed in a community setting by a non-government agency, the responsibility and accountability for the restrictive interventions can be uncertain. A client may be cared for by an agency’s support worker but also have a professional disability case manager. Legal authority for detention and the use of force is given to the NGO provider, who then needs to rely on other organisations to provide assessment and advice. The chain of responsibility for decision making can become blurred. If a client’s behaviour is out of control, it is not clear at times who is responsible for finding the solution — the NGO that has been contracted to provide care, or the disability services case manager. It is on these occasions that people are sent to hospital emergency departments.

Conclusion

Work towards the minimisation of restrictive practices continues. While the work to implement an OPA policy has allowed us to engage with many committed disability providers, the experience so far has confirmed the need to have a legislative response.

We confirm our recommendations made after our 2010 Restrictive Practices review: it will be necessary for a new Disability Act to define the restrictive practices of detention, seclusion, physical restraint, mechanical restraint and chemical restraint, and the mechanisms for the approval, authorisation and consent for such practices.

As per our recommendation last year, we consider that a Senior Practitioner can take a significant role as an independent statutory official working with disability providers to improve practice. Guardians should continue to have a role providing consent to such practices: however, the process of guardian consent is not a substitute for the duty of disability organisations to have quality checking mechanisms, along with training and support to ensure that Guardians are not asked to consent to a restrictive practice that might otherwise be avoided.

The Senior Practitioner model is highly regarded in the disability sector. It is such a fundamental part of a system, that it should not be a question of arguing why we should have a senior practitioner, but conversely, should we decide to proceed without one, how this can be possibly justified, and whether the functions of a Senior Practitioner can be addressed in some other way.

Deprivation of Liberty in Aged Care

The President of the Guardianship Board wrote to the Public Advocate in January 2011 to confirm in writing his concerns that people are being detained in nursing homes without valid authority. The President requested that the Office of the Public Advocate consider seeking s32 detention powers in circumstances where this Office has been appointed guardian of a protected person who is, or is likely to be, residing in a secure part of an aged care facility.

This discussion considers the background to this issue, how the detention status of a person in an aged care facility is assessed, and the need for a national response to protect the rights of residents in secure aged care.

Background

In the past, there has been a practice of seeking detention powers under s32 (1) (b) to authorise a facility to detain an aged client in some situations but not others.

When a resident has wished to leave a nursing home, it was expected that the person have either an enduring guardian or a guardian who could apply for s 32 (1) (b) powers. The wish to leave might be manifest not just by a verbal request, but also by certain behaviours, such as constantly walking to the door and trying to open it. In contrast, other residents — ‘wanderers’ — who needed to live behind a locked door because of safety concerns but were not asking to leave, seeking to leave, or objecting to staying, were not placed under s 32 (1) (b) powers.

Now there is an expectation that all people living in a locked nursing home be considered for guardianship and s 32 enforcement powers. In responding to this expectation, our Office has considered the general approach taken in the United Kingdom, in the Deprivation of Liberty Safeguards (an amendment of the Mental Capacity Act 2005) that deprivation of liberty needs to be considered on a case-by-case basis. Therefore, in the same locked facility, some people might be detained and others not.

For example, a resident may live in a locked facility that has a keypad on the door. A resident is **not** detained if they know the code and can use the keypad to leave when they choose. A resident might **not** be detained if staff open the door for the resident when requested, even if the resident cannot use the key pad themselves. However, a resident **is** detained if they cannot come and go as they choose. This has been the approach taken by the Office during 2011.

The expansion in the use of s32 provisions has contributed to the increase in the total number of people under the guardianship of our Office, because the requirement to have s32 orders in place has meant that many guardianships have not been revoked that may have been in the past. For many years, our Office has acted as guardian for people with advanced Alzheimer’s disease who have objected to being placed in nursing homes, and s32 powers were applied for so a person could be ‘placed’. Such people would usually settle into their new home — the residential aged care facility to which they have been placed — and no longer wish to leave. Our Office would then withdraw from the person’s care, seeking revocation of the guardianship order. This is no longer possible and the person must remain under guardianship.

Policy implications

This matter raises a number of policy options. The first is to do nothing, and allow the historical status quo of not seeking orders. The second option is to rely on state-based guardianship

legislation to protect the rights of people living in aged care. A third option is to seek a national mechanism to protect people's rights. Our Office argues for national mechanism.

Option 1: The do-nothing option. The first option is to do nothing, and to continue the traditional practice used throughout the country of placing people in locked facilities on "duty of care" grounds or the common law doctrine of necessity. There are two problems with this option.

The first is that an informal mechanism such as this does not provide for a right to appeal. A procedure prescribed by law does. This was a significant issue in the United Kingdom following the Bournemouth case considered by the European Court of Human Rights, which in turn led to the Mental Capacity Act 2005: Deprivation of Liberty Safeguards. For these reasons, more action needs to be taken to protect the rights of people in secure aged care.

The second reason in South Australia why 'do nothing' is unacceptable, is that we already have specific statutory provisions under s32 of the *Guardianship and Administration Act*. To not use them is against the law. To go back now to the use of informal arrangements in such situations, would require an amendment to our GAA to make an exception for aged care facilities. People could lose rights they already have in our currently regulated system.

In some other Australian states, guardianship legislation does not have enforcement powers to permit detention, so in those states there is no other option but to rely on common law doctrine of necessity arguments to detain people in secure aged care. However, as stated in the previous paragraph, in this situation a person so detained does not have an appeal right.

Option 2: Use guardianship provisions. This is the current situation in South Australia. The Guardianship Board's position in 2011 simply brings expectation in the aged care sector into line with what has been the existing practice in seeking orders for younger people who have been clients of disability services. Of course, the number of people affected by the application s32 powers to aged care is greater than the potential population of younger adults who have a disability, so the implementation of these provisions has significant resource implications.

However, even though the interpretation of our South Australian statute is clear, one could argue that it was never intended for guardianship law and its detention powers to be potentially applied to so many citizens.

The history of South Australia's guardianship law is discussed in the section of this Annual Report on *Monitoring Legislation*. If guardianship was to be the principal vehicle to authorise the detention of hundreds of residents in aged care, one might have expected that this would have been mentioned at the time the GAA was passed in parliament. It was not.

In examining the impact of this practice, we have discussed this matter at length with local staff of the Commonwealth Department of Health and Ageing, staff whose job is to enforce the provisions of the Commonwealth *Aged Care Act, 1997*. This Act is the vehicle for promoting the quality of care in the sector, and ensuring that recipients of aged care enjoy the same rights as other people in Australia.

Those staff and our Office share a concern about the onerous nature of the GAA processes, when used for this purpose. The aged care industry is already subject to significant regulation by the Commonwealth as its principal funder. The need to apply for guardianship in more situations will place a new burden on families and aged care providers at a difficult time. In these

discussions, the question inevitably becomes: what is the purpose of seeking such orders? Will the orders make a positive difference to the lives of people placed under an order, or will it principally fulfil a legal requirement?

When a person is detained under the *Guardianship and Administration Act*, they are considered to be in custody. If a person dies in custody, the *Coroners Act 2003* requires that the Coroner must hold an inquest. This provision makes sense when s32 was used in the way it was applied between 1994 and 2010, when it was applied to a narrower range of circumstances in aged care. However, with its now expanded use, significant numbers of very elderly people in the terminal phases of dementia are likely to be placed under s32 orders in the coming years. People can be in their late 90s and be in custody. Given that residents are in fact detained, it is very appropriate that these deaths be reported to the Coroner (which is the case anyway for all protected people) but one could argue that in the case of people in secure aged care, the Coroner should have discretion to decide if an inquest is necessary and desirable. The fact that the coroner does not have this discretion with s32 orders further suggests that the widespread use of these provisions in aged care was not envisioned.

The conclusion of our Office is that while action clearly needs to be taken to improve the rights of aged care residents who are detained in a secure unit, the use of the guardianship mechanism for people who are wandering and not objecting to where they live is excessive. An alternative mechanism is required that is commensurate with the need.

Option 3: An alternative nationwide mechanism. As noted, the delivery of aged care services generally and the rights of residents are legislated for by the Commonwealth under the provisions of the *Aged Care Act 1997*. The Minister established User Rights Principles under subsection 96-1 of this Act. Our Office suggests that it may be possible to amend the Principles to describe detailed, specific rights for residents in secure aged care. The South Australian *Guardianship and Administration Act* could be amended to recognise such arrangements, and to limit the application of the Act's detention orders in nursing homes to people who are actively seeking to leave. This proposal would need further consideration of the relative roles of the Commonwealth and the states and how duties might intersect.

There is a further opportunity in the near future to put a system in place, because Australia will be ratifying the Optional Protocol to the UN Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). To do this, there would need to be a visitors' scheme to places such as nursing homes where people are detained. The purpose of such visits would be to strengthen the protections for people who are detained. Visits would enable checks to see if people object to their detention and wish to appeal.

This is still theoretical. Under OPCAT, Australia must establish a National Preventive Mechanism (NPM) to oversee visits. It is yet to be decided if aged care will be part of the NPM, and it may not be. Our view is that it should be.

A visitors' scheme could offer an effective way to check on the rights of significant numbers of people with dementia in closed nursing homes without needing to place them under guardianship.

This year the Productivity Commission in its inquiry into Aged Care recommended that a statutory community visitors program be established to promote and protect the rights and

wellbeing of residents (Productivity Commission, 2011a). This scheme would be different to the current community visitors scheme in aged care which is focused on establishing contact between residents and people in the community so as to provide friendship and companionship. A statutory scheme would be similar to the mental health Community Visitor Scheme now in operation in South Australia, and statutory disability schemes in other states.

These mechanisms — legislated rights for residents and community visitors to check that they are upheld, would be an effective way to protect and to meet the significant number of people who have developed dementia and live in secure aged care.

In the future, a Commonwealth Community Visitor Scheme to aged care facilities might be potentially operated from state-based Offices of the Public Advocate. This could provide an independent home for such a scheme outside the Commonwealth's Department of Health and Ageing. There is already a historical precedent of state-based agencies making decisions under the provisions of the *Aged Care Act 1997* — for example, state-based aged care assessment teams have been used to determine the eligibility and classification of potential care recipients for aged care services. Therefore, we suggest that the concept of a state-based Office of the Public Advocate operating an aged-care visitors' scheme is worth further exploration.

Mental Health Deprivation of Liberty

The *Mental Health Act 2009* has only been in operation in 2010–11, and it is still too early to assess its full impact.

This section discusses some of the matters and issues concerning detained patients that involved our Office. These included the provision of information to involuntary mental health consumers and carers about the reasons for detention, the involvement of mental health consumers in decisions about their care, and the protection of detained mental health consumers from abuse.

Provision of information to mental health consumers and carers

A key policy decision not to include written reasons for decision on detention forms given to patients and families was made in June 2010, to be then subject to review after implementation. It had been widely expected that patients and families would receive this information. The Minister of Mental Health was faced with conflicting advice from his Mental Health Policy Unit within the department, on the one hand recommending that written information not be given out, and from a number of individuals and organisations recommending that it should be. The latter included the Public Advocate, the President of the Guardianship Board, professional groups such as the Law Society and the State Branch Committee of the Royal Australian and New Zealand College of Psychiatrists, and the mental health carers group within Carers SA.

The Minister chose the advice of his department as a quick decision was required, but in doing so offered further review.

Now that the Act has been operating for 18 months, the Office of the Public Advocate is hoping that these questions can be reconsidered. This section gives the background to this issue.

With respect to patient rights, all patients in any setting have rights to know about their illness and to participate in decisions about health care. A guiding principle of the *Mental Health Act 2009* is that patients (together with their family or other carers or supporters) are provided with comprehensive information. This can be about illnesses, treatment, services, alternatives and orders (section 7 (1) (i)).

“Order must be made in writing in the form approved by the Minister”

The new *Mental Health Act 2009* requires that copies of community treatment orders and detention orders be given to patients, along with a copy of a statement of rights. The patient is to receive their copy of these documents “as soon as practicable” after detention, to be provided by the doctor or authorised health professional who has made the initial order (Community Treatment Orders s 12 (1), and Detention and Treatment Orders s23 (1)).

The Act also requires that a carer or relatives (amongst others) be given a copy of the form. The psychiatrist or an authorised medical practitioner is responsible for giving the treatment order and statement of rights or notice of variation or revocation the next day to a guardian, medical agent, relative, carer or friend. The Director of an inpatient treatment centre has a similar duty to provide detention orders, notices and statements of rights (Community Treatment Orders s12 (6) and Detention and Treatment Orders s 23 (6)). With respect to carers and others, the psychiatrist or authorised medical practitioner has the power not to provide this information about community treatment orders if it is considered not to be in the patient’s best interests. The Director of an inpatient treatment centre has a similar power not to give information about

detention and other orders to carers and others if it is not appropriate (Community Treatment Orders s 12 (6) (c) and Detention Orders s 23 (6) (c)).

The provision of orders to patients is a new development in this Act. With the *Mental Health Act 1993*, the forms contained a few handwritten lines that explained how the patient's illness, and risk to self or others meet the criteria in the Act. It was generally expected with the new Act that patients would receive an order that contained the same few lines outlining the reasons for detention: that is, that the purpose of the new law was to ensure that patients received meaningful information.

Just prior to the implementation of the Act, the Public Advocate and the President of the Guardianship Board learned that SA Health was to put to the Minister a draft form that did not contain a section for reasons for decision. The Minister would be asked by the Department to approve this form.

The news that the forms for the new Act might not contain reasons was most unexpected because of the widely held assumption that the purpose of the sections of the new Act, which required that orders be given to patients, was to provide information in writing as to why a person was detained or placed on a community treatment order.

The Office of the Public Advocate certainly acknowledges that this would have been the first time in Australia that consumers and carers have been given such written information. This practice would be groundbreaking for this country. However, since that time an exposure draft of the Mental Health Bill in Victoria has been released. Section 65 (5) of the draft, which is on making an assessment order, requires that the order must state the basis on which it appears to the registered medical practitioner or mental health practitioner that each of the criteria applied. Section 66 (1) (a) requires that the practitioner give to the person who is the subject of the order a copy of the order. These legislative provisions, if incorporated in the final Bill that goes to the Victorian parliament will ensure that Victorian consumers are able to see specific written information about why they have been detained.

Approval of forms subject to implementation review

In South Australia, we do not have the provision in the Act requiring that reasons be written on forms as is the case in the draft Victorian law. The drafters of the South Australian form did not include this requirement when preparing a form to be approved by the Minister, and there is no legal requirement for the form to have this information.

As noted, the Minister decided to take the advice of his department because of the imminent commencement of the new Act, while recognising that with any new legislation there may be issues with the operational aspects of the Act once it is implemented. Accordingly, the Minister requested the Chief Psychiatrist to establish a best-practice working group. The deliberations of the working group would allow this matter to be further considered.

The Public Advocate and the President of the Guardianship Board continue to believe that patients and carers should receive a traditional detention form that contains brief reasons for decisions, rather than the current form that does not.

Without a requirement to provide written reasons, patients receive a verbal explanation of why they have been detained. Patients' lack of knowledge about the reasons for their detention continues to be an issue. It had been an issue in South Australia under the former *Mental Health*

Act 1993. Under that Act, a form was completed which did contain reasons but it was put in the file and not provided to consumers, which has the same effect as the arrangement under the new Act of giving the form to the consumers but not putting specific information in it.

For example, an initial analysis of qualitative interviews completed in late 2010 for the Rotary Mental Health Law project gives an indication of the situation that applied under the old Act. Of 58 consumers² who had been subject to involuntary detention orders (prior to July 2010), there were mixed results: 10 could not recall being provided a reason for their detention. Seven used phrases such as “they told me I was a risk to myself and other people.” Several consumers recall having the decision to be detained explained to them in some treatment centres but not in others. Only one of nine Aboriginal consumers stated that the reasons for detention were discussed with him. Three consumers felt that they were too ill or medicated to recall.

Although any impression about the operation of the new 2009 Act is anecdotal, it is likely that the situation is unchanged. Our Office receives calls from consumers seeking information about how to appeal their order. Staff in our enquiry service remark that many consumers report not knowing details as to why they have been detained. While this may in part be due to their illness, the consumers who call our service are well able to discuss other aspects of the detention process.

The conflicting arguments — for and against —providing written information

With respect to clinical staff reaction to the prospect of having to provide their written reasons, there seemed to be a mixed response. The senior clinicians spoken to by our Office were not concerned at all. They already considered that they explained reasons for detention well to their patients, and saw the handing over of a piece of paper simply as written confirmation of information that had been said already. There was confidence that this could be done well. The Mental Health Policy Unit, however, received concerns from clinicians that providing this information may make patients agitated, and that carers may receive inappropriate information. Some clinicians told the Mental Health Policy Unit that they would be forced to ‘sanitise’ what was written on the forms if they were provided to patients.

In response to this, our Office put forward the view that the new law already gives the clinician the discretion to give the form to a patient when it was practicable — it would not be practicable if the situation was not safe, and the law already allows the clinician to withhold the form from carers (as described above).

The difference of opinion on the issue of giving written reasons to patients and their families needs resolution. Our Office regards the completion of good quality reasons by detaining practitioners as an important discipline — when done well, writing the reasons can improve the quality of detention decision making. A requirement to give the order to the patient and family will help ensure that what is written is respectful and of good quality. For the patient, having this information will help them form a view about whether a detention has been made on solid

² It should be noted that the consumers and carers who came forward to be interviewed for the Rotary Project were volunteers. This was not a random sample. The qualitative research approach can identify issues, but cannot describe the frequency of the issues in the broader population. The percentages cited in this paragraph relate to the group who came forward to be interviewed only, not the entire population of people who are detained.

grounds or on erroneous information. This can then be raised with the psychiatrist who reviews the order after 24 hours so that information can be corrected, or form the basis of an appeal to the Guardianship Board. For the carer, guardian, medical agent, family or friend who receives this information it could help in providing support to their family member who is receiving care. This could be support in reassuring the patient through explanation of why they are detained, or support in the appeal process.

The contrary view from the Mental Health Unit in SA Health, which was the advice given to the Minister and cited in his response to this Office, is that the forms are provided as a notification mechanism. Full clinical reasons for the decision to issue a Community Treatment Order or Detention and Treatment Order are contained in the clinical file and made available to the Guardianship Board on appeal. The Minister noted that the Guardianship Board does not routinely provide reasons for its decision to consumers or caregivers/family members. There is also a risk to the appropriateness of the information recorded, the impact that the information on the forms may have on the consumer and their family member/carer/guardian who receives a copy of the form, as well as the possibility of 'sanitised' reasons. The Minister had been advised that clinicians will be expected to continue to verbally explain to consumers why they are subject to orders.

This is where the matter rests. Because the provision of written reasons was to be a new initiative, the question remains open as to how the rights of people may have been better protected or not if this provision has been implemented in the way that it had been expected.

There is no doubt reopening this issue will raise risks and costs to the Department of Health if we were to proceed with the original vision of this new Act as it was understood. It was clear from the work of the Rotary Project that there were some doctors who completed these forms poorly. In extreme examples, only a few words were written. A patient seeing such poorly completed forms used as a justification for their detention might indeed be upset. There would need to be further training for many practitioners on how to carefully and respectfully document reasons for the decision to detain. It is also likely that there could be more complaints from disgruntled patients.

These risks should be worth it. Detention is a major step. Anything that provides for more transparency and patient and family involvement, should not only better uphold rights, but also improve the quality of care. This is why there should be a right to information at this initial stage of detention.

The Right to Information for Detained Patients

In late 2010, the Public Advocate received an unsolicited letter from a health professional working in the frontline offering personal observations. This professional observed that people could be too easily detained after brief assessments. Instead, people should be more comprehensively assessed, a risk assessment made, and consideration given to the human dignity and rights of the patient. Clinicians should perform these duties thoroughly, not merely to avoid criticism if something goes wrong.

This correspondent observed that although detentions are reviewed by a consultant after 24 hours, this is still a long time to wait, and at this point of first detention, criminals have more rights than mental health patients.

These comments are pertinent because they highlight the potential lack of protection of rights during this initial period of detention, and the lack of redress available to a person who is detained for a short time and then discharged.

One of the key protections against unjustified deprivation of liberty is the ability of a patient to appeal to a specialist tribunal — in our state, the Guardianship Board. However, this protection can take a little while to mobilise. It is there and available for the person who has been detained for days or weeks. It is certainly not immediately available during the first hours of a detention, and in some cases, a person detained at the beginning of a weekend may need to wait a number of days for a hearing to be held.

Many people are detained for just one or two nights. In a crisis, this can be lifesaving. However, as the correspondent suggested, people could be detained at times when detention could be avoided if there was a more thorough assessment completed and alternative options offered.

It is in this context that giving people written information about why they have been detained can provide better accountability and preserve rights. While patients do receive a verbal explanation, this might not be remembered. The simple written facts of the reasons for decision can be a reference point for patient and family over the following hours and days.

Does this matter? There are two conceptual approaches to considering such matters. One is rights-based legalism — it emphasises individual rights and access to justice, as well as access to treatment and care. The other contrasting approach is benign paternalism — that the patient's best interests will be looked after by the system.

The human rights approach sees the deprivation of liberty in mental health detention, even for brief periods, as significant. Not only does a person lose their liberty, they also lose the ability to consent or refuse consent to treatment. Ensuring a person is fully informed is an additional way to protect rights, particularly at this initial stage of detention when other mechanisms of external review are not effective. Benign paternalism results in a lack of accountability and a risk of errors.

Absconding from Mental Health Facilities

The *Mental Health Act 2009* permits the detention of patients³ at risk to themselves and others. During a period of involuntary inpatient care, mental health staff have to manage competing priorities. On the one hand, there is a need to keep a patient safe; on the other, the purpose of the admission is to provide treatment and care so that a patient can recover and leave the hospital environment. Most detained patients are managed on open wards. Doors are not locked, except at night to keep people out, and a patient is responsible for complying with the order. Of course, if the patient under treatment does leave hospital without permission, clinical staff or the police have the power to return them. There are secure locked units available for patients unable to comply with the open ward regime.

This approach of using open wards where possible is consistent with both professional best practice, and the need to provide the least restrictive option. As a patient in recovery gets better, they will take back more responsibility. This is a risk, but one that is carefully assessed for a therapeutic benefit.

However, the issue is not straightforward. While the least restrictive policy approach has very wide support, there can be issues in the implementation. These were evident when this Office engaged with clinicians, carers and consumers about this topic.

For example, clinicians who strongly support the use of open-ward care whenever possible, report difficulty in obtaining closed ward beds for their patients when they consider that this is needed. These closed beds as well as providing security also deliver intensive care through higher staffing numbers per patient. Often a patient may need a few days in this intensive care setting before returning to the open ward.

The number of closed ward beds in the system is determined based on the needs of people with mental illness in the general community, but these closed beds are also routinely used to manage 'overflow' admissions from James Nash House, the forensic mental health facility. The number of such forensic patients is small but their use of acute closed-ward beds can make a critical difference in a finely balanced system. For example, if there are two or three forensic patients occupying beds in the 10-bed secure unit at Glenside for a prolonged period, many other patients who might have spent a few days in those beds will not get this service.

The acuity of patients in open wards has also increased. In the past, there were few other options than hospital, so at any one time an open ward would have people with varying degrees of severity of illness, who generally stayed longer. Now, because there are services to peoples' homes, as well as residential care units such as the new 'intermediate care', the inpatient units care for and supervise patients who as a group have higher needs than in the past. For this reason, staffing levels and ward procedures need constant review.

Clinical staff report difficulty monitoring all patients when there are many high needs patients on a ward. The patients who are identified as having the highest need may be observed, but then another lower-need patient might slip away. On occasion, staff can find their time diverted

³ In this situation, the word "patient" is used as this is the term used in the *Mental Health Act 2009*. It also describes a person receiving inpatient care. In general, this Office uses the term 'person', 'consumer' or 'service user' depending on the context.

from acute patients to long-stay patients with high nursing needs, who are inappropriately on acute wards for months due to a lack of long-stay ward places or 24-hour supported accommodation.

The concerns of carers about absconding are straightforward. Believing a family member to be safe in hospital, there can be an anxious time worrying about the safety of that absconding patient before they are found. In other situations, carers can be in a difficult situation when a patient absconds to their home, and then needs to be returned to hospital.

Background in South Australia

At various times, absconding has been a major topic of concern in South Australia. This has included absconding from psychiatric settings, as well as from emergency departments.

In July 2010, SA Health provided the Public Advocate with statistics on absconding from Glenside Hospital. These were raw numbers, and were not a 'rate' as they were not divided by a denominator such as the number of detained patients at a particular time.

In 1998, there was an average of 30.25 patient-absconding incidents per month. This went down to a low of 8.58 per month in 2007, and fluctuated since. The numbers per month in 2008, 2009 and 2010 (up to 31 May) were 11.25, 9.33 and 13.6 respectively. During this time, total patient numbers at the hospital have decreased — in particular, as one of the three acute wards has moved off-site.

Of note is that a major initiative to reduce absconding occurred in 2005. Based on the data provided by SA Health, within 12 months absconding rates were reduced from 27.08 per month to 16.58. At the time, a number of wards that were 'open' were made 'closed'. In subsequent years, wards have again been re-opened, using risk assessment and clinical observation as alternative strategies to keep people safe on open units rather than behind locked doors. Also, some buildings in use in 2005 regarded by nursing staff as very difficult to prevent absconding because of poor layout and limited 'lines of sight', have now been closed.

In 2010, a research group from Flinders University published a 'Retrospective analysis of absconding behaviour by acute care consumers in one psychiatric hospital campus in Australia' (Mosel et al., 2010). While the hospital studied is not named in this publication, the description is suggestive of Glenside.

The researchers note the lack of research in Australia on absconding, and also the need to better understand the use of risk assessment and management. An actual rate was calculated for 2007 by dividing the number of absconding events (reported as 64 events that year), by the number of detained patients who were discharged that year from the three acute wards at the hospital (480). The calculated rate was 13.33%: this was 14.84% for males and 9.79% for females. Most absconding events were for males who had a diagnosis of schizophrenia, and 62.5% of absconding events occurred for people who were on their first 21-day detention order.

The authors endeavoured to compare their results with other studies, which was difficult because of different definitions of absconding. The rate was higher compared to some studies but lower than others. The patterns identified can be used to recognise at-risk times during an admission and patients' circumstances. Also, 40% of absconding occurred by people who had absconded before, so past absconding is a particular warning sign of future absconding.

Mosel et al. (2010) remarked that as 1 in 8 detained patients behave in this way, they warrant close and sustained attention. This can lead to more effective nursing practices.

Quality and safety considerations

In 2010, the *National Confidential Inquiry into Suicide and Homicide by People with Mental Illness* in the United Kingdom published data on the social and clinical characteristics of people who absconded from an inpatient psychiatric ward prior to suicide.

Examining 10 years of data, 469 suicide deaths of patients who had absconded were identified in England and Wales. Schizophrenia was the most common diagnosis. When compared to a group of patients who died by suicide while on leave that had been agreed with staff, the group of people who had absconded were more likely to have been legally detained, non-compliant with medication and to have died in the first week of admission (Hunt et al., 2010).

Recommendations from this paper included having tighter control of ward exits, more intensive observation of patients during the early days of admission, and ensuring that the ward environment is supportive and less intimidating to patients (Hunt et al., 2010).

These observations are relevant to the Australian context, as similar groups of people abscond.

The findings of Hunt et al. (2010) about the ward environment are also applicable. The researchers cite the recommendation from the United Kingdom NHS Institute of Innovation and Improvement, that services place a greater emphasis on wards that engage patients and provide structured and supporting activities. In South Australia, we hear consumers and carers report a lack of activities on wards. For example, when a young male consumer who had absconded was asked by the Public Advocate why he had done this, his reply was that there was not enough to do on the ward.

This can reflect how a ward is well ordered, and organised with a daily routine. Bowers (2009) calls this the “structure” of wards, and in a detailed study of 136 wards in the UK surveying staff he demonstrates that ward factors influence absconding rates, along with other “conflict and containment” behaviours such as patient aggression, substance use on the ward, absconding and the use of restraint. In a follow-up paper, his group examined the interaction between these factors. Based on a detailed staff survey in these wards and statistical analysis, their conclusion links the concepts this way: “... leadership impacts on teamwork, teamwork impacts on structure, structure influences burnout, and burnout influences attitudes towards difficult patients” (Bowers et al., 2010).

Discussion

Current research has implications for how we consider and respond to absconding as an issue, to inform practice.

It can also influence professional and public debate about this matter. There are two contrasting arguments that are brought up when the matter is raised.

The first is that mental health involuntary inpatient admission is different to other forms of detention (such as police custody); therefore, the community should consider absconding from mental health involuntary inpatient care differently to absconding from other forms of detention. A potential weakness of this argument in its simplest form is that it can be used to

argue against criticism of any episode of absconding. It may be appropriate to use such an argument on some occasions, but not appropriate on others.

The second contrary position is that physical measures should be tightened— wards should be locked, or indeed a fence or wall be erected around Glenside to stop this from occurring.

It is worth considering the first proposition in more detail. It is true that there are significant differences between civil involuntary inpatient admission for the purposes of receiving care and treatment, and the placement of a person in police custody who has been alleged to have committed an offence. The motivation for taking away a patient's liberty is different (a therapeutic rather than law enforcement focus), as are the means of detention, with the majority of people in a mental health setting managed on an open ward and choosing to comply with legal requirements rather than being stopped by a physical barrier such as a locked door.

The patient on an open ward is, of course, aware that if they should abscond then police will be called, and they will be returned.

However, the loss of rights for involuntary inpatients is the same if not greater than other forms of detention. There is a loss of liberty, but in addition there is a loss of the right to make choices about treatment. The State is taking away a person's freedom in this way, and then provides safety, care and protection in return.

In this respect, the expectation that a patient will remain safe in hospital, and not be able to leave is no different to the expectation that a person not be able to leave other forms of custody at will. It is the means of keeping a patient safe on a hospital site that are different — through professionals assessments of risk, observations of a patient's behaviour, the provision of adequate staffing numbers to meet patient need, the delivery of care in wards designed for the purpose, and ready access to closed ward beds when required. The patient should be engaged in a program of meaningful activities, delivered by a well-led and effective team.

The sum total of these measures is that absconding should be minimised, particularly when a patient is at risk if they abscond.

At times, it is also necessary for professional staff to take a clinical risk, to give a patient more freedom as patients take back responsibility for their own welfare. The therapeutic benefits to the patient of this risk should outweigh the risk itself. This risk should be understood by consumers and carers, as well as treating staff.

Therefore, when a patient absconds from detention and an incident is reviewed, many different factors need to be considered.

This then leads to discussion about the second contrasting argument: the routine locking of doors to all wards or the building of a fence. Mental health care is not custodial in nature but therapeutic. It is likely that patients' recovery would be significantly slowed by unnecessary restriction in a custodial environment. Patients would not be able to take back responsibility for making decisions in the same way that can happen on an open ward. For these reasons, a blanket use of locked wards or fenced compounds would be counter-therapeutic. In the longer term, patients who receive effective treatment and rehabilitation will be better able to look after themselves at discharge than those who have been locked away with limited personal responsibility during their time in hospital. In the longer term, a custodial rather than a therapeutic response may actually increase risk.

These are some of the reasons that the wall that surrounded Glenside was lowered from a high barrier, to a low decorative wall approximately 50 years ago.

It is very understandable that the idea of putting up a fence is raised during discussions, particularly when the community hears of a person absconding repeatedly and other measures such as careful risk assessments and the limited use of closed wards failing.

This is why the mental health services need to drive the professional therapeutic model as effectively as possible to reassure the community of its effectiveness. Wards may not be routinely locked but there are clinical strategies to keep people safe.

Conclusion

Currently in South Australia, as in other parts of the world, absconding from inpatient mental health units remains a topic of concern. For this reason, routine monitoring of absconding rates, along with ongoing research is needed.

Data can be used to identify when problems develop, as the regular monitoring of data could identify changes in patterns. In the future, it may be possible to compare wards and services with national benchmarks for absconding rates. Even though national and international evidence suggests that some level of absconding is unavoidable in inpatient psychiatric practice, this should not stop services regarding absconding as a preventable problem, and reviewing incidents to prevent further recurrences in similar situations.

Currently, there are particular issues that need to be monitored. One is the access to closed-ward beds for community patients who might then be cared for on an open ward, when no closed ward is available. This access issue can be a particular problem when closed wards that are intended for community patients are used for forensic patients, because of a lack of forensic beds. This situation is now commonplace — occurring on most occasions that our Office enquires. Adequate staffing levels and clear responsibilities and staff structures within inpatient units are further issues to be considered.

Sexual Safety in Inpatient Settings

The Office of the Public Advocate has been approached about isolated instances of alleged sexual assault or exploitation of detained patients. We then assist a person to lay a complaint with the Health and Community Services Complaints Commissioner for investigation. Many of the issues about the identification of assault, and lack of prompt police reporting are similar to those for people with a disability (and described in the section on Disability Justice Strategy).

The sexual safety of vulnerable people in inpatient psychiatric settings has been a major issue in other states in Australia and in other countries. There is no reason to expect that the risks for mental health consumers in South Australia would be any different to the risks in other states. It is likely that without a strategy to prevent and identify at-risk situations and to respond to incidents and allegations, instances of abuse or assault can be missed. While some people who allege assault or have been exploited come forward, it is likely that other people who have been through a traumatic experience while unwell choose not to do so. The number of specific instances that our Office is aware of is small, but we consider that sexual safety in inpatient care is a significant wider problem for our system to address.

Risks can include those of assault by fellow patients, visitors or staff. A further risk for some patients is that their illness may lead them to agree to a sexual relationship that they would otherwise choose not to have. Due to their illness, the patient is unable to consent to sexual intercourse. One purpose of mental health detention is to protect the person from engaging in such sexual behaviour. Should this happen on a ward, it is a breakdown in care systems. Patients can also be at risk of experiencing fear and harassment, which in itself can be traumatising — particularly for people who are more likely to have experienced trauma in their lives in the past.

South Australia could benefit from having in place comprehensive guidelines such as the Victorian Chief Psychiatrist's document, "Promoting sexual safety, responding to sexual activity, and managing allegations of sexual assault in adult acute inpatient units" (Chief Psychiatrist Victoria, 2009). There are existing operational policy guidelines in place by the Adelaide Health Services which run most specialist inpatient services, and while they serve a purpose, they do not substitute for a statewide comprehensive document.

Some of the work required overlaps with that of a Disability Justice Strategy. For example, the need for better identification and prompt police reporting issues is very similar.

Other issues for a sexual safety strategy include making fundamental decisions about the operation of mental health services. For example, for a few years now there has been a policy discussion about the re-introduction of segregation of sexes in mental health units. This can involve allocating women-only lounges, designating 'pods' of bedrooms in existing units as either male or female, and establishing single-sex wards (for example, a women's intensive care unit). As part of the Stepping Up plan, some inpatient units will become smaller, so this could be an ideal time to implement such a proposal.

Women-only areas may not be costly, although it then becomes necessary to have available vacant female- and male-designated beds at any particular time. In 2011, the Victorian Government in its budget allocated funds for the provision of gender-specific areas, and in September 2011, a women-only unit was opened at The Alfred Hospital, so that women can receive treatment with less fear of victimisation, violence, sexual assault and traumatising.

The Health Department in Victoria has also prepared a new Service Guideline for Gender Sensitivity and Safety (Department of Health, 2011). The guideline aims to provide trauma-informed care, recognising that many people seeking psychiatric care have experienced past traumas and are vulnerable if exposed to new traumas.

There are other procedural issues that can be standardised. For example, when wards provide single room accommodation it should be possible for patients to lock their own doors. Staff of course can override the lock to gain access, but other patients or visitors could not. This would be only one part of an overall sexual safety strategy. It is a topic that needs comprehensive consideration as to how instances of abuse and exploitation of a vulnerable group of patients can be responded to and prevented.

The Office of the Public Advocate has raised the need for Sexual Safety Guidelines in the past with SA Health, and again in September 2010.

Action is now needed to address specific issues about the safety of vulnerable people under mental health detention, as well as to bring responses in line with an overall Disability Justice Strategy as it is developed. Many of the issues identified are similar: for example, instances of alleged abuse can be discussed with police by mental health services, and at times no formal report made. Clearly, a formal report is essential to enable a response. Similarly, advice by a counsellor from Yarrow Place, the sexual assault referral service, can be critical for both the vulnerable person and staff.

While the safety of detained and other vulnerable patients in wards is a critical issue, a sexual safety strategy could also address the safety of consumers living in community accommodation, where similar issues can exist in both preventing abuse, and recognising it when it has occurred.

Increased awareness may also increase the reporting of incidents, which in turn will lead to more investigations, and information that will guide the effectiveness of both a wider Disability Justice Strategy that encompasses the needs of people with a psychiatric disability, and a more specific sexual-safety policy document to increase the protection of vulnerable inpatients in psychiatric units.

Conclusion

The Disability Justice Strategy should also protect people with a psychiatric disability.

A sexual safety policy for psychiatric inpatient settings in South Australia would aim to prevent assaults, improve recognition of assault if it occurs, and lead to an effective response with police reporting and attendance by sexual assault referral services.

Further safety could be provided with the provision of a women-only psychiatric intensive care unit, and the allocation of single-sex pods in existing wards to separate male and female bedroom areas. If possible, single-sex open wards should be considered. A simple measure that might be implemented quickly for mixed wards is the provision of a women-only lounge.

Seclusion and closed circuit TV

This particular issue, raised by our Office in 2010–2011, demonstrates the value of complaint reporting and investigation of specific incidents leading to improvements.

The Office of the Public Advocate learned indirectly of an allegation that a consumer had been nursed naked in a seclusion room in a major metropolitan hospital's psychiatric unit. The report was that the consumer had taken off her clothes, rather than had them removed. The consumer's care was monitored in the staff station by closed circuit TV (CCTV) as there was a camera in the seclusion room.

The Mental Health Services confirmed that such an incident occurred. The Office of the Public Advocate as an advocacy agency does not have the powers to investigate such a matter, which is properly investigated by the Health and Community Services Complaints Commissioner (HCSCC). For this reason, the Public Advocate laid a complaint with the HCSCC (the person who was nursed naked in the seclusion room had not contacted our Office or made a complaint herself).

The OPA attended a meeting at the hospital convened by the HCSCC. As the complainant, the Public Advocate became aware of the actions taken by the Mental Health Service in response to reviewing the matter both internally and through external experts. There were a significant number of issues that were considered in the review. Major responses related to the use of seclusion policies and the use of CCTV.

In particular, the review recommended the urgent re-evaluation of seclusion policies and the inclusion of the national seclusion guideline that no person should be placed naked into seclusion. When a patient removes their clothes, alternative clothing will be offered—it was not available in this unit, but was available in other units. The unit where this incident occurred now has canvas gowns available to be offered to consumers.

The viewing of a person in seclusion via CCTV is an issue in itself because of the lack of privacy and personal dignity, but it also reflects broader practices regarding the use of 1:1 staff. With sufficient staffing, it should be possible to provide continuous nursing support and observation to an unwell patient, so the need to monitor remotely via video from a staff station no longer exists.

The review also identified the need to ensure that medical assessment was available on this unit as required by seclusion policies. Potential gaps in after-hours medical review of seclusion have now been filled.

Different seclusion policies had been in use in different units in Adelaide—some policies were more comprehensive than others. For this reason, a policy will now be agreed upon and used in all public psychiatric settings in Adelaide where seclusion is practised.

This then led to discussion by the reviewers about the use of CCTV in seclusion rooms generally. For those rooms that currently had CCTV, it would be turned off if a person removed their clothes. It was also considered unnecessary for the new Glenside Psychiatric Intensive Care Unit to have any video monitoring installed in its seclusion room.

The Public Advocate understands that these recommendations have been accepted by the Mental Health Services in 2011. The new Glenside seclusion areas will not have CCTV monitoring installed.

This outcome is supported by our Office. It should be noted that the absence of CCTV monitoring does not compromise the safety of a person in seclusion. If a person is so unwell that seclusion is required, then the constant presence of a staff member outside the seclusion room is also needed. This will be more therapeutic and supportive in the long run than monitoring from a staff station via video.

There is still more work to be done. CCTV is still used in many existing seclusion rooms. This will need to be considered on a case-by-case basis. If a ward has been designed well, and there are adequate staff numbers, there should be no need to use CCTV at all in any seclusion unit. Its use in each situation needs careful consideration.

There is also a more general review held by SA Health on the use of CCTV in mental health units. This will include the use of CCTV monitoring and the storage of videotapes. Hopefully, the perspectives of mental health consumers, carers and staff will be considered in this work as the use of CCTV is considered more generally in mental health units, not just in seclusion rooms.

Our Office has not reviewed this broader topic. We note that the Mental Health Services in reviewing this incident contacted three other Australian states to see practices in those settings. Two did not use CCTV at all in inpatient settings, and one did. It would seem that there is no compelling case to use CCTV in mental health units, and CCTV is not standard practice. If it is possible to avoid the use of CCTV in mental health units, this is desirable.

However, there is a difference between placing cameras in public areas of wards such as communal areas and corridors, and placing them in personal areas such as seclusion rooms. In some settings, patients and carers have been reassured that potential blind spots in corridors are monitored at nights via CCTV as a matter of personal security. In wards with share rooms and unlocked doors, this can be a protection against people wandering into others' bedrooms.

Seclusion areas are personal areas. Most people placed in seclusion will be distressed. The example of a patient who is naked is an extreme one, but the invasion of privacy at a vulnerable time, will still happen in many if not most situations, leading to personal dignity being compromised. The position that our Office puts forward is that all CCTV in seclusion rooms should be disabled. Most units in Adelaide are relatively new, having been built or remodelled in the last 15 years. It is difficult to understand why any of our current wards should not be able to monitor and support a person in seclusion through one-to-one care with direct personal observation when required.

The value of complaint investigation

The Office of the Public Advocate was struck by the benefits of the complaint investigation.

Seclusion practices have already been subject to considerable scrutiny as part of a national improvement effort to prevent the use of seclusion. With all this other recent good work focusing on seclusion, one might have thought that there would be little more to be learned about good practice from a complaint investigation.

Yet, this single complaint brought to light critical issues that could improve the care of people in seclusion across Adelaide. The incident was degrading and undignified, but the response to the complaint was commendable.

Such issues are not just those reported by patients, but by staff and other whistleblowers. It is likely in the future, now that South Australia has a Community Visitor Scheme, that more issues will come to light in this way leading to similar investigations.

Promoting Rights and Interests

Right to Supported Housing

Introduction

Supported housing can be a fundamental need for people who have a significant disability (including psychiatric disability), and require support workers or rehabilitation workers to visit their home to assist with daily living tasks or with skills development.

This discussion particularly concerns programs operated or funded by the health and disability sector for people who have high needs, require assistance to manage their behaviour, and are not able to meet many of their own self-care needs. People in this group historically may have been housed in psychiatric hospitals or institutional disability accommodation, or placed in supported residential facilities (SRFs).

Supported housing, as the name implies, is the provision of a home, and support services to allow a person to remain independent.

This discussion follows on the review of Supported Residential Facilities in the 2010 Annual Report; additionally, it draws links between our ongoing reliance on SRFs with gaps and shortcomings in our implantation of mental health policy, and delivery of disability housing.

The interrelationships between the different government-funded programs are discussed, and there is a more detailed discussion of the gap in 24-hour cluster accommodation for people who experience a psychiatric disability.

Observations and Recommendations of Previous Annual Reports

2009 Annual Report

- Gaps in the provision of **disability supported accommodation** were described and numbers on the unmet need list cited (see the *Review* section of this year's report for an update).
- Plans for **mental health supported accommodation** were noted, in particular the stepped model of care that would provide 73 additional 24-hour supported accommodation places for people who would have previously had prolonged stays at Glenside Hospital.
- **Impact of lack of accommodation on acute wards.** The lack of supported accommodation places was leading to long stays in acute wards by people who took these places, preventing some patients from being admitted to acute care and causing other patients to wait in emergency departments. A number of client stories were also featured in the media at this time, which further informed the public of this issue.

- **The need for clear counting to ensure that the group with complex needs do not miss out:**

To rigorously define which supported accommodation beds are part of the count for stepped supported accommodation and which are not.

This can make it clear then which beds are the replacement for the Glenside beds (building costs funded by the \$20.46m commitment as part of Stepping Up, and recurrent costs funded by money formerly allocated to Glenside) as opposed to other supported accommodation, which may not target the same group with complex needs (Annual Report 2009 p. 36).

2010 Annual Report

- The provision of supported accommodation in the **supported residential facility (SRF)** sector was reviewed. As of June 2009, SRFs were providing accommodation to 869 people: 52% had a primary psychiatric disability, and the next largest group were people who had an intellectual disability (17%).
- **SRF residents are not considered homeless but should be.** For statistical purposes, the Australian Bureau of Statistics does not consider SRF residents homeless, although a resident in a boarding house would be. The Office considers that it would be more accurate for SRF residents to be considered marginally housed or homeless rather than appropriately housed.
- **Subsidy of \$12 a day is insufficient.** The Government subsidises SRFs by \$12 a day per resident, which is on top of the residents' contribution of 79% of their disability pension.
- **Impact of low financing of this sector.** This low subsidy contributes to a poor quality of life for many SRF residents: problems can include lack of privacy due to sharing bedrooms, lack of heating and cooling in bedrooms, and variable quality and palatability of food. It was also noted that some SRFs had been able to operate effectively. These problems are not universal, but they are widespread.
- **A new SRF Act.** This Office suggested that new SRF legislation was required to better outline the rights of residents, and properly recognise SRFs as care providers, working to a support plan, and visited by a volunteer from the Community Visitor Scheme.

Updates on matters raised in past reports

There have been responses to the matters raised in past reports.

Disability Clients in Acute Hospital Beds. In 2010, the South Australian Government's health policy provided for an extra \$3.5m annual recurrent funding to provide alternative accommodation to disability clients in hospital beds who do not require the bed on medical grounds but stay in hospital as a place of accommodation.

In 2011 we still had disability clients spending weeks or months in hospital, but it has been possible to ask that they be considered for this new funding source. While we have not made a quantitative comparison, the need for OPA to respond to dire situations of people stuck in hospitals has been less frequent. However it still does occur, and can have a significant impact on patients caught in this predicament, as well as affect hospitals in need of acute beds at peak time.

This matter will not be resolved until there is funding to meet the Category 1 unmet needs list (see the Review Section on Disability services.) The money to do this is already being spent — but in the health sector on hospital beds rather than in disability sector on accommodation.

Supported Residential Facilities. It is our observation that there have been no significant changes in the situation for residents of SRFs since our review in 2010. It is worth noting some responses made by practitioners in the sector about the 2010 Annual Report SRF Review. There was little disagreement with the observations made about the sector, or the need for reform. There was also general agreement about the need for single rooms, proper heating and cooling throughout buildings and good food.

It was suggested to us that the OPA review could have acknowledged the progress made by SRF proprietors in the last two years in improving service delivery standards, staff training and getting the Government to review allocations. Private SRF proprietors were the principal motivators in getting the South Australian Government to commission a viability study in 2003, and then repeating this work in 2009–10, resulting in an increase in resource allocation to the sector. It was also noted that significant funding inequities remain for the sector.

While our review was appreciated by those concerned about the welfare of SRF residents — workers, policy makers and proprietors — it was pointed out that these shortcomings had been relayed to successive ministers by advocates, other people associated with the disability sector, the SRF advisory committee, and SRF proprietors. The concern expressed was that our review might 'gather dust' whereas urgent action was needed to address this situation.

Overall, our Office stands by our recommendation last year that a new Supported Residential Facilities Act be put into place that better describes the rights of people with disabilities who live in SRFs, that sees SRFs as disability care providers, better defines health and support standards, and legislates for a Community Visitor Scheme.

Taking the point from some of the feedback, SRF reform is urgent, and should not wait for the inevitable delays associated with new legislation. Even if the need for new legislation were accepted, a plan to introduce single-room SRF accommodation should start now, with requirements for heating and cooling in clients' bedrooms, new food standards to improve nutrition and palatability, and a properly resourced care and rehabilitation plan for every resident.

Disability supported accommodation providers — gaps between services

It is relevant to quickly review the major providers of supported housing to this group with complex needs.

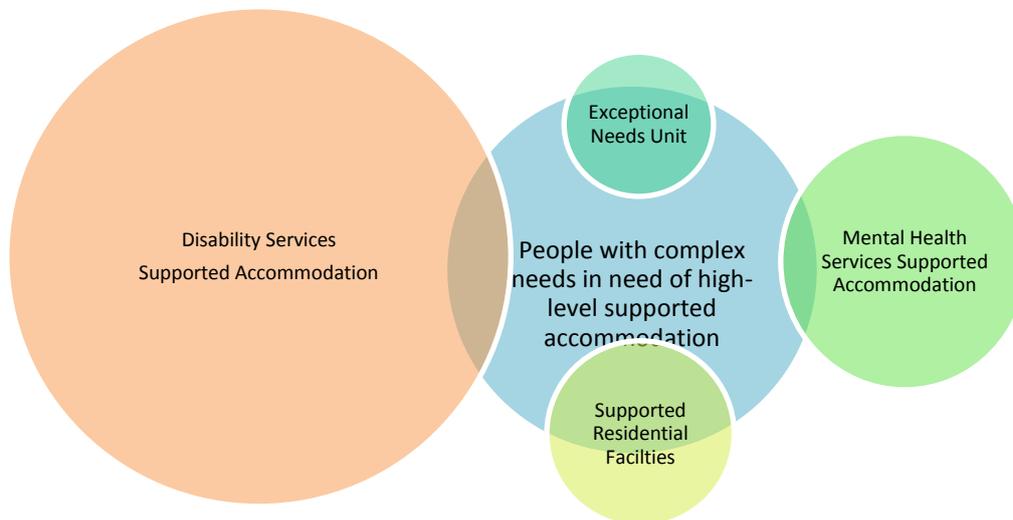


Figure A11. Providers of high-level supported accommodation for people who have high and complex needs.

The diagram above (A11) illustrates the key providers and funders of high-level supported accommodation, in this case for the population of people who have high and complex needs — Disability Services, Mental Health Services, Supported Residential Facilities and the Exceptional Needs Unit. This discussion focuses on the sub-group of people with complex and high needs, although disability services and mental health services have a much broader role in providing a range of support services that high-needs clients may also access.

Some readers might be surprised that SRFs have been included as a ‘high and complex needs’ provider. In reality, if a person requires on site 24-hour assistance it is likely that they have high needs and SRFs become an option. People who have significant behavioural problems or very high-level personal requirements (e.g. incontinence) may not be accepted for SRF care by the government’s SRF intake team.

In addition, there are a range of other supported accommodation providers financed through the Commonwealth and state-funded homelessness sector. Gaps are also filled by the aged care sector, which admits young people who have a disability, acute medical wards in general hospitals, and acute psychiatric wards. Hospitals can provide accommodation by default for people who need longer-term supported accommodation for a mental illness or other disability but who do not need acute care. The prisons also take on a role, as people who have a behavioural problem secondary to a mental illness or disability, and left with insufficient support in the community, are more likely to be arrested and incarcerated.

Each service has eligibility criteria, and the process of navigating between the gaps creates critical delays for people who are homeless. It is not uncommon for both advocacy and guardianship clients of the Office of the Public Advocate to experience a dual diagnosis — having a disability (usually an intellectual disability, brain injury or autism spectrum disorder) and a mental illness (for example, a mood disorder, psychosis or post-traumatic stress disorder). This can lead to uncertainty and disagreement as to whether behavioural problems are due to an underlying disability and therefore a funding responsibility of disability services, or a mental illness, so therefore a funding responsibility of mental health services.

Disability Support

An extract from the eligibility criteria for Disability Services was reproduced in our 2009 Annual Report (page 15). These criteria need to be met to receive any SA Government funded specialist disability service, but the focus of this discussion is the need to meet these criteria to receive supported accommodation. Criteria included providing services to children and adults with intellectual disability, autism spectrum disorder, acquired brain injury, or a physical or neurological condition that cannot be resolved with medical treatment. The person must have experienced significantly reduced function in a range of areas, require a specialist disability service, and the disability must be permanent or likely to be permanent. People accepted into disability-supported housing must meet these eligibility criteria.

As noted in the *Program Review* section of this report, as of August 2011 there were 454 people on the supported accommodation unmet need list for services that are described as Category 1, where the need is critical because a person is homeless or is at immediate and high risk of harm to self or others.

The lack of tenancy rights for Disability Services clients emerged as a significant issue in 2011. Even when notionally housed, clients with disability can be vulnerable to becoming homeless quickly. A crisis can lead to a hospital admission, and clients are then not able to return to their previous accommodation. Residents in disability accommodation funded under the current *Disability Services Act 1993* do not have the same basic rights as residents in the aged care sector. The result is that instead of problems being solved in the community after a behavioural incident — either in a person's existing supported home, or at an alternative residence — people can instead be sent to hospital, and then be effectively evicted by their existing provider. Some people in this group have then spent months in an acute hospital bed waiting for accommodation to be found.

The converse can also occur. While there are instances of eviction due to a lack of tenancy rights, there are other instances of providers continuing to deliver care in very adverse circumstances. While this on the one hand is commendable, it can create risks for the safety of clients and staff, and disruption to neighbours. There needs to be a short-term respite solution for clients whose behaviour deteriorates, and who need a brief period of extra support beyond that which can be provided in their usual home, without requiring the use of hospital as respite.

In these situations when a behavioural crisis develops, difficulties are generally successfully managed in the medium- to longer-term. Input from skilled psychologists to put in place a behaviour support plan, and mental health staff to give advice on the management of co-morbid psychiatric illness can all be effective, and often people can then live successfully in community-supported accommodation.

As discussed in the *Program Review: Disability Services* section of this report, urgent funding is required to meet the unmet demand on the Category 1 waiting list, and the needs of people who require high-level supported accommodation can be particularly acute.

Psychiatric disability support

With respect to Mental Health Services, the South Australian Mental Health and Wellbeing Policy 2010–2015 (SA Health, 2010) commits the State to ensuring that community mental health services are “...accessible to all South Australians, regardless of age, cultural background, geographical location or circumstances in life.” For people who have high and complex needs the policy commits the State to “Provide an integrated, co-ordinated approach to mental health care for people with high and complex needs.” The State will “Ensure that psychosocial rehabilitation and support services are linked to secure and affordable long term housing options.”

With deinstitutionalisation, there has also been a change of traditional responsibilities for some client groups. Historically, when patients lived in hospitals, mental health services would take responsibility for all of a client’s care needs: for example, if a person has experienced both a psychotic illness and then brain injury secondary to substance misuse, mental health services would deliver care for all the client’s needs. Now there is a strict demarcation of funding responsibilities. A person with very high needs who requires significant support services — for example, a person who experiences both schizophrenia and an intellectual disability, can have their support needs divided between the two relevant departments with Mental Health funding the care deemed to be related to the mental illness, and Disability for care needs related to the intellectual disability. The Office of the Public Advocate now has a number of clients in receipt of services that are jointly funded by both departments. This has not been without delays in setting up arrangements.

Mental Health and Disability Services both operate a separate preferred-provider panel of NGO providers. Even though the NGOs perform similar tasks, the preferred provider list for each department is not identical to the other. So for example, Mental Health Services cannot pay a disability provider who is not on their list and vice versa. It is now possible for a client to be funded by two departments, but to have one care contract for this service through Disability Services, delivered by one provider who is on the disability provider list, but funded by both Disability Services and Mental Health. The administrative arrangements to make this happen need to be put in place on a case-by-case basis.

Ideally, in the future these arrangements should be invoked automatically. The needs of people who have such ‘dual diagnoses’ are predictable. A modern service system would allow a ‘no wrong door’ approach. If a person presents to Disability Services and also needs Mental Health funding this should be arranged by the services, and vice versa. It should not be necessary for consumers and advocates to negotiate with both services.

Disability and Psychiatric Disability Support — Exceptional Needs

The Exceptional Needs Unit (ENU) provides support and advice for people with complex needs, including people with disabilities, mental health conditions and chronic health problems (Department for Families and Communities, 2011). In May 2011, at the time when our Office

collected information prior to presenting to an Upper House Committee on Disability Funding, there were approximately 30 clients receiving funding, and another 40 provided with consultation. The Exceptional Needs Unit spends approximately \$2.8m on clients.

This has been an excellent service for some time and in the last three years has moved to redefine its role, as it risked becoming ineffective. The intention was that people would receive intensive rehabilitation input for a few years and would then return to mainstream services. This input included expert advice from the Management Assessment Panel (MAP) that is part of the Exceptional Needs Unit, as well as additional funding which could range from a few thousand dollars to hundreds of thousands.

However, this flow was severely constricted because the return of ENU clients to mainstream mental health and disability services had slowed to a trickle. At the same time, referrals were made from other services for care of people who did not have complex needs, but still required substantial funding. Rather than needing specialised input for complex needs, it had become a program for people who had high-cost support needs (which otherwise might have been expensive but straightforward needs and dealt with by either the disability or mental health systems), or for people where services could not agree who should take responsibility.

This has changed because over the last three years, Disability Services and Mental Health Services have committed to take people who had completed their care at the ENU, and not refer people who were not considered to have genuinely complex needs.

Even with this refocusing, in the last few months of the 2010–2011 financial year, the ability of the ENU to accept new clients who required funding packages ground to halt. It became apparent to the frontline staff at our Office and other practitioners in the sector that the ENU had spent all its support funds, and was not in a position to fund new clients. It was still able to offer expert advice through the MAP, but not to fund extra care. This significantly limited the options for some high needs clients, including those in hospital for some months.

The situation has now resolved for 2011–2012; however, this period of time did illustrate the precariousness of funding for the ENU. This is not because of the services offered by this highly regarded provider, but because of its position and dependence on underfunded disability and mental health services, as it attempts to return stable high-needs clients back to either the Mental Health Service or Disability Services.

The Exceptional Needs Unit and the Management Assessment Panel that it operates have been highly regarded South Australian innovations. In the future, MAP could be given greater authority to provide professional advice to both Disability and Mental Health services, and to direct which service should be the 'lead agency' and take key responsibility. As discussed in the Program Review section of this report the ENU also funds some "non-exceptional" services. The financial demands on ENU may be less in the future if there is a state forensic disability plan in place, as well as a planned response to the needs of adults who experience autism, that do not require an exceptional needs package, freeing more ENU funding for clients with exceptional needs.

Supported Residential Facilities

The role of supported residential facilities is defined in the *Supported Residential Facilities Act 1992* as “premises at which, for monetary or other consideration (but whether or not for profit), residential accommodation is provided or offered together with personal care services (other than for members of the immediate family of the proprietor of the facility)”.

Personal care services, (summarised from the Act), can include nursing care, assistance in bathing, showering, personal hygiene, toileting or continence management, dressing, consuming food, direct physical assistance, the management or assistance with medication, the provision of substantial rehabilitative or developmental assistance, and the management of personal finances.

The significant limitations of SRFs were described in our 2009–10 report and commented on early in this section. SRFs provide additional capacity for both the disability and mental health sectors.

Once in an SRF, it can be difficult for a client then to access housing, and it would seem, other mainstream disability and mental-health disability support services. People who are admitted to an SRF are considered to be either (i) transitional and therefore other community supports are being actively searched for, or (ii), SRF is considered to be a long-term option for them.

A person who is considered a long-term SRF resident can then become stuck. Officially, people in an SRF are not homeless — they are considered to be safely housed. As noted in our 2009–2010 annual report, while a person in a boarding house is considered to be homeless (because they do not have their own bathroom and kitchen facilities), a person in an SRF sharing a room in similar physical circumstance is not. In that annual report, we also noted that: “These definitions have significance at both statistical and policy levels. If a person is not considered to be homeless, then there is no need to find alternative accommodation.”

This matter was further clarified in 2011. In South Australia, a person who is homeless is automatically eligible for Housing SA Category 1, the public housing with the shortest wait. However, because an SRF resident is considered housed, there is no such guarantee. Instead, a person is individually assessed. This can mean that an SRF resident who is desperately unhappy with SRF life — for example, sharing a bedroom with a stranger, distressed by the lack of privacy, and not coping with the inevitable challenges of living with 30 to 40 other people, can be offered Category 2 housing, with many years’ wait for a community unit.

Fortunately, Housing SA are currently reviewing a number of their policies under the banner of the Access Project. This project aims to introduce a new housing and support needs-assessment process to ensure that public housing is given to those people with the highest need. Our Office understands that currently under consideration is the introduction of a well-recognised definition of homelessness based on a person’s actual living situation. We understand that this will better recognise the needs of SRF residents waiting for Housing SA referral. We anticipate that this should mean improved access to public housing.

With respect to people who need disability and support services, people in SRFs, if discharged into the community, are likely to require a relatively high level of support services. This could be regular visits from support workers that might vary from weekly to daily, and for some, depending on the nature of the person’s underlying disability, it may be necessary to live in

clustered disability accommodation, mental health housing with high-level support, or disability group homes.

As discussed in last year's Report, the ongoing role of SRFs needs to be redefined through a review of the *Supported Residential Facilities Act 1992*. The role of SRFs as part of the disability and mental health systems needs to be recognised and funded.

These sectors are summarised in Table A12.

	Disability Services	Specialist Psychiatric Disability Support	Exceptional Needs Unit	Supported Residential Facility
Funder	Department for Families and Communities	Department of Health	Department for Families and Communities and Department of Health	Department for Families and Communities
Nature of client's primary disability	Disability as per Disability Services eligibility criteria	Psychiatric disability	Any disability in which there is an exceptional need	Disability, Psychiatric disability
Provider	NGOs on disability preferred-provider panel	NGOs on mental health preferred-provider panel	NGOs	Private proprietors receiving a \$12 per day subsidy per client 24 privately operated. 3 government-owned and operated by NGOs
Clients	Community support: 14,951 Accommodation support: 4947 (this figure includes people receiving congregate institutional care)	Individual psychosocial support packages. Housing and accommodation support partnership (HASP) —73 Community Recovery Centres (CRC) — 60	Approx. 30 clients very high needs in receipt of direct funding	846 residents

Table A12: Supported housing for people who have a disability (including psychiatric disability). Disability Services data from AIHW (2011). Supported residential facilities data from SRF Advisory Committee (2011). Numbers for HASP and CRC from SA Government's Stepping Up plan. These figures do not include future expansion in HASP and CRCs with Commonwealth funding.

24-hour supported accommodation for people who experience a severe mental illness

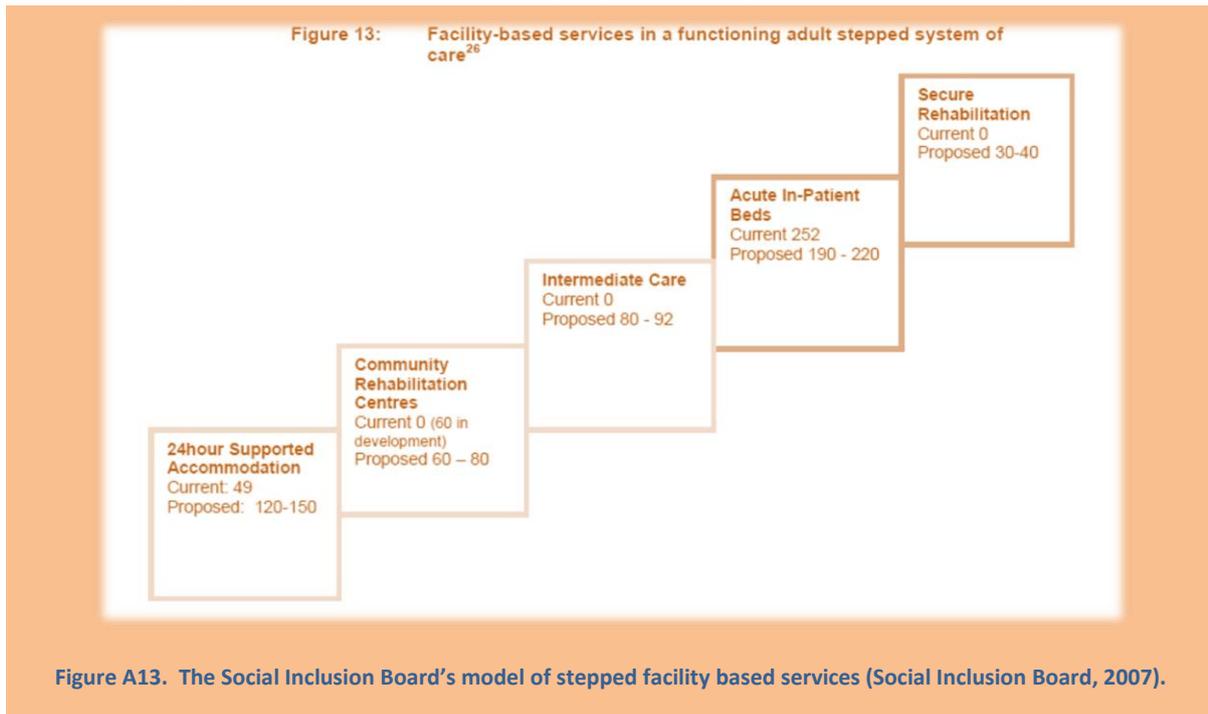


Figure A13 represents the stepped model as put forward by the Social Inclusion Board in its *Stepping Up* report (Social Inclusion Board, 2007).

With respect to 24-hour supported accommodation, it is the view of this Office that the model has been implemented differently than originally planned. In particular, there are only 20 assured 24-hour places whereas 73 were planned. The remainder are “up to 24 hours” a day, often delivering less than 5 hours a day. While the Government has made a genuine commitment to offering 24-hour care to anyone who needs it, there are structural barriers to delivering this, and in practice, people who might need this care are instead being sent to SRFs, where the relative opportunities for rehabilitation are less. By comparison, future quality of life and opportunities will be limited.

This criticism is of the implementation of one step — the 24-hour supported accommodation step. There has been significant progress in other areas of the stepped model. The Government has promised, and delivered community recovery (rehabilitation) centres, intermediate care centres, and the new Glenside Hospital will be operating in 2012 delivering both acute beds and secure rehabilitation beds.

However, for the model to be fully operational, each step needs to be adequately resourced. The levels of care are not interchangeable. The 24-hour supported accommodation was to replace long-stay open-ward beds at Glenside, in combination with the community recovery centres (CRC) and secure rehabilitation beds. This was an excellent plan, as the total number of long-stay places would increase; responding to the demand for ‘more beds’ but delivering supported housing instead for many people.

Within the group of people who require long-stay accommodation, needs are not interchangeable. There are some people who need the more intensive rehabilitation of the CRC over a 6–12 month period. These are the same people who may have had similar-length

admissions to Glenside long-stay beds in the past. There are others who need a gentler pace of rehabilitation, and would not be able to meet the demands of the CRC program, but can still live independently with support if they can have access to a staff member day or night. This is the 24-hour accommodation step for people who in the past would have spent a year or more at Glenside, including some who might live there for life and will now live in supported accommodation.

Some of the consequences of not having sufficient long-stay high level of support mental health places include:

- People with mental illness who need ongoing support can become stuck in acute mental health beds, thereby reducing the number of those beds available to people waiting in the emergency department.
- People are discharged to ‘satellite’ supported houses scattered in suburbs with visiting support which is limited in hours. This has been common in the past and can create risk and lead to incidents at a person’s home if sufficient support is not delivered and can lead to conflict with neighbours.
- People discharged to SRFs. Opportunities and quality of life will be limited by comparison to living in a conjugate setting. Living skills — such as food preparation — can be lost. In theory, the 24-hour supported accommodation step should be offering a level of care that would suit people who have greater needs than those that can be managed in an SRF but in practice, the lack of a 24-hour support place can lead to an SRF referral.
- In the future, it is possible that people will also be admitted to the new secure rehabilitation unit for want of other alternatives, when ongoing cluster care accommodation in a non-secure environment is what is required.

Clustered housing — usually single bedroom units — with staff on site 24 hours a day

The Social Inclusion Board described the 24-hour step as “clustered housing — usually single bedroom units — with staff on site 24 hours a day” (2007).

The report from Andrews et al. (2006) which was the basis of the modelling, assumed that the average length of stay in such accommodation is two years. Like the long-stay open wards that these facilities replace, there is likely to be a significant range of average lengths of stay, with some people living in such accommodation for a shorter period and others, for life.

Cluster housing is distinct from support provided in the community. The Board noted that a greater number of people required “supported public housing places”. Using the model of Andrews et al. (2006), South Australia would require 350 such places.

The government response to this proposal in 2007 is illustrated below in figure A14.



Figure A14. The Government Response (SA Health, 2007)

guardianship clients who either have been directly affected by the change in plans, or might have benefitted from more 24-hour places. Our Office is in a position to talk directly with consumers, family members, frontline staff, and managers. Through this approach we collected the following concerns that apply to a larger group of people, including current patients of long-stay open wards at Glenside who might be in need of 24-hour care, and patients in acute wards in need of 24-hour supported accommodation on discharge.

An additional 73 places offering 24-hour supported accommodation would be provided to meet this need. A budget of \$20.5m was allocated for their construction, and recurrent staffing costs would be paid for by recurrent funds freed up from Glenside Hospital. In reviewing statements made about this initiative, up until 2010, the places were routinely referred to as “24-hour supported accommodation”.

The 24-hour accommodation step is known as the Housing and Accommodation Support Partnership (HASP). There are two components — the 20-unit cluster and the metropolitan cluster of 53 units.

The parameters for each of these clusters as they have been delivered by government are described below (figure A15). The 20-unit cluster is offering 24-hour supported accommodation as required in the Stepping Up plan. The metropolitan service offers 1–5 hours support and “Access to higher levels of daily support, including 24 hours a day...” (SA Health, 2009). This is less than was expected.

It should be noted that the Office of the Public Advocate has not formally reviewed the roll-out of the program. Rather, the advocacy discussion in this Report describes the issues that we have observed in undertaking work for a small number of advocacy and

20 Unit Cluster : HASP Service & Support

Number of places	20.
Configuration	Co-located units.
Consumer need	Consistent high levels of daily support, with persistent and chronic levels of psychiatric and/or functional disability.
Daytime psychosocial support	Active support is available 12 hours daily.
Daytime CMHS support	Available as required on a daily basis.
Night-time support	NGO, active, 12 hours (initially)
Key Partners	Consumer, Carer, Housing Manager, Support Coordinator, Key Worker.

Metropolitan HASP Service & Support

Number of places	53 plus
Configuration	Mostly individual dwellings and duplexes, with some collocated groups of 5 as determined by consumer need.
Consumer need	<ul style="list-style-type: none"> High: High levels of daily support. Medium: Consistent medium levels of daily support, with periods of requiring higher levels of support.
Daytime psychosocial support	<ul style="list-style-type: none"> Daily as required, between 1 - 5 hours.
Daytime CMHS support	<ul style="list-style-type: none"> Daily to fortnightly as required.
Night-time support	<ul style="list-style-type: none"> NGO, on call. (Active or passive NGO overnight support available for periods determined by consumer need)
Key Partners	Consumer, Carer, Housing Manager, Support Coordinator, Key Worker

Table A15: Housing and Accommodation Support Program (Extract from SA Health, 2009)

(1) Limited number of 24-hour HASP places. Some long-stay Glenside patients who wish to live in a unit, rather than an SRF, had hoped to move into the 20-unit cluster, only to miss out on allocation. If a patient was not well enough to move at the time that the cluster opened, a unit was not allocated. People in this group will instead need to wait either for a vacancy to occur in the 20-unit cluster, or obtain one of the 53 metropolitan places, and have support levels lifted, at least initially, to 24 hours. Some long-stay Glenside patients continue to have other options suggested — such as SRFs — because of an expectation that it will be difficult to obtain a spot in the 53 places, many of which have already been allocated, and that if a place is obtained, the hours of support will be insufficient.

Because metropolitan HASP housing has been built as individual units, duplexes and some co-located units (up to 5) it can be logistically more difficult and expensive to base staff for 24 hours in such locations than it might be if accommodation is clustered together.

It should be noted that the Government made it clear in early 2011 that any person who needs 24-hour care in the 53 places will receive it, which is most welcome. The challenge for consumers, their families and advocates is to make the case that 24-hour care in a community unit is required.

While the metropolitan HASP program will provide support up to 24 hours this has yet to be demonstrated, and may not be, as referrers seek other options such as SRFs. At one point when visiting a HASP provider, our Office discovered that this organisation already had 19 metropolitan HASP houses occupied. None were receiving 24-hour support funded by Mental Health. One client had 24-hour support, but this was because top-up funds had been provided by Disability Services.

If metropolitan HASP places had 24-hour on-site staffing ongoing, rather than having increased staffing subject to approval, it is possible that more people in the high-needs group currently referred to SRFs could then be considered for HASP. This would mostly meet the person's own aspirations of living in their own apartment rather than living in conjugate accommodation.

(2) The role of 24-hour supported accommodation is blurred with that of Supported Residential Facilities. A common understanding of clinical staff was that the new 20-unit cluster required a degree of independence that many open-ward Glenside patients did not have. Therefore, if a person was able to leave hospital, but required prompting with medication, prompting with personal hygiene, or was unable to do personal laundry, then staff understood that these services could only be provided in an SRF and not by the new 24-hour supported accommodation.

One of the key non-government organisations involved in HASP clarified this matter for us. Their staff will do medication prompting, and assist with the daily living skills listed (prompting for showers, washing personal clothing), so the assumption by clinical staff that this would preclude a HASP placement should turn out to be incorrect. While this will assist people in the 20-unit HASP, it could remain an issue for people in metropolitan HASP who have daily visits of a few hours, where the NGO worker may not necessarily be on site to assist with these tasks.

Current Glenside patients, as well as patients in other acute wards, continue to be referred to SRFs in situations that our Office would consider suitable for HASP, based on the Stepping Up plan.

It is acknowledged that this program, even if implemented as intended, would cater for just 73 clients and the need for SRFs would continue; and the much larger population with mental illness receiving 24-hour on-site support at SRFs (over 400 people) would mostly continue to live in those settings. However, at the very time that the HASP Glenside replacement accommodation is being built, it has been frustrating to see Glenside residents and other acute patients who might have gone to Glenside previously, offered SRFs because of their need for 24-hour on-site assistance if required, which will not be delivered by metropolitan HASP. In most cases, this 24-hour assistance is not intensive — just a matter of having someone there in case of need overnight.

Our assessment of the policy basis for HASP is that it should have met the needs of people who either live in Glenside, or would have been referred to Glenside for prolonged admissions. This would then have included people who have been marginally housed in SRFs with frequent moves and evictions, who in the past would have been offered a period in a long-stay bed at Glenside. Our Office meets clients who have been evicted from SRFs, who might thrive with high-level supported accommodation but instead will have a brief hospital admission and referral to another SRF.

(3) Differing expectations of the level of support provided by HASP. Mental health professionals had anticipated that HASP would take higher-level clients than what has turned out to be the case for both the 20-unit cluster and the metropolitan cluster.

With respect to the 20-unit cluster, we are aware of at least one instance where mental health staff assessed a person with high needs, who wanted to live in a unit, as suitable for HASP; however, when the non-government operator was appointed, the person was not accepted.

On more than one occasion, our Office has been advised by mental health clinical staff that a client's needs are too great for HASP. It can be suggested that if a person wishes to live in HASP accommodation they should live for a time in a community recovery centre (CRC) first. While completing a CRC program may be necessary for people receiving community support packages in private or Housing SA accommodation, it should not be required for HASP because of the higher level of support that HASP should offer.

In making the recommendation for CRC rehabilitation prior to HASP referrals, clinicians note the allocation of limited support hours for the metropolitan HASP group. However, in putting forward this view that a successful CRC admission is required first, it underlines the limitations in the HASP program, as high needs clients should be able to go straight to HASP.

(4) Desensitisation of the sector which tolerates the unacceptable — unmet support needs. With respect to community mental health reform, mental health services nationally (and internationally) have a poor record of considering housing options to be acceptable for high-needs clients when in fact the options are unacceptable. The sector becomes desensitised to the poor housing options, because this is all that is available.

Clients with high needs in the past housed in the community have been offered two alternatives, both underfunded for their needs. At one extreme, clients have been placed in independent community units with an underfunded package providing insufficient support hours. At the

other extreme, if this is deemed inadequate, clients have been provided 24-hour care by the underfunded SRF sector.

A consequence of not having more 24-hour support places is that people will be diverted into one of these two options.

Accommodation models in mental health

At this point, it is relevant to review recent evidence regarding supported accommodation models and mental health.

There has been debate for some time about what constitutes the best form of housing in mental health. Initially this was a debate between the supporters of conjugate housing (where people live together in one building) and outreach support (where people live independently in community housing). There has also been debate about the role of cluster housing (people living in self-contained units on one site) vs. outreach support in community housing.

The Social Inclusion Board Plan in its stepped model argued for both: clustered housing, usually single bedroom, with staff on site 24 hours a day to serve as a replacement of long-stay hospital beds, as well as the provision of outreach NGO supports for a larger group.

The current implementation in South Australia is scaling back on the clustered housing. As our Office understands the reasons, it is because of a wish to provide stable accommodation, where supports can be increased and decreased according to a person's need. This does not happen in a cluster model, where people move on to new accommodation on average after two years, when their needs lessen.

The following evidence demonstrates the need for more research and evaluation in this area.

A review of national and international literature on the relationship of mental illness and homelessness was undertaken for the Commonwealth Department of Health and Ageing by St Vincent's Hospital and Craze Lateral Solutions in 2005. This review described evidence that most adults who experience a mental illness would prefer to live independently, rather than living in a group home; and the least preferred housing options for Australian consumers are shelters, crisis accommodation and hospitalisation.

Kyle and Dunn (2007) have also noted that while there is good evidence in the literature for the benefits of supported housing for people who are homeless who also have a mental illness, more evidence is needed about the optimal housing solutions for a broader group of people who experience severe and persistent mental illness and who are inappropriately or marginally housed.

There have been recent studies on the effect of giving people choice and control. Nelson et al. (2007) in Toronto demonstrated that providing mental health consumers with choice and control improved their perceived quality of life and adaptation to community living. This choice and control extended to not only housing choice, but also to the nature and extent of support services received. People in apartments had more choice and control than those in group-living situations. However, in this study participants were not randomly assigned to the two different types of housing (Nelson et al., 2007), although the groups of consumers living in each setting were similar.

While many studies have measured outcomes for clients on standardised scales, there has been other qualitative research that gives a richer insight into residents' choice and preferences. In a study by Tsai et al. (2010), the authors noted that many residents with a mental illness changed their housing preferences over time.

Work has also been done on residential mobility of people who are diagnosed with a mental illness — similar to work in the general population. In a recent UK study, mobility of people with severe mental illness was strongly associated with a younger age, and drug and alcohol misuse. It was not associated with wanting to move (Tulloch et al., 2010).

There is often a concern that people in community housing will become lonely. A study from Israel by Weiner et al. (2009) compared loneliness and quality of life of people living in traditional 30-person residential settings that provide rehabilitation, with people living in a new model independent unit. In this latter Israeli model, consumers usually lived in pairs. There was no difference in the experience of loneliness, quality of life and social supports between the two groups (Weiner et al., 2009).

Leff et al. (2009) considered the question: "Does one size fit all? What we can and can't learn from a meta-analysis of housing models for persons with mental illness." Their meta-analysis concluded that different housing models (from conjugate to permanent supported housing) all improved the outcomes of people with mental illness, which was statistically greater than providing treatment alone without a housing model. They noted that different sub-groups may need different housing models.

In their discussion, the researchers noted that permanent supported housing in concept is seen by many to cost-effectively provide any housing service bundle, and will deliver any outcome as well or better than any other model. They concluded that their analysis suggests that this may not yet be the case, because either the concept is incorrect or the implementation has been flawed.

This is relevant to South Australia because, in our opinion, the view of the primacy of permanent supported housing scattered throughout the suburbs over other models such as cluster housing of groups of 20 has influenced the change away from the Social Inclusion Board model of 24-hour supported housing. This is because 24-hour models can only ever be economically delivered in the longer term by building clusters rather than scattered dwellings. Cluster accommodation is usually not permanent, because residents are expected to move on after a couple of years to more independent housing.

However, the evidence base for cluster housing does not really exist either. The Cochrane Database of Systematic Reviews has the most comprehensive repository of trial data in medicine, and has reviewed supported housing (Chilvers et al., 2009). In the latest update of its review on supported housing for severe mental disorders, Chilvers et al. (2009) sought to compare clustered supported housing, with an outreach support scheme, where people live in self-contained accommodation but do not share a site. It was not possible for the review authors to find any studies that addressed this question or that were of a suitable standard.

In the conclusion of their Cochrane Review, Chilvers et al. (2009) said:

Dedicated schemes whereby people with severe mental illness are located within one site or building with assistance from professional workers have potential for

great benefit as they provide a 'safe haven' for people in need of stability and support. This, however, may be at the risk of increasing dependence on professionals and prolonging exclusion from the community. Whether or not the benefits outweigh the risks can only be a matter of opinion in the absence of reliable evidence. There is an urgent need to investigate the effects of supported housing on people with severe mental illness within a randomised trial.

The authors said that in the absence of evidence, decisions about accommodation could only be made based on professional judgement, patient preference and availability. The review also advised policy makers that co-located supported housing should be considered with caution, and if implemented, would require rigorous evaluation.

Conclusion

So, where does this leave the situation in South Australia, with only 20 of the 73 planned 24-hour places operating as a cluster with on-site support, and the remaining delivering something else?

The departure from Stepping Up can only be justified if high levels of support are readily available to residents in the remaining 53 places.

Even with the guarantee that anyone who needs 24-hour support will get it, it is difficult to claim against this guarantee when people may be referred to SRFs instead.

Instead, clients who might have been suitable for these metropolitan HASP places are at times not referred because their needs are considered too high for the level of funding available.

Nationally, clear benchmarks are needed for the provision of supported accommodation, and the Office of the Public Advocate considers that the 73 places with 24-hour support as originally planned are still required.

Promoting Rights and Interests

Adult Protection: A Right to Safety

The Office of the Public Advocate has been heartened by the interest in developing new models of adult protection in South Australia in 2010–2011.

In 2009 and 2010, our annual reports described the benefits of a rights-based approach to adult protection — an approach that sees freedom from exploitation as a right, and aims to assist at-risk people with practical help to prevent abuse, and to recognise and respond to abuse when it occurs. Examples have been given of coordinated adult protection approaches in the United Kingdom (the “No Secrets” approach) and North America.

This policy discussion engaged decision makers, culminating in the funding of a project based in this Office — the Vulnerable Older Adults Project.

This project was funded by the Disability, Ageing and Carers Branch of the Department for Families and Communities, South Australian Government, through *Improving with Age— Our Ageing Plan and Community Care Innovation Funds*.

Our Office worked with the University of South Australia Human Rights and Security Research and Innovation Cluster. State, national and international best practice in adult protection law and policy was reviewed, and over 130 practitioners engaged in consultation. Issues were also examined by a Community of Practice group over the course of two workshops. The project was overseen by a Strategic Advisory Group that comprised senior officers or nominated representatives from key agencies involved in preventing and responding to elder abuse in health, social services and the law.

A report for this project was completed, along with a draft Whole of Government Policy for the Protection of Older Persons from Abuse.

Feedback from our funders about the quality of the work has been positive. The findings are not reproduced here, because the report now belongs to the Department; however, with the enthusiasm for further developments in this area, we are expecting to hear more in 2012.

Particular acknowledgements need to be given to the work done on this project by:

Ms Elly Nitschke, Senior Project Officer, Vulnerable Older Adults Project, Office of the Public Advocate

Associate Professor Wendy Lacey, School of Law, University of South Australia

Ms Margaret Farr, Assistant Public Advocate, and member of the Project Steering Committee

Ms Diane Chartres, Office of the Public Advocate, who developed the initial project plan

Professor Nicholas Proctor, Chair, Mental Health Nursing, University of South Australia

Associate Professor Kay Price, School of Nursing, University of South Australia

As well as the above, there were many people from so many different organisations who happily gave their time to contribute. They were both frontline practitioners and managers.

It was very positive that this project could benefit from such enthusiasm and commitment to see developments in this area from so many people in the sector.



A workshop meeting of the Community of Practice, held in the ABC Boardroom, Collinswood in June 2011.

Above: from left to right – Doris Gioffre, ARAS; Tim Walsh, Domiciliary Care, Margaret Farr, OPA; Helen Hill, Domiciliary Care; Chris Boundy, Legal Services Commission; Jane McCarthy, RAH Social Work; Marcia Stewart, Public Trustee, Lorraine Coventry, Mental Health, Andy Kelly, RDNS, Sharon Walker Roberts SAPOL, Cathy Isbester, Eastern Health Authority, Marge Pitcher, Domiciliary Care, Geoff Bloor, RGH, Tara Simpson, Legal Services Commission, Kay Pearce, Uni SA;

Left: Wendy Lacey, University of South Australia, Elly Nitschke and John Brayley

Promoting Rights and Interests

Supported Decision Making Project

In our 2009 Annual Report, we examined Article 12 of the UN Convention on the Rights of Persons with Disabilities, and the need to have strategies to support people make their own decisions as an alternative, where possible, to substitute decision making.

A stepped model of supported and substitute decision making was put forward. This stepped model was further refined in 2010. Our annual report last year (p. 107) defines each of the steps in such a model. A stepped model allows an option for each person that will be the least restrictive, as it provides a number of choices between supported and substitute decision-making arrangements. Based on this work, the Office of the Public Advocate proceeded with the development of a non-statutory model of supported decision making. This model is to provide assistance to people who have a disability that might affect decision making, as part of our role giving advice as an alternative to taking action under the *Guardianship and Administration Act 1993*. . Funding was obtained in 2010 from the Julia Farr MS McLeod Benevolent Fund, and during 2010–2011, the first phase of a project has been completed offering help for people to establish a supported decision-making agreements with a family member or friend, who is willing to provide this support.

The South Australian project is trialling an approach to Supported Decision Making, in which a person nominates one or more people whom they know, to act as a supporter. An extra person, a ‘monitor’, helps with the process and identifies problems if they occur. The roles of each of the parties to an agreement are described in the table on the next page (Figure A16).

The family member or friend who acts as a decision supporter, can assist by collecting information and helping the person choose options. The supporter cannot substitute their own view for the person’s decisions about what should occur.

Agreements, when in place, will assist people make decisions about health care, accommodation, and life style issues.

Ultimately, it would be helpful for supported decision making to be recognised in legislation. This would give validity to a supporter’s role. As discussed in the *Monitoring Legislation* section of this Report, the Office of the Public Advocate also considers that our current legislation should also be amended to require all practicable steps to support a person make their own decision be made prior to the appointment of a substitute decision maker.

Supported Decision Making — Participant Roles

The person receiving support needs to be able:

- To express a wish to receive support
- To form a trusting relationship with another person (s)(supporter or monitor)
- To indicate what decisions they may need support for
- To indicate who they wish to receive support from for which decision
- To express a wish to end support if that time comes
- To be aware that they are making the final decision and not their supporter.

The decision supporter needs to:

- Respect and value the supported person's autonomy and dignity
- Know the supported person's goals, values and life experiences
- Respect the individual decision making style of the supported person and recognise when and how support may be offered
- Form a trusting relationship with the supported person
- Be willing in the role of supporter, to fulfil their duty to the supported person, and not use this role as a way of advancing their own interests or any other person's interests
- Be able to spend as much time as is required to support a person make each decision.
- To assist in the expression of that decision to others if required.

The monitor's tasks are:

- To be aware of all decisions made and how support is provided
- To provide assistance to the supported person and supporter in undertaking the supported decision-making process
- To act as a resource for the other parties when a matter is difficult to resolve
- To take necessary action if the monitor believes that the supported decision-making agreement has broken down.

Figure A16: Supported Decision Making Participant Roles

Supported Decision Making Committee

A Supported Decision Making Committee was established in February 2010 to guide our work.

This Committee has been formed under the provision of the *Guardianship and Administration Act 1993 Section 21(3)*, which allows the Public Advocate to establish committees for the purpose of providing him or her with advice in relation to the performance of any of his or her functions. The terms of reference for the committee were published on page 104 of the 2009–2010 annual report.

The South Australian Supported Decision Making trial is being undertaken as a research program. External funding for the project has been provided by the Julia Farr MS McLeod Benevolent Foundation.

The project has submitted applications for research ethics approval to the Human Research Ethics Committee of the Department of Health, SA Government.

The Supported Decision Making Committee has met monthly during 2010–2011.

The Committee acts as a Project Control Group for the project. As an official committee, its activity is reported in this Annual Report.

The Committee brings together a mix of knowledge from both lived experience and professional practice. The Committee brings the following experience and expertise to the project: Four members of the project control group have a lived experience of disability. One member is the carer of a person with a disability. Members have experience in the law, social work, psychology, medicine, nursing, disability service reform, guardianship, quality improvement, counselling and academic research.

The membership of the Committee is as follows:

<i>John Brayley</i>	<i>Chair</i>
<i>Robbi Williams</i>	<i>Chief Executive, Julia Farr Group</i>
<i>Graham Mylett</i>	<i>Commenced April 2011</i>
<i>Tiffany Bartlett</i>	<i>Commenced April 2011</i>
<i>Margi Charlesworth</i>	<i>Commenced December 2010</i>
<i>Ian Cummins</i>	
<i>Dell Stagg</i>	
<i>Margaret Brown</i>	
<i>Ian Bidmeade</i>	
<i>Helen Mares</i>	
<i>Julie-Anne Harris</i>	
<i>Elly Nitschke</i>	
<i>Di Chartres</i>	<i>2010 Churchill Fellow studying Supported Decision Making</i>
<i>In attendance</i>	
<i>Cher Nicholson</i>	<i>Senior Practitioner and Project Coordinator Supported Decision Making Project</i>
<i>Margaret Wallace</i>	<i>Independent Evaluator</i>
Participation at key meetings to review the work of the project	
<i>External reviewer and commentator</i>	<i>Barbara Carter, Victorian Office of the Public Advocate</i>

A tender selection process occurred in January 2011 that led to the appointment of Ms Margaret Wallace as the independent evaluator of the project.

The Committee had significant discussions regarding the nature of supported decision making and the methodology of the project, leading up to the development of a draft model and project plan in mid-2010.

Contact with other jurisdictions

In August 2010, we were honoured to be visited for the day by Professor Neil Rees, Ms Emma Cashen and Mr Martin Wimpole of the Victorian Law Reform Commission to consider the SA approach to supported decision making. We were able to provide information about the developing South Australian approach. It was also an opportunity for us to be challenged on our assumptions, and to learn from both the extensive research undertaken by the Commission team, and the experience of Professor Rees.

Meetings were held at the OPA offices, and Committee members and other invited parties attended a lunchtime meeting with Prof Rees and his staff.

It was positive to see supported decision-making mechanisms at the top of the list of important changes proposed to Victoria's *Guardianship and Administration Act* when its Consultation Paper was released in February 2011 (Victorian Law Reform Commission, 2011).

The project team and the Committee have also liaised with the NSW Public Guardian's Office, which is also developing a supported decision-making project with that state's Office of Ageing, Disability and Home Care.

In February 2011, Michelle Browning, a Churchill Fellow working with the Public Guardian in NSW reported by teleconference to the Committee on her observations of supported decision making in the United Kingdom and in Canada.

Subsequently, John Brayley and Cher Nicholson presented our SA work to the NSW team and officials in Sydney in June 2011.

Di Chartres, Committee member and Churchill Fellow, was able to liaise with Michelle, as Di prepared for her own Fellowship visits overseas in mid-2011.

The Project was also assisted by Barbara Carter of the Victorian Office of the Public Advocate, who acted as our external reviewer, and gave feedback on our work at key committee meetings. She came to this role having previously prepared papers on supported decision making for the Victorian Office. With Barbara's retirement from the Victorian OPA in mid-2011, John Chesterman, the Manager of Policy and Education at the Victorian Office has agreed to take on this external reviewer role.

Phase 1 of the Supported Decision Making Trial

In November 2010, Senior Practitioner and Project Coordinator Cher Nicholson commenced work on the trial.

With ethics committee approval, Phase 1 of the project began in December 2010. This was a preliminary phase, providing assistance to set up supported decision-making assistance to 10 people and their families using an in-house evaluation.

Much of the work in committee concerned the operation of the developing model. This led to the development of Practice Guidelines for Supported Decision Making, the first version of which was completed in June 2011, along with the internal evaluation of Phase I for the ethics committee. This work continues to be updated as the project progresses.

The Committee considered the balance of personal autonomy and protection issues for people using supported decision making who might be vulnerable. Thinking through the practical issues was greatly assisted by reference to the UN Convention — both Article 12, Equal recognition before the law, and Article 16, Freedom from exploitation, violence and abuse.

For those who wish to read more about the role and practice of Supported Decision Making, the SA practice guidelines can be read on the OPA website, by following the link in the reference list (South Australian Supported Decision Making Committee, 2011).

The Project is now under way and will continue through 2011–2012.

Current funding of the project is to November 2012. It is hoped that this work will lead to ongoing access for people with disabilities to assistance establishing supported decision-making agreements, and that supported decision making will be recognised in future legislative reform in South Australia.

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 2010–2011, 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. The frequency of these meetings has generally been on a quarterly basis with the Minister for Mental Health and Substance Abuse and the Minister for Disabilities, with other appointments reflecting particular issues of relevance to the mandate of this Office.

Meetings with Ministers:

Hon. John Rau MP, Attorney General

Hon. Jennifer Rankine MP, Minister for Disabilities

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

Hon. Jay Weatherill MP, Minister for Education

Meetings with Members of Parliament:

Dr Duncan McFetridge MP, Shadow Minister for Mental Health and Substance Abuse

Hon. Kelly Vincent, MLC

Hon. Stephanie Key MP

Mr. Steven Marshall MP

Section 22 (3) Report

The matter of the funding and independence of the planned Community Visitor Scheme was raised with the Minister for Mental Health and Substance Abuse using the provisions of Section 22 (1) and therefore required to be noted in this Annual Report under Section 22 (3).

As reported in last year's annual report, the independent community visitor scheme was to be under the auspices of the Office of the Public Advocate. The scheme was not allocated new funding and the costs of refurbishing extra office space at the ABC Building could not be afforded. Instead, for financial reasons the scheme would initially be under the auspices of the Department of Health which would fund it from savings.

As the Principal Community Visitor was yet to be appointed, the Office of the Public Advocate took an advocacy position to argue for the independence of the scheme. Representations were also made by others, in particular the Health Consumers Alliance.

It was argued that the scheme, as it was to be in Health, should be under the auspices of the Health and Community Services Complaints Commissioner.

Ultimately, with changes to a job description, an excellent and renowned advocate, Maurice Corcoran AM was appointed Principal Community Visitor.

In the longer term, as the scheme expands to cover the disability sector, this Office would wish to be administratively linked with this scheme. Such a co-location and collaboration could support both entities that could work synergistically together. For example, the systemic advocacy work of the Public Advocate in Victoria is fuelled by information collected from hundreds of community visitors across that state.

In furthering the advocacy for the future scheme, The Public Advocate requested the Attorney-General to lay on the table a report before parliament on the topic "Community Visitor Scheme in South Australia." This was done in the House of Assembly on 3 May 2011.

Presentation to select committees:

The Office of the Public Advocate presented to the Select Committee of the Legislative Council on Disability Equipment and Services on the 6 May 2011.

Give advice on legislative powers: *Guardianship and Administration Act 1993*

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.

Monitor Legislation

Guardianship and Administration Act 1993

Guardianship and Administration Act 1993

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

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

Introduction

The second part of this Annual Report demonstrates the continuing expansion of guardianship in South Australia over many years. In the second half of 2010–2011, this accelerated rate of growth increased further, beyond the baseline rate of increase in recent years. We consider this reflects a policy shift by the Guardianship Board towards a broader welfare view of guardianship.

The role of the Public Advocate monitoring the administration of the Act provides a critical balance to the power of the Guardianship Board in our system. This sets up mutual accountability. The Board holds the Public Advocate accountable in how individual guardianship decisions are made when our Office presents evidence at hearings. The legislation allows the Public Advocate to hold the Board systemically accountable in its administration of the Act. This, along with the role of our Office promoting rights, sets up a tension between the roles of the Board and the Public Advocate, which is a positive and constructive feature of the relationship between the two statutory bodies. (This was discussed further in our 2009 annual report, p. 81).

The debate about the role of guardianship is a policy debate. On the one hand, there is a rights-based view of guardianship, which limits the role of guardianship to situations where a person needs to have decisions made, and there are no other alternatives. On the other hand, the welfare view sees guardianship as a protective function, so that orders can be made even when no decisions are required. The South Australian legislation is written in a way that it can be interpreted in either direction (rights-based or welfare-based) so the different positions cannot be resolved through statutory interpretation alone.

In fact, it can be argued that there are mixed messages coming from the existing Act, that encourage the least restrictive option on the one hand, but also incorporate welfare concepts on the other. These are discussed in this section. One way to resolve these tensions is for matters to be debated as a part of law reform. Some of the amendments to the *Guardianship and Administration Act* that our Office has previously suggested would help resolve this conflict.

This discussion puts the argument that guardianship should be rights-based, with less people placed under guardianship. It should be noted, however, that this does not mean that vulnerable people are not assisted. Public guardianship retains a significant role as an option of last resort. The role of advocacy is clearer, recognising that in many situations issues stem from service incapacity to deliver suitable options, rather than an individual's incapacity to make decisions between the unsuitable options that are available. The model also reassures consumers, carers and families, because expansive guardianship provisions in the past, prior to the current Act, were considered to have led to unnecessary interference and control in the lives of people who have a disability and their families.

Fundamentally, these issues can be addressed through law reform — starting with simple amendments to recognise the decision-specific nature of mental incapacity.

In the medium term, also if we do not address this issue, it the ability to consider other alternative policy solutions to adult protection. Should we rely on placing more people under guardianship, or consider other solutions such as the local adult protection models put forward as part of the Vulnerable Adults project of this Office (discussed elsewhere in this Report).

Observations and Recommendations from Previous Annual Reports

2009 Annual Report

- The South Australian GAA has a broad definition of mental incapacity. It was suggested that an additional principle be added describing capacity as decision-specific, and this would lead to a greater focus on a person's actual ability to make necessary decisions.
- In addition, legislation should define that there be a presumption of mental capacity, and a requirement that all practical steps have been taken to support a person to make their own decision before a substitute decision maker is appointed.

2010 Annual Report

- The 2009 changes are supported, but the need for more extensive law reform is outlined.
- A new law could make assisted and supported decision making the primary intervention for people who need help with decision making, ensuring that substitute decision making is truly a last resort.
- Similarly, there should be a range of stepped options, so that the Guardianship Board has a range of choices to match the level of intervention to a person's needs (based on the Stepped Model of Supported and Substitute Decision Making, p. 107 of the 2010 annual report). For example, in a stepped model, the Board could order that a person enter into a Supported Decision-making Agreement, or order the appointment of a second person as co-decision maker, in contrast with the current situation where the Board is limited to either appointing a guardian, or taking no action.

The proposal for law reform is described in the following table (figure A17).

A proposal for additional Section 5 principles, *Guardianship and Administration Act 1993*.

Existing principles, plus new suggested principles in italics.

Where a guardian appointed under this Act, an administrator, the Public Advocate, the Board or any court or other person, body or authority makes any decision or order in relation to a person or a person's estate pursuant to this Act or pursuant to powers conferred by or under this Act—

- (a) *the decision maker must begin their consideration from a presumption of capacity, that is:*
 - (i) *an adult will be assumed to have capacity to make their own decisions unless it has been established that the person lacks that capacity*
 - (ii) *mental capacity is decision specific. Capacity must be determined in relation to the specific function or task and the decision that needs to be made at a particular time*
 - (iii) *a person is not to be treated as unable to make a particular decision unless all practicable steps to help the person to do so have been taken without success*
- (b) consideration (and this will be the paramount consideration) must be given to what would, in the opinion of the decision maker, be the wishes of the person in the matter if he or she were not mentally incapacitated, but only so far as there is reasonably ascertainable evidence on which to base such an opinion; and
- (c) the present wishes of the person should, unless it is not possible or reasonably practicable to do so, be sought in respect of the matter and consideration must be given to those wishes; and
- (d) consideration must, in the case of the making or affirming of a guardianship or administration order, be given to the adequacy of existing informal arrangements for the care of the person or the management of his or her financial affairs and to the desirability of not disturbing those arrangements; and
- (e) the decision or order made must be the one that is the least restrictive of the person's rights and personal autonomy as is consistent with his or her proper care and protection

Figure A17: Proposed Additional Principles *Guardianship & Administration Act 1993*

It should be noted that the Attorney-General has accepted the need identified by this Office for these questions of law reform to be considered. It is expected that the task of considering the suggestions by this Office will be undertaken by the South Australian Law Reform Institute.

Rights-based versus Welfare-based Approach to Guardianship

This tension arises from the *Guardianship and Administration Act* itself. On the one hand, it is clear that parliament intended the guardianship sector to have a limited role in people's lives. On the other, the Act has welfare features that support a wider role.

For example: while mental capacity both in the common law, and in the medical, psychological and ethical literature is related to decision making, the definition of mental incapacity in the Act is essentially a welfare definition. It begins as follows:

mental incapacity means the inability of a person to look after his or her own health, safety or welfare or to manage his or her own affairs, as a result of—

It then goes on to list various conditions. It could be argued that rather than being a definition of mental incapacity, it is actually closer to the definition of "disability" found in some other Acts (such as the NSW *Guardianship Act 1987*). By labelling this concept "disability", it allows

“mental incapacity” to be considered in the usual way it is understood in law, but by labelling this concept “mental incapacity”, it creates potential confusion.

Similarly, with respect to the focus on protection, a person who is the subject of an order under the Act is called the “protected person” in South Australia, suggesting that the purpose of the order is protection rather than substitute decision making. In contrast, in many other jurisdictions, the person under guardianship is called the “represented person.”

Yet, in spite of these protection elements in the substance of the Act, it is clear that the GAA is focused on decision making. The Act establishes the substituted judgement principle as its paramount consideration. It expects that limited guardianship always be considered first as an option, and full guardianship orders only be made when limited guardianship would not be appropriate (*GAA* s 29 (d) and (e)). For example, a guardian’s power may be limited to the areas that decisions need to be made such as health, lifestyle or accommodation. In practice, it is only possible to determine whether a limited or full order is needed by considering areas of decision making. Furthermore, the emphasis in principle 5 (d) is that the decision or order be the least restrictive of the person’s rights and personal autonomy as is consistent with proper care and protection.

These contrasting features have allowed the South Australian Act to be interpreted at different times in both a narrow rights-based way and in a broader welfare-based approach. For example, in the past, it was generally understood that an order would not be granted unless there were decisions to be made, and after decisions were made, an order would be revoked. It was common for a person to be placed under public guardianship for a limited time while a difficult accommodation decision was made, but once the person had settled into their new residence (e.g. a nursing home) an order would be revoked and decision making would revert to the person themselves or to family through informal arrangements.

At the present time, the pendulum has swung back to a welfare approach. The Board’s position is that a Guardianship order sends a signal to the community that a person enjoys special protection, discourages abuse and exploitation, and therefore it does not necessarily follow that the absence of decisions to be made should preclude the making of a guardianship order.

In the current environment of significant gaps in services for vulnerable people, the Board routinely sees many people in dire circumstances who are at risk in some way. A genuine concern for human beings leads to this approach. Anecdotally, it also occurs in other jurisdictions where tribunals ask the staff of public advocates or guardians’ offices to plug the gaps between services on an individual client-by-client basis.

The Public Advocate’s stance is that the Guardianship Board’s concern about welfare issues is moral, ethical, and legal in that it is consistent with the *Guardianship and Administration Act 1993*.

However, our Office disagrees with a welfare approach to guardianship. People with a disability of any type have a right to safety and freedom from exploitation. There is also a right to access necessary services. It should not be necessary to lose one set of rights — in the case of guardianship, the right to make one’s own decisions, and to be recognised as an adult before the law — to acquire these other rights.

There is also a secondary issue of resourcing. Parliament has determined policy settings that support a 'narrow' view of state guardianship. Government has funded the Office of the Public Advocate accordingly. If there is to be a policy shift to a more expansive role, it is preferable for policy to be changed by parliament so that resources can be allocated for this purpose. Of course, the amendments suggested by our Office would reinforce the application of the rights-based model. Any increases in resourcing would only be required to reflect long-term trends related to the number of people in need, rather than a policy change leading to a rapid expansion of guardianship.

It is also possible that in the past, the pendulum had swung so far in the direction of not making orders, that many people who should have been under guardianship were not: for example, some people with a significant intellectual disability living in long-term disability accommodation, without family or friends.

This was not consistent with a rights-based approach either, because although such an approach limits guardianship when alternatives can be found, it also requires that orders be made when needed. Just as a person loses rights by being placed under guardianship unnecessarily, there is also a loss of rights if a person does not have an independent guardian and decisions are made within services by service providers.

The following table (figure A18) illustrates the view of our Office of the contrast between welfare-based and rights-based models of guardianship.

Welfare-based models	Rights-based model
Capacity is defined in welfare terms	Capacity is decision specific
Purpose of appointment: protection	Purpose of appointment: substitute decision making
Appointment can be made even when there are no decisions to be made	Appointment made in the context of decisions
Lower threshold for making an order (underlying philosophy — benign paternalism)	Higher threshold for making an order (underlying philosophy — rights-based legalism)
Less emphasis on the presumption of capacity	Emphasis on the presumption of capacity
Plenary (full) orders are used more often	Plenary (full) orders are discouraged
Orders are ongoing	Orders are time limited

Figure A18: Models of Guardianship

In addition, another factor leading to an increased recognition of the need for orders has been the greater importance placed on the identification and response to restrictive practices now than in the past. This has led to people requiring orders, in particular guardianship with special powers (s32) when they were not on orders but should have been.

Parliament's intention

The current guardianship system emerged from a review of the former Guardianship Board established under the *Mental Health Act 1977*. This 1989 review identified problems to be solved such as a lack of consideration of alternatives to guardianship, because the Board had assumed that alternatives are explored prior to applications being submitted, which was not always the case. The previous system inappropriately restricted and undervalued the potential role of families and carers.

The appendix to the report considered three models of guardianship: legalistic, welfare oriented and 'parent-child', and noted that all states in Australia were considered to follow paternalistic welfare objectives. South Australia was considered to have a welfare approach.

In 1993, when the Bill to establish the Guardianship Board was introduced into parliament, the Minister for Health, The Hon. Martyn Evans said:

The Bill focuses on maintaining family and local support for individuals with a mental incapacity. It seeks to reduce and minimise the level of bureaucratic intrusion into the lives of such people, yet ensures that checks and balances exist for protecting these vulnerable members of the community. (Hansard, 9 March 1993, p. 2350).

The current expansion of the guardianship sector and our office in particular was clearly not envisioned. The Minister said that:

The Public Advocate will operate on the fundamental principle of promoting agency and community responsibility rather than seeking to develop an extensive service provision role for its staff. Thus it will remain a small, but vital, advocacy agency.

The Minister noted that the Public Advocate would seek to resolve problems, so that Board processes need not be invoked.

This restricted role for guardianship was supported by both sides of politics. Mr. Stan Evans said:

For the sake of goodwill, it is important to do all we can to keep a person within the family structure and outside the control of the Guardianship Board. That should be the Guardianship Board's role. It should be the last resort; it should not attempt to go the other way and get as many clients as possible. I support the Bill.

The creation of the registrar role with semi-judicial functions

Further analysis occurred during a legislative and operational review of the GAA undertaken prior to 1999. The operational review led to the Guardianship and Administration (Miscellaneous) Amendment Bill 1999. The Bill created semi-judicial functions for the Registrar. The Hon. Dean Brown noted:

The Registrar may provide preliminary assistance in resolving proceedings before the Board. This may include ensuring that the parties to the proceedings are fully aware of their rights and obligations; identifying issues in dispute; canvassing options that may obviate the need to continue proceedings; and facilitating full and open communication between parties. The Board, the President or a Deputy President may refer proceedings or issues to the Registrar for mediation.

The operation of the Registrar's role is another point of difference between the Office of the Public Advocate and the Board. The Registrar has not been operating with the full delegations as envisaged under this Amendment for some time. Our observation is that the focus of the Board's administrative staff is on scheduling hearings within a 2-week target rather than engaging in a pre-hearing process.

A registrar recognised to be operating with full powers would have the standing to challenge professional applicants although ultimately, this pre-hearing work remains an informal process, and an applicant can still insist on a hearing. Has the applicant considered other solutions? Has all the preparatory work been done that would normally be expected of a case manager or key

worker before seeking guardianship? If the potentially protected person has fluctuating capacity or is currently improving, when should the hearing be scheduled to give the client the best chance of retaining their rights and avoiding an order? Will guardianship be of benefit to the individual, or is the application a strategy to manage the service's risk?

Arguably, the Registrar providing this preliminary assistance is better able to challenge applicants about their reasoning, and suggest other solutions than proceeding to a Board hearing, because the work can be done in a patient, step-wise way through a series of phone calls, letters and e-mails over days or weeks rather than the problems prematurely being brought to a head at a hearing.

In contrast, convening a Board hearing quickly might itself set up expectations that an appointment will be made. The hearing room can be full. There can be many in attendance including, the person who is the subject of the application, family and sometimes a number of workers. The expectation from those who have travelled to the hearing can be that the Board will assist the person in some way, and this can be by making an order.

The pre-hearing work of the Registrar may involve a slow, patient process of negotiation, which can give the client the best possible opportunity of avoiding a guardianship order. It is our view that the Registrar should resume previous delegations as envisioned when the 1999 amendment was passed.

The Nature of Mental Incapacity

The OPA position on amending the principles of the Act is consistent with modern rights-based thinking as espoused in Article 12 of the United Nations Convention on the Rights of Persons with Disabilities.

It is also consistent with a very traditional approach to mental incapacity in the law.

Debelle J in *Dalle-Molle vs Manos* [2004] SASC 102 at 17 summarised the presumption of capacity:

All persons who have reached the age of majority are presumed to have the capacity to enter into contracts or other transactions so that those who assert the contrary bear the onus of proof: Borthwick v Carruthers [1787] EngR 73; (1787) 1 TR 648, 99 ER 1300. The principle applies with equal force where it is alleged that a person lacks the required mental capacity: Re Cumming [1852] EngR 427; (1852) 1 De GM & G 537 at 557[1852] EngR 427; 42 ER 660 at 668; Masterman-Lister v Brutton & Co [2002] EWCA Civ 1889; [2002] EWCA Civ 1889; [2003] 3 All ER 162 at [17]. The plaintiff, therefore, has no onus of proof to discharge. The burden is on those who assert incapacity.

A principle of the presumption of capacity, if added to the *Guardianship and Administration Act*, would bring the Act into line with the common law position of over 200 years.

Similarly, the decision-specific nature of capacity was defined in the High Court nearly 60 years ago. Dixon, Kitto and Taylor JJ in *Gibbons v Wright* [1954] HCA 17; (1954) 91 CLR 423 at [7] said:

The law does not prescribe any fixed standard of sanity as requisite for the validity of all transactions. It requires, in relation to each particular matter or

piece of business transacted, that each party shall have such soundness of mind as to be capable of understanding the general nature of what he is doing by his participation.

So, once again the adding of a principle, in this case defining the decision-specific nature of incapacity, would not be radical.

In fact, it could be argued that the need for such amendments to the GAA is unnecessary, as these principles are so universally recognised that they are inherent in the way our jurisdiction operates. However, the definition of mental incapacity in the current GAA as “the inability of a person to look after his or her own health, safety or welfare or to manage his or her own affairs” clouds this issue.

In 2011, the Client Capacity Committee of the Law Society of South Australia published its Client Capacity Guidelines for legal practitioners. This publication highlights and explains key basic principles about capacity, based on detailed research:

- Capacity is decision-specific and/or time-specific
- Apparent limitations on a client’s ability to understand or communicate information do not necessarily signal incapacity to instruct
- Capacity to instruct is not an ‘all or nothing’ ability
- Different degrees of cognitive ability are required for different transactions
- Bad decisions do not necessarily signal incapacity to instruct
- Some apparent incapacity on the part of the client does not necessarily signal incapacity to instruct on the subject matter of the retainer.

The guidelines go on to recommend client-focused practices, and other strategies that, although not named as such, are consistent with assisted and/or supported decision making. Suggested strategies include breaking up decisions into component parts, and delaying the process of decision making.

The approach to mental incapacity in this authoritative Law Society document is once again consistent with the common law approach. Applied to guardianship, this approach supports the rights-based view, and the addition of the suggested principles to the Act proposed by this Office.

At a systems level, the issue of incapacity can take on greater significance, when the driving reasons for a Guardianship order are factors unrelated to the individual. This can raise questions about where the true “incapacity” arises, as explored in the following table (figure A19):

Examples of other forms of “incapacity”	Alternative response to Guardianship
Family incapacity (e.g. inability to make informal arrangements work due to conflict between family members)	Mediation to avoid guardianship hearing and order
Service incapacity (e.g. limited ability by others to offer suitable accommodation options or necessary professional care)	Advocacy to provide accommodation options professional assessments, care and accommodation
Service and Community incapacity to assist a person make their own decisions	Assisted and Supported Decision Making
Community incapacity to protect vulnerable people	Adult protection responses: Based on UK- and US-style policies or legislation that offer a prompt practical response that seeks to avoid guardianship.
Incapacity of justice system to deter perpetrators of abuse on vulnerable people	A disability justice strategy to be applied by police, prosecutors and the courts that deters perpetrators.
Economic incapacity and social exclusion. People under guardianship more likely to be poor with less access to resources	Practical social work assistance for people who are poor or disadvantaged and unable to access community resources.

Figure A19: Forms of incapacity and response to Guardianship

What is least restrictive?

The *Guardianship and Administration Act* requires that decisions be the least restrictive of a person’s rights and personal autonomy as is consistent with proper care and protection.

However, ‘least restrictive’ is not defined. It is likely that what is seen as least restrictive will vary according to the eye of the beholder.

For example, in the area of mental health, what is seen as least restrictive can vary between policy makers, clinicians and consumers (Clisby and Starr, 2007). It is reasonable to apply this conclusion about what is seen as least restrictive to guardianship as well as mental health practice. Whether or not a limited or full guardianship order is seen as least restrictive may also be a matter of perception.

This is why one of the three principles in the *Mental Capacity Act 2005(UK)* is so potentially useful. In the context of making a guardianship appointment, it defines what is least restrictive. It states:

A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.

This gives a very definite description of what is least restrictive. With respect to a specific decision, a tribunal could ask: What assistance has been offered? How has information been explained? Has the role of a supporter been considered? Does the person have someone in their life who could act as a supporter?

The need to support disadvantaged communities

Elsewhere in this Annual Report, we have presented an analysis of disadvantage of the people placed under guardianship who are more likely to be poorer, isolated and have fewer resources than the general population.

While this may in part be secondary to disability, it is also likely that people from a disadvantaged background who experience a disability are more likely to be brought to the attention of tribunals, than people with a similar disability but who have more social advantages.

While our State does fund public guardianship, we do not fund systems to help disadvantaged people to make their own decisions. If a guardian is required, family members who are disadvantaged and have received less education may need assistance to present themselves to tribunals, and if a private guardian appointment is made, guidance from a private-guardian support program. Currently with our imbalanced system we are more focused on the state taking over people's decision making, than providing tangible assistance to help people make their own decisions, or to help families take on the private guardian role.

Conclusion

Key law reforms suggested in past annual reports will be considered by the Law Reform Institute.

If accepted, this could lead our South Australian system towards a presumption of capacity, a decision-specific understanding of capacity, and a requirement to check that support has been offered before a substitute is appointed.

The Office of the Public Advocate, in promoting a narrow rights-based view of incapacity, does however support people's rights to have access to a service. It may be a clinical or support service, or an adult protection service. The fundamental proposition however, is that it should not be necessary to lose decision-making rights in order to gain advocacy or practical social work assistance.

Social Determinants of Guardianship Project

A project undertaken in 2011 by Advocate/Guardian David Cripps demonstrated the social disadvantage of people under public guardianship compared to the general population. The project analysed demographic data for 45 people under guardianship, in a randomly drawn sample. This was compared with census data for the general population in the 2006 Social and Economic Indexes for Australia (SEIFA), Index of Economic Resources (IER) published by the Australian Bureau of Statistics. SEIFA and the IER have been used in a range of social research settings, especially in health and education. The analysis demonstrated, with 95% certainty, that the population of people under guardianship suffer social and economic disadvantage at a greater rate than the general population. The project was conducted under the academic supervision of faculty of Carnegie Mellon University Australia. The following is a report of the methods used, results, conclusions and implications for practice.

Measures Used

The IER reflects the economic resources of households within an area. There are 15 variables included to measure a wide range of concepts, such as: household income, housing expenditures (e.g. rent) and wealth (e.g. home ownership). Some of the variables, such as those relating to lone-parent families and overcrowded housing, have clear social as well as financial aspects. The method used here is congruent with other instances of similar research. For example, the Australian Institute of Health and Welfare used IER 2006 to measure the social gradient of disability in Australian capital cities.

A **low score** indicates a relative lack of access to economic resources in general. For example, an area may have a low score if there are:

- many households with low income, or many households paying low rent; and
- few households with high income, or few owned homes.

A **high score** indicates relatively greater access to economic resources in general. For example, an area may have a high score if there are:

- many households with high income, or many owned homes; and
- few low-income households, or few households paying low rent.

As census-based data, the ABS recommends using SEIFA IER at the level of the Census District (or CD). A CD is the number of houses that a census collector can reasonably get to on census night. In 2006, a CD equated to approximately 250 houses. Each CD in South Australia is ranked in relation to every other Census District, permitting comparisons to be made. The IER is typically divided up into deciles, percentiles and rankings, with the lowest scores occurring in decile1/ 1st percentile and the highest in decile10/100th percentile. Note that the 2006 edition of SEIFA is the current one, with a new edition due shortly.

Results

The mean rank of CDs in the SEIFA 2006 Index of Economic Resources for South Australia is 1589.

It is reasonable to conclude that there is more disadvantage present in guardianship populations than in South Australia as a whole

The results of our inferential analysis show that we can be 95% confident that the mean CD rank of guardianship populations is significantly less than the mean rank for SA as a whole.

30% of CDs are in the bottom 3 deciles with the most disadvantage in South Australia. The equivalent percentage in the Guardianship population was 42%. Statistical analysis suggest that the true size of the most disadvantaged Guardianship population is likely to be between 30% and 56%. See figure A20

disadvantaged Guardianship population is likely to be between 30% and 56%. See figure A20

Fig 1. Distribution of disadvantage in the guardianship population compared to all South Australians

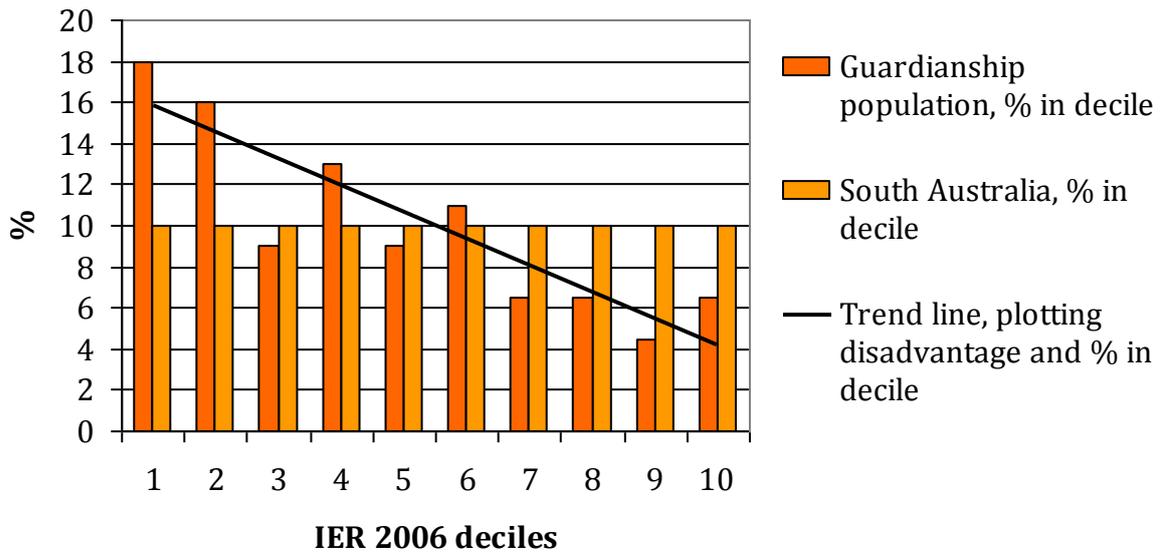


Figure A20: Comparison of disadvantages in guardianship population & South Australians

We conducted secondary analysis on the Social Health Atlas of South Australia, published by the Public Health Information Development Unit of the University of Adelaide. In this analysis, we compared disability and mental health prevalence data between deciles 1–3 (the most disadvantaged group) with deciles 9–10 (the most advantaged group).

This analysis found that the prevalence of disability in deciles 1–3 was 5.2%, whereas in 9–10 it was 4.1%. The difference between top and bottom deciles is 1.1%, a level insufficient to account for the disproportionate amount of disadvantage in guardianship populations.

There were significant differences in prevalence estimates of mental ill health between bottom and top groups. Approximately 70% of areas in deciles 1–3 had greater than expected rates of mental ill health in the Social Health Atlas, compared to 10% in deciles 9–10. Much of this mental illness is associated with younger people. However, when we analysed age data in the guardianship population, we found that in deciles 1–3, 74% of people were over 65, and 26% were under. In deciles 9–10, 80% were over 65, and 20% were under. Given the similarity in age profiles between the top and bottom of the distribution in the guardianship population, it seems unlikely that there is a significantly larger younger population with mental illness at the bottom of the distribution as compared to the top.

Conclusions

On this analysis, there seems to be a disproportionate amount of socio economic disadvantage amongst people under Guardianship Orders.

The relationship between socioeconomic disadvantage and guardianship was significant. A further analysis suggested that this is unlikely to be accounted for by gradients of disability and mental ill health.

Implications

This work is the first analysis of socioeconomic disadvantage and guardianship in Australia. It demonstrates a strong association between guardianship and low social and economic status, but it does not explain the cause of the relationship.

Hitherto, Guardianship Board hearings have focused principally on individual factors such as the presence of mental incapacity and individual conflict. The results of this study strongly suggest that the Guardianship Board should consider the impact that socioeconomic disadvantage has on a potentially protected person equally with these other factors.

It is likely that a person with social and economic disadvantage will have less personal resources to mobilise when confronted by a mental incapacity. It is possible that people experiencing disadvantage may then be more likely to have professionals take their affairs to the Guardianship Board. When in front of the Board they may have less people in their life who might be available to take on a guardian role, therefore increasing the likelihood that the Board will be unable to appoint private guardians as its preferred choice, and instead appoint the public guardian. Similarly, orders are often made due to the presence of conflict surrounding the person under guardianship. More effort at conflict resolution may need to be directed towards families and friends who may also be living in social and economic disadvantage and otherwise have fewer resources to resolve conflict.

A fuller version of this research is available on request from the Office of the Public Advocate.

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.

What is guardianship?

Guardians are appointed by the Guardianship Board (under Section 29 of the *Guardianship and Administration Act 1993*) to make decisions on behalf of individuals who are unable to do so for themselves due to mental incapacity. A person may have a mental incapacity and still be able to make certain decisions in their life on their own or with support. It is important to preserve an individual's legal and personal rights to be in control of their own decision making as far as possible. Guardianship orders should only be made when this is not possible and there are health, accommodation and lifestyle issues which require decisions by a legally appointed guardian. The person under guardianship is called a protected person.

Within the parameters of the *Guardianship and Administration Act 1993*, there can be significant variation in how it is interpreted, and whether an order is required. There is a tension between individual rights and welfare objectives in the Act. This topic has been discussed in Part A of this Report in the section on Promoting Rights.

The principles of the Act require the Guardianship Board to consider whether informal arrangements are working for an individual and to appoint guardians only if there is evidence to the contrary. Informal decisions can be both supported and substitute decisions. The Act permits relatives to make medical and dental decisions when a person has an incapacity without the requirement for a guardian to be appointed, and accommodation and lifestyle

decisions can also be made in an informal way. Informal decision making though can be challenged in the presence of conflict.

The Act also requires the Board to consider the least restrictive intrusion into the life of individuals affected by its orders. This also will lead to the least intrusion in the life of families. The Board will consider whether a limited order is sufficient to address the decision making issues. Guardianship is fundamentally a role for families and friends who know a person well. The Public Advocate should only ever be guardian of last resort.

When guardianship is considered necessary, the Board will look for a suitable guardian within the family or amongst friends. Individuals appointed by the Board are referred to as Private Guardians. However, some people do not have suitable people in their lives who can become private guardians. Some families do not have the confidence to take on the role, or family members themselves may have difficulties making decisions due to their own decision making disability.

Family conflict can lead to applications before the Board, and responding to issues raised in the setting of conflict is a component of the work of the Office of the Public Advocate.

Ideally, adults should have advance directives in place nominating who they wish to look after their personal affairs. If a person has an advance directive appointing another person as their enduring guardian, and that enduring guardian (usually a family member) is in conflict with other family members, then this conflict alone is insufficient reason for the advance directive being overturned. The Board can only revoke the enduring guardian's appointment if the Board finds that the enduring guardian, in that capacity, has acted in an incompetent or negligent manner or contrary to the principles stated in the Act.

Similarly, even when there is no advance directive in place and family conflict exists, the Board can still appoint a private guardian. The District Court in 2010 considered the question of appointment of private guardians by the Board in the presence of conflict. The Court said:

...the mere existence of conflict should not of itself be a barrier to appointment. The crucial matter is whether the conflict will be detrimental to the protected person, in the sense of being likely to affect the proposed guardian's ability to make decisions about the protected person's care, protection and welfare, in a fair, impartial and objective way.

Nevertheless, in the presence of conflict, family members may decline to put themselves forward as guardians because of the pressure that they might be placed under in this role and the task falls to the Public Advocate, even though a private guardian might have been able to make effective decisions.

The Board may also choose to appoint joint guardians. The Public Advocate can be appointed joint guardian with a family member or other person. This could be to assist the private guardian in their role, or act as a safeguard if there are doubts about the private guardian's capability to act alone. At times in the presence of family conflict, the Board has appointed the Public Advocate to liaise with other parties involved in the family conflict and act as a channel of communication with the family member who is joint guardian.

The Board has provisions for making emergency short-term orders for the protection of individuals whose health and wellbeing may be at imminent risk. These orders are called

interim orders. The Public Advocate is usually appointed until such time as the matter can be fully considered by the Board. In some cases, there are family members who are willing and able to take on this responsibility; in others, the orders simply lapse because the issue requiring attention has been resolved.

Public guardianship and its operation

As previously stated, the Public Advocate is appointed as guardian of last resort where no suitable private guardian exists or the Board decides on a joint appointment with a private guardian.

The Public Advocate delegates some aspects of his authority to employees of the Office of the Public Advocate who in turn become responsible for substitute decision making for particular protected persons. Decisions that are more complex remain the responsibility of the Public Advocate or his senior staff. Concerns about decisions made by delegated guardians or processes used can be referred to the Public Advocate who ensures that a review of the decision or processes is conducted by a more senior officer.

The current legislation does not provide for legal appeal mechanisms against a decision of the Public Advocate after this decision review is complete. To provide an avenue for further appeal, the Public Advocate will offer to interested parties to take the matter to the Guardianship Board seeking advice or direction under S74 of the Act should any of the parties still have a significant disagreement with the decision of the Public Advocate.

Under s74, The Board can issue directions to the Public Advocate which are legally binding. As they are decisions of the Board, they are also subject to the appeal mechanisms in the Act and available to protected persons and other interested parties thus providing individuals with an additional external legal remedy. If a person is dissatisfied with the advice or directions given by the Board to the Public Advocate, the nature of the Board's advice or directions, they can appeal to the appeals division of the District Court.

Similarly, s74 is available should there be a disagreement in decision making between joint guardians. (in the Complaints section of this Annual Report there is a discussion about the benefit of law reform to allow people to appeal decisions made by the Public Advocate.)

Central to guardianship decision making is the application of the principles of the Act to the individual circumstances of each client. These principles have been reproduced in Part A of this Report. Paramount consideration must be given to what would be, in the opinion of the decision maker, the wishes of the person if he or she were not mentally incapacitated, but only so far that these are reasonably ascertainable. The present wishes of the person should be considered, and a decision should be least restrictive of the person's rights and autonomy, as is consistent with his or her proper care and protection.

In addition to the principles contained in the Act, public guardianship is practised in accordance with the United Nations Convention on the Rights of Persons with Disabilities. In October 2009, the Australian Guardianship and Administration Council updated the National Standards of Public Guardianship to be consistent with this convention, in particular Article 12.

These standards are accessible from the AGAC website (<http://www.agac.org.au/agac-publications>).

In particular, the standards state:

Accordingly for all people there is a presumption of capacity and all possible efforts should be made to assist a person exercise their own capacity. When a person does not have full legal capacity, such incapacity is decision specific, and therefore a person's decision-making capacity needs to be considered for each and every decision.

These standards guide practice in guardianship and are consistent with the common law view of incapacity. Notwithstanding the terms of a guardianship order, a delegated guardian will consider whether or not the individual under guardianship can make a decision themselves or with support (a supported decision) rather than the guardian making a substitute decision. As discussed in Part A, we consider that it would be ideal if the principles of presumption of capacity, and the decision-specific nature of capacity could be incorporated into the Act.

The 2009 Australian Guardianship Standards also refer to Advocacy:

Represented persons have a right to access housing or accommodation, health care, support services, and assistance to participate in the community.

Staff making guardianship decisions will:

Assess whether all options have been presented to the decision maker by service providers, and seek to recognise when a preferable option has not been presented.

Make all possible attempts to advocate for the best option so that a decision can be made between meaningful options that improve both quality of life and opportunity for the represented person.

This advocacy work can comprise a significant part of an advocate/guardian's workload.

Guardianship Activity 2010-11

During 2010–11, the Office of the Public Advocate provided guardianship services under the *Guardianship and Administration Act 1993* on behalf of 793 people (705 in 2009–10). This represents a 12.5% increase over the previous year and reflects a continuing upward trend. In the previous three reporting periods, the increases were 6.7%, 9.6%, and 17%. This is illustrated in Figure B1.

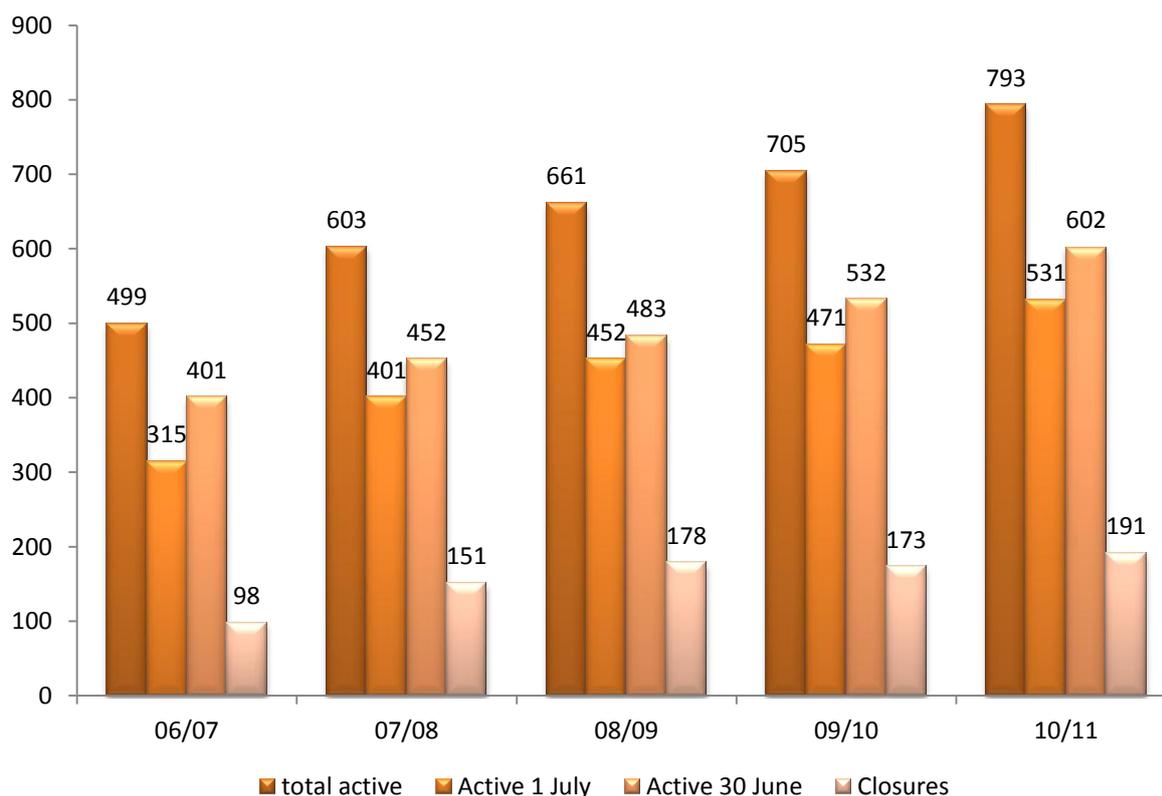


Figure B1: Guardianship Activity 2006–2011

The number of active cases managed by the Office continues to grow. The rate of growth each year is largely due to the number of new cases exceeding closures each year.

As at 30 June 2011, there were 602 active guardianship cases compared with 531 at the beginning of the year — a 13.4% increase in active cases at year-end. This also represents a 50% increase since 2006–2007. This is depicted in the next chart (Figure B2).

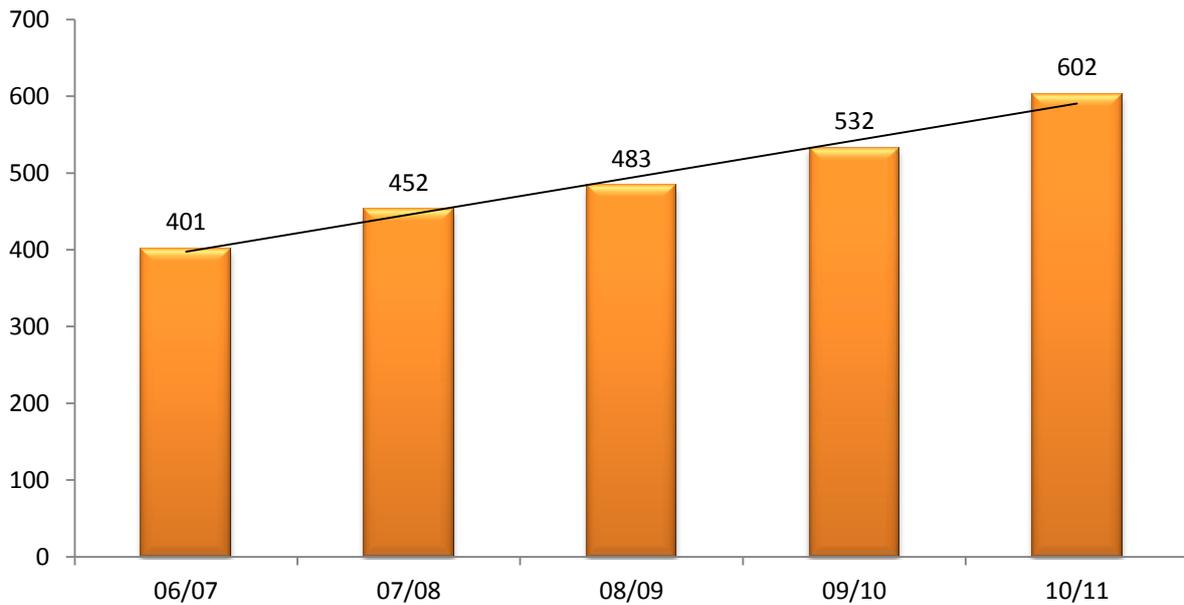


Figure B2: Comparison of Active cases as at year-end 2006–2011

This year, 258 new Public Advocate guardianship appointments were made, a 10% increase on last year’s figures (234). The following graph (Figure B3) shows a continuing upward trend. Of the 258 new appointments, 150 were limited orders, 96 were full orders and a further 25 were full and limited orders involving joint appointments with family members. 71 matters involved an interim order. 133 (53%) were allocated to the short-term team in the expectation of a need for short-term guardianship only.

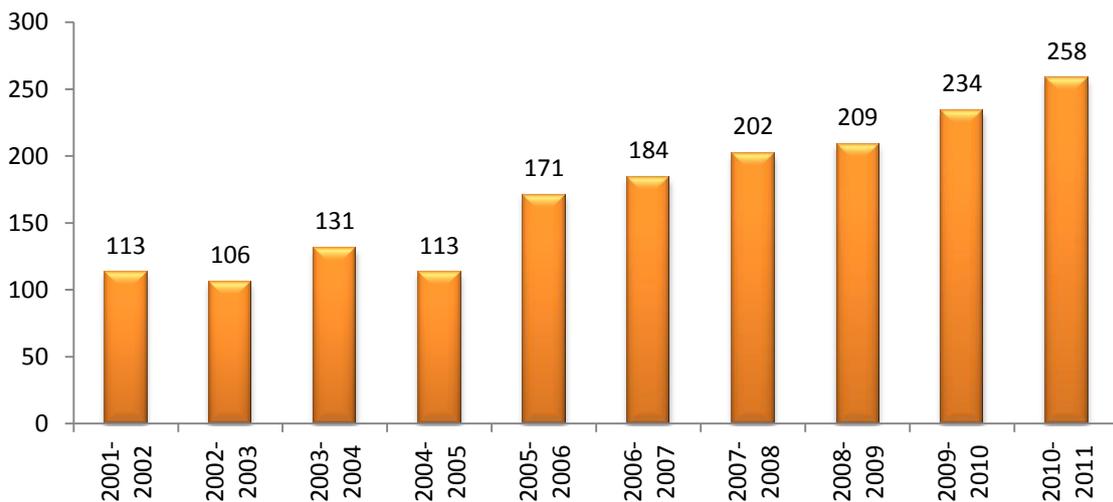


Figure B3: New appointments 2001– 2011

The number of new statutory appointments made each year has steadily increased over the past decade, most likely due to the demographic processes (see Figure B3). However, other policy and practice issues impinge on the rate of appointment such as legal interpretations of the need for guardianship, changing practices within the Guardianship Board itself and contemporary risk-management concerns by service provider organisations. The Office of the Public Advocate may exert some influence on these factors but, in the end, is not in control of its workload.

During 2010–11, 191 cases were closed — an increase of 10% (18) when compared to 173 closures in 2009–10. Of the 191 closures, 84 were due to revocation of orders, 67 due to death, and 40 due to private guardians being appointed. Reasons for closure are illustrated below (Figure B4). This year there was a reduced percentage of closures due to revocation by the Board. This is analysed in more detail in the following pages.

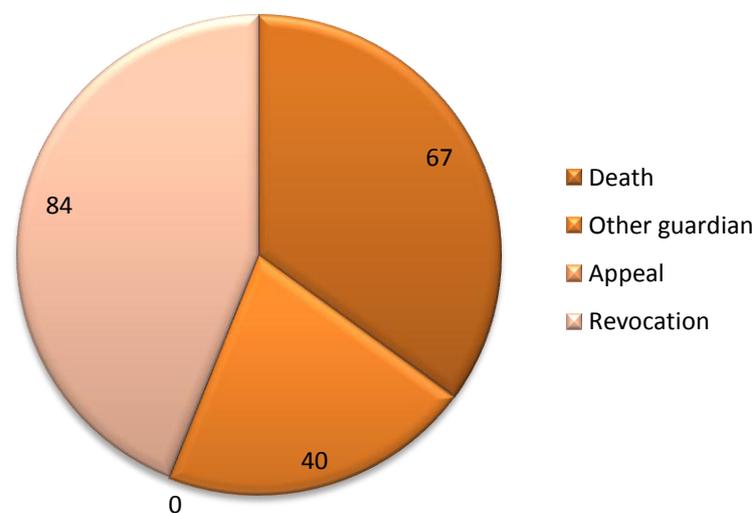


Figure B4: Reasons for closure of guardianship cases 2010–2011

The rate of closures in 2010–11 as a percentage of all orders was 24.1%. This compares to 24.5% in 2009–10. Rates of closure for the past 6 years are illustrated in Figure B5 demonstrating a relatively steady pattern over time.

Figure B6 compares numbers of guardianship cases and closures over a 3-year period. This reporting period represents the lowest rate of closure of the past 4 years.

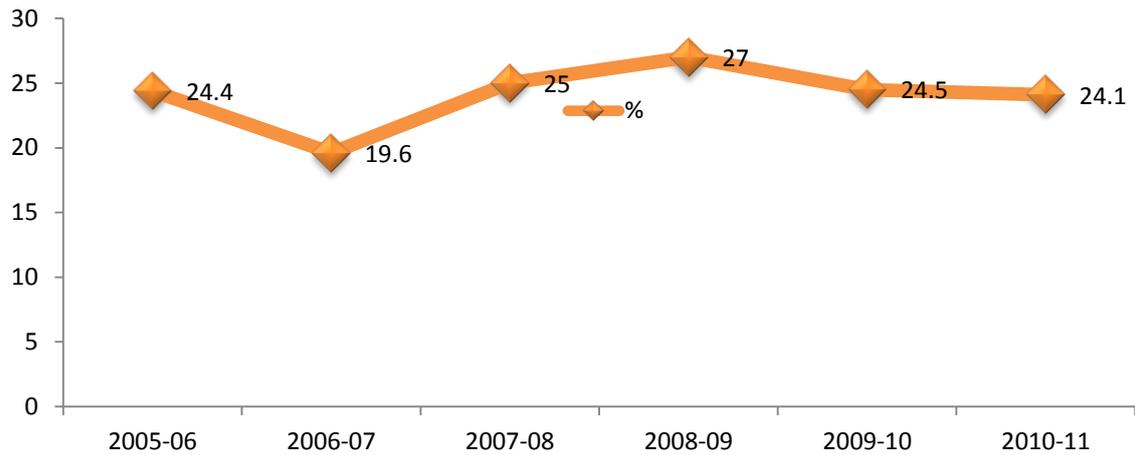


Figure B5: Rate of Guardianship closure 2005-2011

Closures as Percentage of Guardianship Services Provided				
	2007/2008	2008/2009	2009/2010	2010/2011
Closures	152	178	173	191
Services	603	661	705	793
%	25.2	26.9	24.5	24.1%

Figure B6: Closures 2008-2011 as % of all guardianships

The next table (Figure B7) compares reasons for closure for a 3-year period.

Reason for Guardianship Closures									
Reason	2008/2009			2009/2010			2010/2011		
	Number	% of Closures	% of G Services	Number	% of Closures	% of G Services	Number	% of closures	% of G Services
Revoked	118	66%	18%	110	64%	16%	84	44%	11%
Deaths	53	30%	8%	40	23%	6%	67	35%	8%
Private guardian	7	4%	1%	19	11%	3%	40	21%	5%
Other	-	-	-	4	2%	0.5%			
Missing	-	-	1	-	0	1	-	-	-
Closures	178	100%	27%	173	100%	21.5%	191	100%	24%

Figure B7: Reasons for closure 2008-2011

Of those clients whose guardianship orders were revoked during the year, 39% were under guardianship for less than 12 months, 71% for less than two years and 77% for less than three years.

Whilst the number of cases closed this reporting period exceeds the previous year, it is interesting to note that revocations as a percentage of closures have gone down by 22% over the past three reporting periods and private guardian appointments up by 16%. Death as a reason for closure has fluctuated. The figure below takes a longer-term view of closures representing activity for the past seven reporting periods (Figure B8).

Closure Type	04/05	05/06	06/07	07/08	08/09	09/10	10/11
Revocation	58	56	51	96	118	110	84
Death	22	42	44	51	53	40	67
Private guardian	5	8	0	4	7	19	40
Other	0	0	3	0	0	4	0
Total closed	85	106	98	152	178	178	191
Total Active	349	430	499	593	661	705	793
% total active cases closed in year	24.3	24.7	20	25.6	26.9	25.2	24.1

Figure B8 Guardianship Closure Patterns from July 2004 to June 2011 Inclusive

The Board has a policy of actively seeking the appointment of private guardians. This is supported by the OPA and the practice would appear to be reflected in the number of cases shifted to a private guardian after the initial appointment of the OPA, particularly from interim order appointments. This strategy helps to slow the rate of growth of public guardianship. Although it may not be possible to find a family member or friend prepared to take on this role at the time of an initial hearing, it is not uncommon to find that with new arrangements (such as nursing home placement) there may be family or friends prepared to then be guardians for ongoing decisions.

On the other hand, our staff members have noted the Board's reluctance to support some OPA requests for revocations. The Board's concerns include the welfare of elderly people in nursing homes who do not have an involved family or friend, and concerns about the ongoing authorisation and monitoring of psychotropic medication in elderly people who have dementia. These factors have contributed to the reduction in revocations of Public Advocate guardianships.

In addition, as discussed in Part A in the section on Deprivation of Liberty, there has been a significant change in practice regarding the use of detention powers under the *GAA* for people in aged residential care facilities. Those clients who are at risk of wandering are now judged as needing ongoing guardianship orders to legally validate their confinement. In the past, their guardianship orders would have been revoked when they settled into secure care.

These issues have led to delays in final consideration of revocation of orders and, in some matters, the ultimate continuation of orders because of these concerns. It is also known from

past experience that, as caseloads rise, it is more difficult to review stable cases with a view to preparing a report to the Board asking for revocation of orders. This, and the lack of staff devoted to monitoring work, would also contribute to the relative reduction in revocations.

Figure B9 below compares the number of closures which have occurred as a result of revocation over the past seven reporting periods.

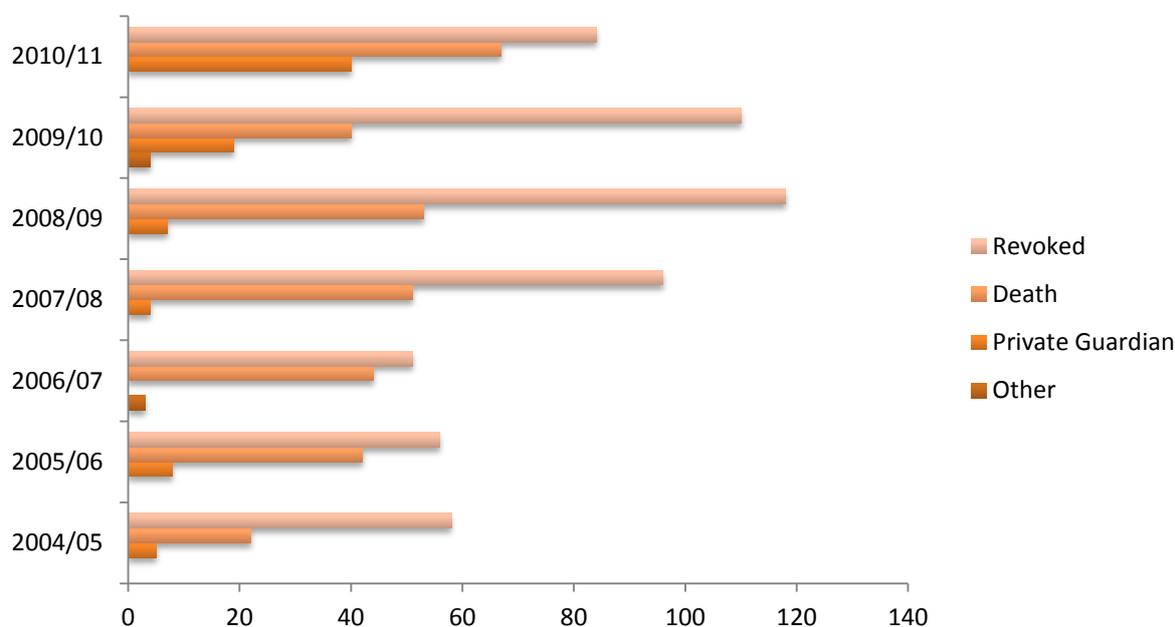


Figure B9: Guardianship Closure type as a % of all closures for past 7 reporting periods

During 2011-12, the OPA will collate data on reviews initiated by the Board and by the Public Advocate in order to better understand the relationships between recommendations and outcomes.

The average length of guardianship for closed cases was 1.75 years (median 1.2yrs). This compares with an average length of 1.7 years (median 1.3yrs) in the 2009–10 reporting period. Average length of guardianship has risen slightly between the past two reporting periods but median length has reduced.

The tables (Figure B10 and Figure B11) below compare age groupings and diagnostic groupings with length of guardianship for those cases closed in 2010–2011. As with the previous reporting period, clients with a diagnosis of dementia had shorter lengths of guardianship on average than all other diagnostic groupings. However, age seemed less of a predictor of length of guardianship than in the previous reporting period.

A small cohort of clients with intellectual disability stood out because of their significantly longer period under guardianship. This reflects the likely ongoing nature of issues requiring substitute decision making, including issues around the authorisation of restrictive practices in response to behaviour of concern (addressed in Part A of this Report).

Guardianship Cases Closed in 2010-2011

DIAGNOSIS, AGE AND LENGTH (months) OF GUARDIANSHIP

Diagnosis	Number	Average length (months)	Median Length (months)	Age at end of Order	Number	Average Length (months)	Median Length (months)
Brain Damage	15	23	15	<41	25	26	12
Dementia	92	17	12	41<71	57	20	11
Mental Illness	32	27	19	>71	109	20	14
Intellectual Disability	14	30	29				
Dual Diagnosis	27	23	12				
Other	11	5	2				
Total	191	21	13		191	21	13

Figure B10: Closed guardianships diagnostic and age profile

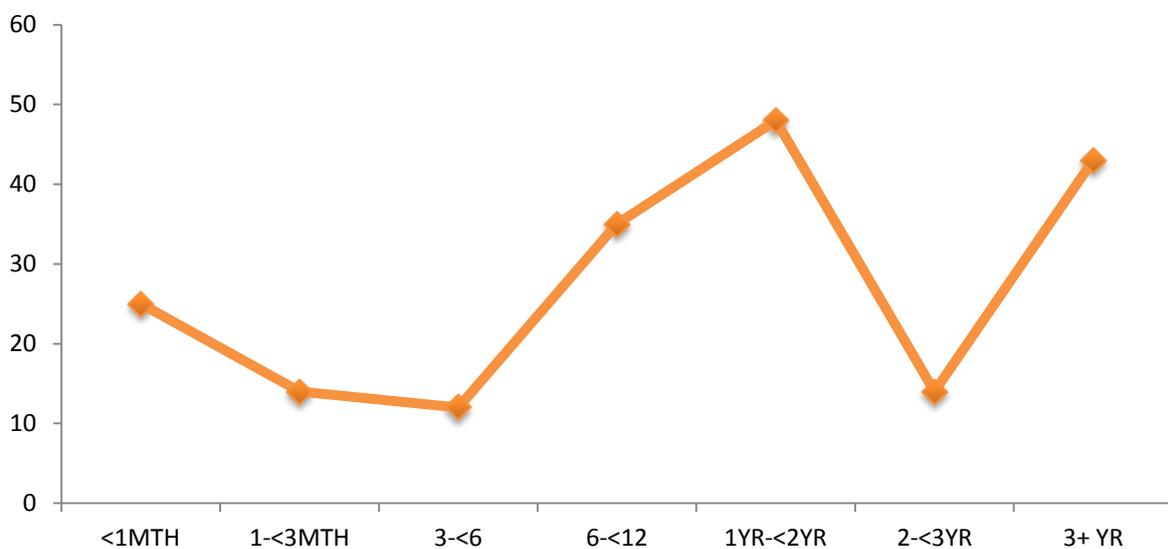


Figure B11: Number of closed cases by length of guardianship (for cases closed in 2010-2011)

For the 602 guardianship cases open as at 30 June 2011, the average length open was 2.3 years (median 1.6yrs). 28% of these cases had been active for over 3 years.

The table below (Figure B12) compares length of guardianship for those cases open at the end of the past two reporting periods and those closed during these reporting periods. The rise in percentage of closures occurring in the first 12 months of appointment is indicative of the rise

in interim statutory appointments (71 this reporting period) which then lead to private guardian appointments. In contrast, the length of guardianship profile for end-of-year active guardianship cases remains similar to the previous reporting period.

Length of active guardianship				
Comparison of length of Guardianship	Open cases 30/6/ 10	Open Cases 30 /6/11	Closed cases 2009/10	Closed Cases 2010/11
Average years	2.3	2.4	1.7	1.75
Median years	1.6	1.7	1.3	1.1
Less than 12mths	36%	34%	38%	45%
12mths to < 2yrs	24%	22%	31%	25%
2yrs to < 3yrs	14%	16%	14%	7%
3 years plus	26%	28%	17%	23%

Figure B12: Length of guardianship

The graph below (Figure B13) compares active cases as at 30 June, from June 2008 to June 2011 and their length as at those dates.

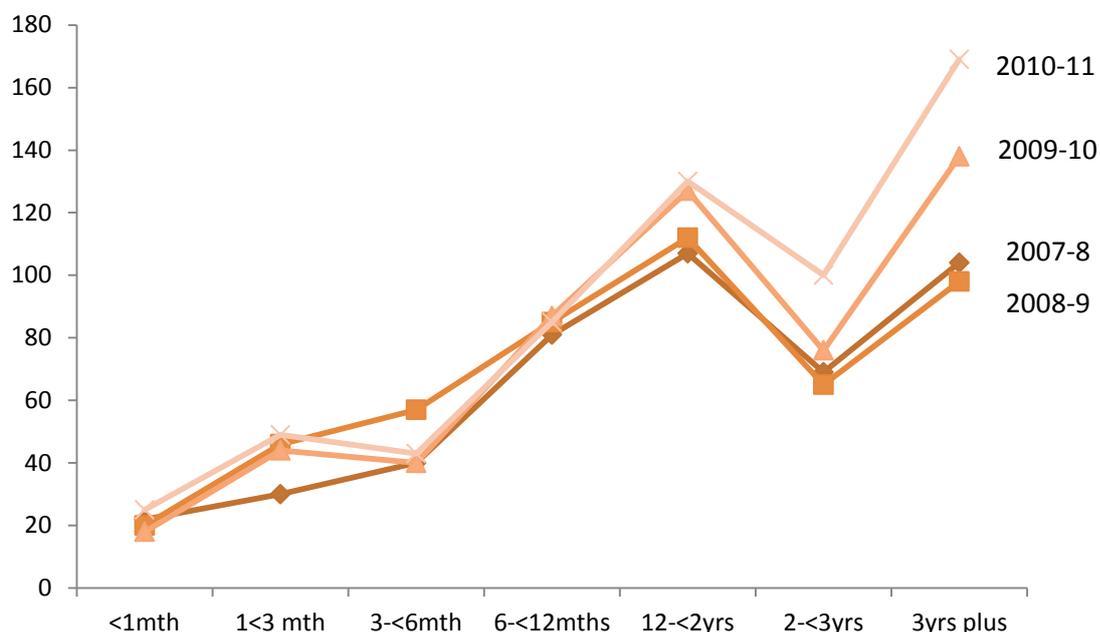


Figure B13: 4-year comparison of Length of guardianship for open cases as at 30 June each year.

The age profile of active, new and closed guardianship cases as at 30 June 2011 is compared in the table below (Figure B14). Note that the over 70s age group accounts for 58% of the new

guardianship cases (44% in previous reporting period) and 57% of those closed. However, in the end-of-year active caseload, their representation reduces to 32%. This is the group which has the highest rate of turnover. Note also the significant drop in new cases in the middle-age range over the two reporting periods.

Age Profile of Closed, Active and New Guardianship Cases 2009–2011						
	Closed Cases 2009 - 10	Closed Cases 2010-11	Active Cases 30/06/2010	Active Cases 30/6/2011	New Cases 2009 - 10	New Cases 2010-11
Age < 41 years	21%	13%	29%	28%	21%	24%
41 to 70 years	33%	30%	36%	40%	35 %	18%
> 70 years	46%	57%	35%	32%	44%	58%

Figure B14: Age Profile of guardianship clients 2009–2011

Diagnostic profiles of all guardianship clients active during the reporting period are illustrated in the following chart (Figures B15). Clients with dementia as the primary underlying cause of mental incapacity are the biggest category (186), followed by intellectual disability (132) and mental illness (127). There were 99 people with a dual or multiple diagnoses and 56 with some form of brain injury.

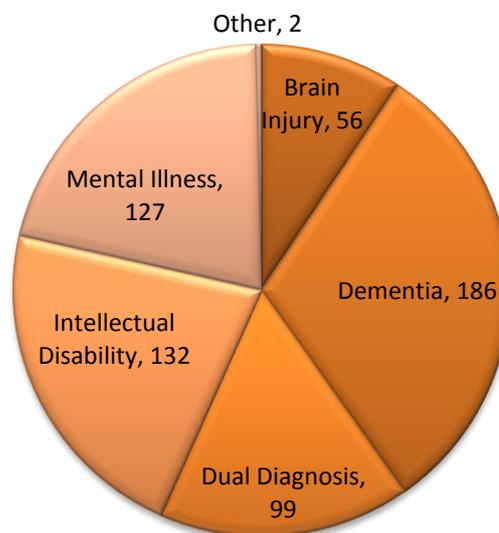


Figure B15: Diagnostic profile all active guardianship cases 2010–2011

Use of Enforcement Powers by Guardians

32 - Special powers to place and detain etc protected person

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

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

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

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

Guardians consent to and monitor the use of s32 powers by service providers. Guardians require evidence of the need to exercise restrictive practices and a plan for their implementation in the least restrictive way possible. During this year, the Office of the Public Advocate upgraded its requirements for authorising restrictive practices. The background to this is described more fully under Section A of this Annual Report.

Section 32 powers and all active guardianship cases 2010–2011

In the 2009-2010 annual report results of an extensive audit of S32 powers was published. This year focus has been on new orders. In 2010–2011, 171 active guardianship clients (21.6%) were subject to orders of the Board under section 32 of the Act at some time during the reporting period. This compares with 146 (21%) in the previous reporting period. Note that a proportion of these S32 orders was made prior to this reporting period and continued into the 2010–2011 financial year and beyond.

Section 32 powers and new guardianship cases 2010 2011

Of the 258 new guardianship orders made in 2010–2011, 88 matters (34.5% of new guardianship clients) subsequently involved the granting of S32 powers at some time during this reporting period.

72 of the 88 matters (82%) involved the granting off S32 powers at the initial hearing or within two weeks of the initial order being granted.

51 of the S32 orders granted were made within the context of an emergency interim order where the Guardianship Board appointed the Public Advocate as guardian without a full hearing due to the urgency of issues about which decisions were required. As the Public Advocate was appointed as guardian on an interim basis in 71 matters in 2010–2011, 72% of interim orders appointing the Public Advocate included the granting of special powers under section 32 of the Act.

Of these 88 matters, there is evidence that the statutory guardian issued directions using the S32 powers in 41 cases (46.6%). In last year’s report, we discussed the greater use of directions in matters where S32 powers were sought later in the lifetime of the guardianship order — where the application for section 32 powers by the guardian was for a specific issue rather than as a precautionary measure in the beginning stages of guardianship.

Of the 88 matters, 41 had their section 32 powers “ceased” during 2010–2011. This may be due to the lapsing of an interim order, transfer of a matter to another (private) guardian, death of a client or revocation of the order by the Board. 27 of these “cessations” (66%) occurred in the first four weeks of the guardianship order, probably due to lapses, appointment of other guardians or a lack of justification for their continuance when interim matters were presented to the full Board for hearing.

Of the 88 cases, 29 were actually closed by the OPA during the reporting period — 7 clients died, 9 had family or friends appointed as alternative guardians and 13 had their guardianship orders revoked (lapse of order or revocation by the Board).

Of the 88 orders of S32 powers issued by the Board, 50 were under S32(1) (a) enabling a guardian to issue directions regarding residence, 44 provided the Board’s authority for the protected person to be detained in the place of residence in accordance with S32 (1) (b) and 35 included authority for the use of reasonable force as provided for in S32 (1) (c) of the *Guardianship and Administration Act 1993*. This is depicted in the chart below (Figure B16)

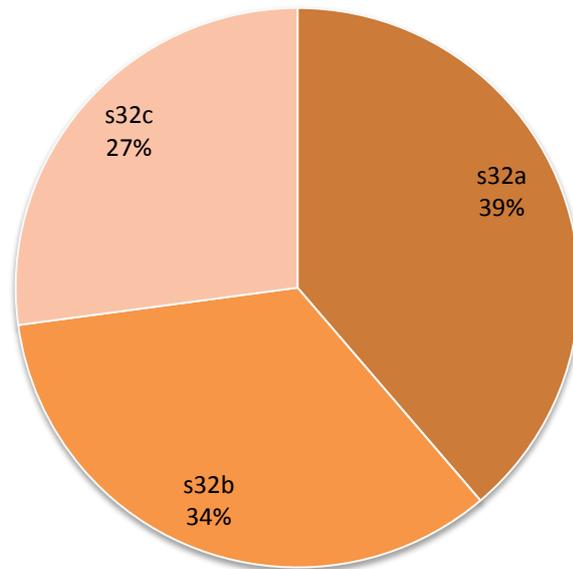


Figure B16: Breakdown of Section 32 Orders 2010-2011

The key reasons for issuing s32 directions were outlined in our previous Annual Report as:-

- Accommodation: To direct accommodation change or direct that the protected person remain at the same place of residence unless a shift is authorised by the guardian
- Detention: To direct that a person not leave a premises or to prevent them from being removed by another person
- Restraint or force used: To authorise some form of seclusion, confinement or physical intervention which could be construed as restraint
- A combination of the above and/or health care intervention requiring physical or pharmacological restraint or force to perform the procedure.

Rate of Appointment of Public and Private Guardians South Australia

Of 975 applications for consideration of the appointment of a guardian received by the Guardianship Board of South Australia during the 2010–2011 financial year, 258 (26.5%) resulted in the appointment of the Public Advocate compared with 234 (23.9%) in 2009–2010 and 209 (30.1%) in 2008–2009.

465 (47.7% of all applications) led to private guardian appointments in 2010–2011 compared with 256 (26%) in 2009–2010 and 197 (28.4%) in 2008–2009.

723 of the 975 applications (74.2%) resulted in the appointment of a statutory or private guardian compared with 490 (50.5%) in 2009–2010 and 406 (58.5%) in 2008–2009. These figures are presented for the previous five reporting periods in the table below (Figure B17).

YEAR	06/07	07/08	08/09	09/10	10/11
Guardianship Applications	709	734	694	978	975
Guardianship appointments	318	402	406	490	723
% resulting in appointments of guardians	44.9	54.8	58.5	50.1	74.2
% resulting in appointments of the Public Advocate	26.1	27.5	30.1	23.9	26.5
Numbers of Public Guardianship appointments	185	202	209	234	258
Numbers of Private Guardianship appointments	133	200	197	256	465
% of Guardianship Orders which are Public Guardianship	58	50.2	51.5	47.7	32.5

Figure B17: Comparison of Applications and Guardian Appointments July 06 to June 2011

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

The graph below (Figure B18) illustrates the trends in appointment of guardians in the past five years. Whilst the OPA numbers have increased steadily, the rise in private guardianship is much more significant, increasing by 200 between the past two reporting periods. This appears to reflect a major shift towards protective strategies on the part of the Board.

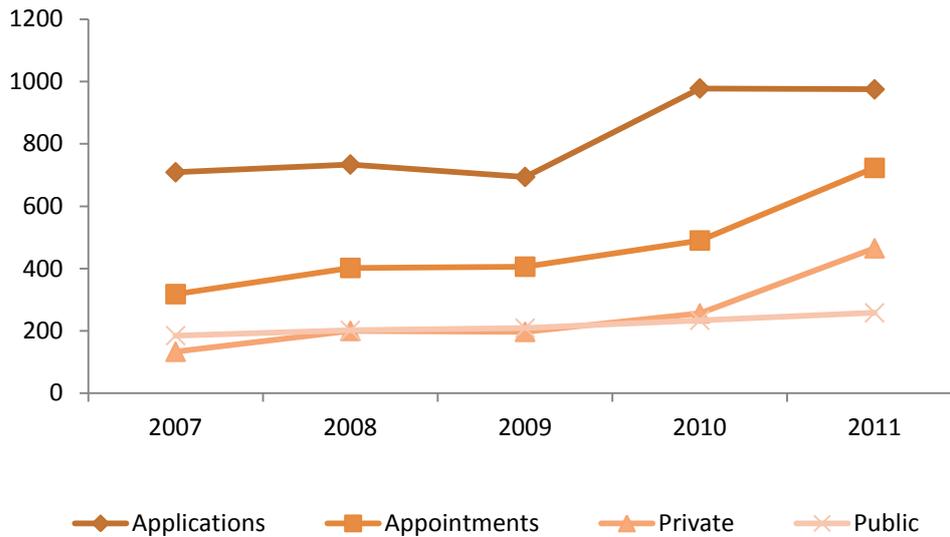


Figure B18: Numbers Guardianship Appointments July 2006 to June 2011

The case for least restrictive application of the Act

The OPA has advocated assertively that competent individuals make provision for a substitute decision maker through the execution of advance directives (Enduring Power of Attorney and Enduring Power of Guardianship in particular). Through this mechanism, individuals can choose whom they believe will represent their views and wishes should they lose mental capacity.

However, when it comes to externally imposed substitute decision makers, OPA has asserted, in line with the principles of the Act, that the application of protective guardianship and administration orders should only be considered as a last resort strategy. That is, it should only be imposed when there are decisions to be made that cannot be supported through informal mechanisms. The data above reflect a substantial increase in the number of guardianship orders being made in the past year (mainly private appointments). It is the view of the OPA that this escalation is due to the Board applying a much broader interpretation of the need for guardianship than in the past, rather than an alternative explanation that there has been an alarming increase in the number of people needing formally appointed substitute decision makers.

The historical understanding of the legal guardian function is one of substitute decision making and this is accepted in all jurisdictions across Australia. However, this interpretation is not imbedded in South Australian legislation and the principles of the Act are open to broad interpretation. Consequently, guardianship can be interpreted as having a purpose in a variety of ways such as advocating for services, acting as a watchdog on quality of care and running interference between family members who are in conflict. The OPA holds the view that the appointment of guardians chiefly to achieve these types of outcomes is in conflict with the rights of people with disabilities to take their place in society as full citizens. Further, we do not believe that guardianship is the appropriate mechanism to achieve system-wide accessible quality services. This is one of the reasons why the Public Advocate continues to press for

legislative reform which provides more focused use of the Act and better recognition of the legal rights of individuals with disabilities.

Further background to these issues and a restatement of the need for legislative reform is contained within Section A of this Report: Monitoring Legislation.

Prevalence of Public Guardianship

The prevalence of public guardianship in South Australia has increased this reporting period from 32.6 to 36.5 people per 100,000 of the general population. Comparative figures are not available from other states for this reporting period: however, in the previous year we were mid-range compared to other jurisdictions (the range — from 26.1 to 44.1 people per 100,000).

Guardianship team structure

The OPA has operated a two-team structure since December 2008. New guardianship clients are allocated according to predicted length of time for which active guardianship would be required. The 'short-term' team takes on guardianship for people who are likely to require intensive guardianship work for approximately 6 months. Because of the nature of its work, this team tends to provide guardianship for older people. The 'longer-term' team tends to have younger people with an intellectual disability, head injury or mental illness.

The teams meet weekly to allocate work and monitor issues. Staff review their caseloads regularly with the responsible Senior Advocate/Guardian and clients of both teams are transferred into a 'monitoring' caseload when their circumstances stabilise. This client group is managed through the short-term team although clients might be reallocated back to the long-term team for particular guardianship activities if the need arises. Between 20% and 30% of guardianship clients are within the monitoring caseload at any given time.

Review of the two-team model and guardianship activity

The work allocation system is under constant review so that improvements in efficiency and effectiveness can be achieved. An activity review was conducted in May 2011 to compare team throughput and average length of guardianship for cases closed to the end of April 2011.

This report was initially completed for internal management purposes, hence only covered 10 months of the financial year. Extracts from the review are included here as a report. Some statistics have been adjusted since the review to reflect the full year activity.

The table below (Figure B19) describes the rate of case throughput per full-time equivalent for each team for the full financial year. Note that these figures are indicative only because there is additional movement of cases back and forth between the teams and 'monitoring' which is not captured.

These data support the model's assumption that there would be a higher rate of throughput in the short-term team.

Team Projections	Active Case throughput 2010-11 reporting period		Monitoring	Total Cases 2010-11
	Number Opened per FTE worker	Number Closed per FTE worker	Number of Monitoring Cases closed	Number of Cases managed per FTE worker
Short Term Team (3.5 FTE)	38	23.4		
Long Term Team (6.7 FTE)	18.7	11.8		
Combined Teams	25.9 per FTE	18.3 per FTE	31*	77.6 per FTE
NB Senior Advocate Guardians not counted in guardian numbers				
* No specific resource allocated to the monitoring cases as at June end (covered by staff from guardianship teams).				

Figure: B19 Comparison of Short- and Long-Term Team Throughput 2010–2011

The review demonstrated the following case breakdown between teams for the period July 2010 to April 2011:

- 56% of new guardianship cases were allocated to the Short-Term Team, 44% to the Long-Term Team
- The rate of case closures per FTE was substantially higher for short-term team members as expected.

Figure B20 below compares the average end-of-month caseloads per FTE in each team for a 6-month period in the 2010–11 reporting period. For most of the reporting period, the monitoring caseload lacked devoted resources because the enquiry /monitoring staffing levels operated at between 1 and 1.2FTE and resources were almost entirely directed to the information and advisory service.

Team	November 2010	December 2010	January 2011	February 2011	March 2011	April 2011
Short	32	33	34	35	31.5	34
Long	37	38	38	38	37.5	39
Monitoring	112	113	115	118	131	129

Figure: B20 Average end-of-month caseloads per FTE short- and long-term teams

A subsequent check after this review indicated that, by June end 2011, the average caseloads for teams had risen to 35.5 for the short-term team and 40.4 for the long-term team.

As part of the team activity review, analysis of closed guardianship cases was undertaken. This demonstrated differences between the teams with respect to average length of guardianship. This is illustrated in Figure B21 below. Note that these figures do not include the monitoring cases which have substantially longer average and median lengths of guardianship than the team figures (for those cases closed in 2010–11 study period).

Length of Guardianship Period for Cases Closed by Teams	Long Term Team	Short Term Team	Difference
July 2010-April 2011			
Average 1.84yrs	588 days or 19.6 months	404 days or 13.5 months	184 days or 6.1 months
Median 1.12yrs	383 days or 12.8 months	309 days or 10.3 months	74 days or 2.5 months

Figure: B21 Comparison of Average and Median Length of Guardianship (Closed Cases July 2010 to April 2011) by Short and Long Term Teams

The split of active guardianship cases between the teams and monitoring was also reviewed. The figure below (B22) illustrates end-of-year figures.

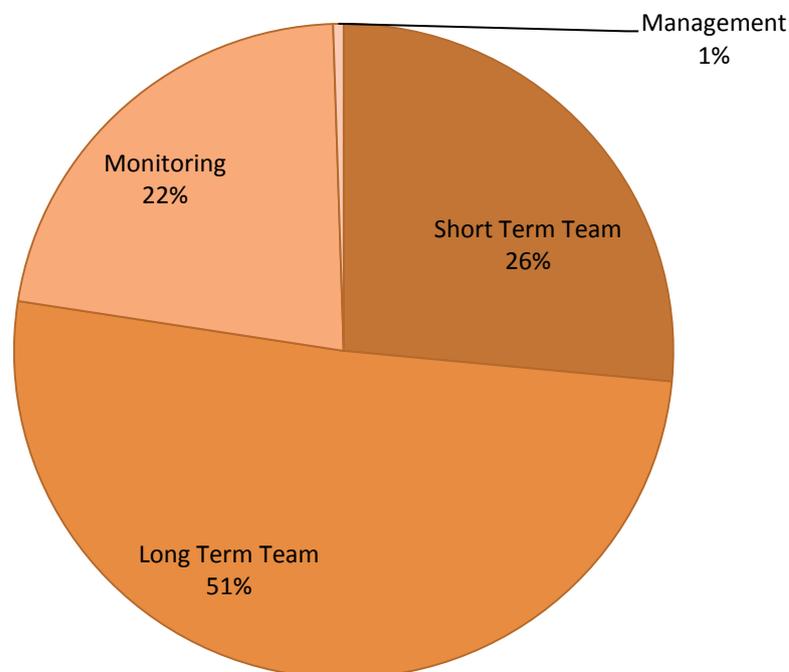


Figure B22: Allocation of open guardianship cases across teams as at end June 2011

The data analysis completed in May 2011 and reviewed again at the end of this reporting period demonstrates that the assumptions of the two-team model have been supported in practice. Whilst there are significant differences in throughput and average length of guardianship between teams, there has not been an overall change in average and median lengths of guardianship for all cases when compared with the performance of the service prior to and after the introduction of the two-team model.

Whilst rate of throughput is a significant factor in managing the upward creep of guardianship numbers, it is not the only determinant of the effectiveness of the introduction of the two-team approach. The model has been positively received by staff as an approach to specialisation and effective practice strategies. Staff rotation, however, is under consideration to ensure that all staff members have a balanced opportunity for skill development.

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 provisions of section 28 are very broad and could allow an open-ended inquiry into all aspects of a person's life. In practice, the investigation focuses on particular issues. Social workers who are advocate/guardians undertake these investigations by contacting all relevant parties to obtain their views, reviewing available documentation and assessing the information obtained.

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

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

Increasingly, staff undertaking these investigations have been requesting that the Board be quite specific about the nature and the extent of the investigation it requires so as to avoid unnecessary intrusion into people's lives, and to minimise delay.

The investigation process, however, defers the decision making of the Board for an average of 3 months due to the complexities of the investigative processes and the fact that hearings are not rescheduled until the OPA report has been received. In matters where the Board determines that a decision maker needs to be in place on an interim basis, the Public Advocate may be appointed as guardian pending the outcome of the investigation. The OPA separates its decision making and investigative functions in such circumstances by appointing different workers to fulfil each of these roles. In this way, we aim to ensure transparency and procedural fairness in the investigation without compromising the need for timely decisions on behalf of the protected person.

Number of investigations 2010–2011

The Office of the Public Advocate responded to 36 requests from the Guardianship Board to investigate matters before the Board.

- 14 were open at the beginning of the reporting period,
- 22 were opened during the year and
- 11 remained open as at 30 June 2010.

Review of Investigation Practices Follow Up

In the 2009–2010 annual report, we reported in detail on an internal review of our investigations practices. This led to an upgrading of our guidelines and an exploration of alternative ways of conducting investigations.

This year, internal workload issues led to exploring of alternative sources of assistance for the conduct of investigations. Because the workload is unpredictable, outsourcing of some investigations is under consideration subject to availability of suitable investigators, funding capacity and obtaining relevant approvals for the delegation of the powers of the Public Advocate to individuals who are not employed within the public sector.

In addition, the OPA has contributed to discussions regarding the establishment of an accredited investigator-training course suitable for staff members who have investigative responsibilities and are employed within the Justice sector. This course has now been approved and the OPA will ensure that several OPA staff members have the opportunity to enhance their qualifications and skills in this area.

Attendance at initial hearings of applications for Guardianship Orders

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

Preparation for the hearing involves reviewing the written application and, where appropriate, making submissions to the Guardianship Board on the merits of the application, the scope of proposed guardianship decisions and the appropriateness of appointing the Public Advocate as guardian. In some cases, additional information will be obtained from the applicant and family members prior to the hearing and/or the subject of the application will be visited. In the Office, this work is referred to as a “screening” matter.

Given the OPA’s commitment to the principles of the Act and, in particular, our focus on autonomy and self-determination for individuals who have a disability, alternatives to guardianship will be suggested wherever possible (e.g. advocacy for services or accommodation). The preservation of natural relationships and the least restrictive approach to guardianship when it is required are also important principles underpinning recommendations for the appointment of a family member as guardian, or advocating for a more limited appointment than initially requested by the applicant.

The Supported Decision Making Project, which commenced seeing clients during the 2010–2011 financial year, models an alternative to substitute decision making for those clients who have the potential to control their own decision making when provided with appropriate and sensitive support. The OPA staff have been involved in recommending a supported decision-

making approach rather than guardianship orders for suitable individuals who are the subject of applications to the Board.

During 2010–2011, the OPA staff reviewed 321 applications which nominated the Public Advocate for appointment as guardian. This compares with 280 matters in 2009–2010. 158 (49%) were allocated to the short-term team and 143 (45%) to the long-term team for screening and attendance at hearings. The OPA is sometimes appointed as guardian without prior knowledge through the screening processes. This is usually when the Board changes the guardian during the review of a private guardianship order or when an emergency order is made. It is therefore not possible to make a direct comparison between the number of matters attended by the OPA staff and the number of the OPA appointments made.

Combining the number of investigative activities performed in each year, the following picture emerges (Figure B23).

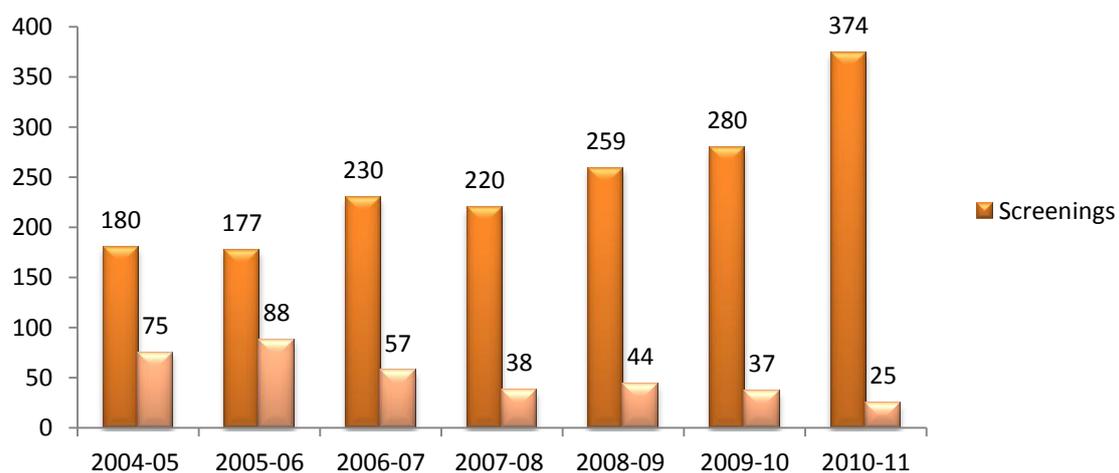


Figure B23: Number of Guardianship Applications Screened & Investigations Undertaken 2003-2011

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 2010–2011, there were no applications for warrants made by the Public Advocate. There have been no warrant applications made by the Public Advocate in the past decade.

Nevertheless, the use of a warrant has been actively considered on occasion — usually when family or friends are concerned about a person they believe to have a mental incapacity. Other strategies have been found; for example, assisting families to meet with services to arrange voluntary home visits.

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 extensive advocacy for people under guardianship. Advocacy is also undertaken as part of our information and enquiry and advisory service. The OPA officers will intervene on behalf of individuals who have a mental incapacity or on behalf of their carers in an attempt to ensure that they receive assistance. This can solve minor issues, which might otherwise have led to guardianship or administration applications to the Board.

The OPA works closely with other advocacy services, referring many matters to these organisations. On occasions, organisations collaborate in order to achieve the best outcomes for clients.

Advocacy matters are referred by clients, their families, other services and members of the public, including the media. Advocacy activities include:

- Provision of letters from the Public Advocate asking questions on behalf of a member of the public, a family member or a person who has a disability
- Assisting with Freedom of Information applications to clarify other service actions and issues
- Providing support to participants in significant case conferences e.g. to private guardians who are trying to negotiate service outcomes for a protected person, with family members who have particular service concerns
- Raising systems issues arising from the treatment and care of persons with a disability
- Assisting a person lay a complaint with a relevant agency.

A number of individual advocacy matters are accepted by the OPA each year. There were 48 new advocacy matters in 2010–2011. Comparison of the past 5 years is featured below (Figure B24).

	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011
Total Active	59	50	44	56	89
New Cases	28	23	27	43	48
Closed Cases	32	41	22	18	23

Figure B24: Advocacy Clients and Diagnosis

Advocacy and Guardianship Board Processes

Guardianship and Administration Act 1993

14. Powers and Procedures of the Board

- (9) A person is entitled to appear before the Board—
 - (a) personally or by counsel; or
 - (b) if he or she is the person the subject of the proceedings—
 - (i) by the Public Advocate; or
 - (ii) except where the proceedings are appeal proceedings—by a recognised advocate; or with the permission of the Board, by any other representative

In our past two annual reports, we have raised our concerns about the lack of routine access to advocacy services for clients appearing before the Board for both Guardianship Act and Mental Health Act matters. Whilst several advocacy services assist clients and families in Board hearings, there is no automatic right of representation and individuals need to be able to make these arrangements themselves. This is often at a time when these individuals are least equipped to exercise their rights.

As previously indicated in our past reports, the above extract from the *Guardianship and Administration Act 1993* indicates that legislators envisaged that the Office of the Public Advocate and other recognised advocates would take an active role in providing individual advocacy before the Board. In our last report we stated:

This role has never been resourced in this office. By way of example, mental health consumers are routinely advised in writing that the Public Advocate can lodge an appeal on their behalf, but, in reality, the OPA very rarely becomes actively involved in these processes. We do provide information via our enquiry service and will provide information to callers about advocacy agencies that work in this jurisdiction. The Disability Advocacy and Complaints Service of South Australia does provide such advocacy. Their service can be greatly appreciated by those who use it, but they are not expected to be available for all matters.

And again, we state:

It remains our view that either the current legal representation scheme should be extended to cover all Guardianship Board matters, or a system which ensures that

all people have access to a lay advocate from this office or elsewhere should be established.

Court related matters

In civil legal matters, when a person is unable to instruct a lawyer because of a mental incapacity, the Court may appoint the Public Advocate to 'stand in the shoes of' the person — to be their 'litigation guardian'. The Public Advocate or delegate then instructs the lawyer, on behalf of that person. This involves taking time to get to know the issues involved and the person's views and preferences, understanding and clarifying legal advice and recognising the consequences of particular courses of action. It is likely to involve meetings with the client, and lawyer, reading court documents, attendances at Court, and signing agreements or court documents with or on behalf of the person. The client may not agree with all decisions made and the role can be time consuming and difficult.

A litigation guardian may have particular responsibilities under legislation regulating the particular matter (e.g. the *Family Law Act 1975*), and the Court's own Act or Rules in addition to following the principles of the *Guardianship and Administration Act 1993*. These different duties do not always neatly coincide, requiring awareness of multiple obligations. The litigation guardian acts in the interests of the person, consistent with these obligations. This role falls within the mandate of the Office of the Public Advocate to promote and protect the rights and interests of people with a mental incapacity.

The OPA commenced the reporting period with five active litigation guardianship matters. A further 10 were opened during 2010–2011. Matters involved included actions in the Youth Court, the Federal Magistrates Court, and the Supreme Court and were about a range of issues involving care of or contact with children.

The OPA internal Litigation Guardianship Protocol was further refined during this year and sent to similar jurisdictions and the South Australian Courts for feedback. The response has been positive.

Advocacy on issues

Part A of the Annual Report highlights some of the systemic issues which have been considered by this Office. The Public Advocate and staff have been involved in a number of other matters during this year. The OPA seeks through whatever means possible to further the interests of people whose lives are affected by mental incapacity.

Education

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

There are a number of groups and organisations that conduct education sessions on similar topics to those for which the OPA may be approached. In particular, the provision of information on advance directives is undertaken by a number of organisations. We share responsibility with these organisations and where possible, informally coordinate our efforts in an endeavour to respond appropriately to all requests and to spread the commitments between us.

The Office of the Public Advocate accepted 43 of 58 invitations to speak at conferences and meetings during 2010–2011. Refusal is usually based on short notice of requests or the appropriateness of the request to the OPA. Several matters were referred on to the Legal Services Commission which has an advisory role on advance directives, wills and other legal processes. Requests accepted by the Office ranged across discussion of the role of the OPA, aspects of legislation affecting the lives of those who have a mental incapacity and advance directives provisions.

The Public Advocate has presented at a number of conferences, workshops and training programs during this period.

In addition, the Public Advocate presents comments on advocacy matters and information about advance directives and guardianship through radio, print and TV media when opportunities arise.

The Public Advocate and the Senior Practitioner involved in the Supported Decision Making Project have also accepted invitations to travel to New South Wales and Queensland to present on the supported decision-making model and progress with the project.

An important educative function is the provision of factual information suitable to service providers and members of the community, in particular, on the provisions of the *Guardianship and Administration Act 1993* and the *Mental Health Act 2009* and the *Consent to Medical Treatment and Palliative Care Act 1995*. A series of Fact Sheets is available on the OPA website and in paper form for distribution as required.

Over the past three years, the OPA has promoted the use of its website as a vehicle for presenting updates on issues of concern and new events. In an effort to encourage debate and transparency, the Public Advocate displays his annual reports, conference papers and his submissions to relevant inquiries through this medium.

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 South Australia Police. It is committed to improving the system's ability to prevent and respond to the abuse and neglect of older people. The Alliance has a website and brochures designed to assist in abuse prevention and protective mechanisms (www.apea.org.au).

Alliance representatives collaborate in delivery of education sessions and also provide cross agency consultancy to find solutions for individual matters of abuse and neglect.

Alliance members formed an important part of the groups consulted in the Vulnerable Adults Project referred to in Part A of this Report.

The OPA has contributed financially to publication of Alliance literature on advance directives.

University of South Australia Collaborative Research Project on Mediation

The Office of the Public Advocate continued its commitment to the prevention of abuse of older South Australians by collaborating with the University of South Australia, the Minister for Families and Communities, Relationships Australia, Alzheimer's Australia (SA) and the Guardianship Board to secure an Australian Research Council Linkage Grant. This two-year study aims to design, pilot and evaluate specialised models of older-person centred family mediation for both primary and secondary levels of intervention as strategies to prevent the abuse of older people by their family members, to apply in situations where the older person has capacity, diminished capacity or lacks capacity.

As a member of the Reference Group, the Office of the Public Advocate provides advice and guidance based on our experience in the area of financial abuse and neglect.

This year, the project has been seeking family groups who may need mediation assistance to resolve aspects of suspected financial abuse or neglect. This work is consistent with our role providing alternatives to guardianship and will provide valuable information for the OPA as it considers the development of family mediation/conflict resolution and communication systems as part of proposed advance care directive reforms in South Australia.

Enquiry Service

During 2010–2011, the OPA capped its staffing allocation to 1.2FTE for its enquiry services. This was as a result of the need to redirect resources to the active guardianship function. Enquiry staff also perform monitoring and review functions for stable guardianship clients. The time allocated between enquiry and guardianship functions varies according to the demands of both activities. In addition, a substantial amount of administrative staff time is spent dealing with enquiries from the public. These staff screen and prioritise calls and provide factual information on behalf of the OPA.

Enquiries are made by people who have a disability, their family members, health care professionals and others providing services. Each person contacting the service may call on a number of occasions to make more than one enquiry. Wherever possible, follow up calls are linked to the first enquiry for the purposes of continuity and are counted then as one episode of enquiry.

This year, there were 3490 discrete episodes of enquiry. A comparison with previous years is graphed below (Figure B25). The substantial drop in 2006–2007 coincides with a new database recording system which has improved our ability to link callers with their previous enquiries.

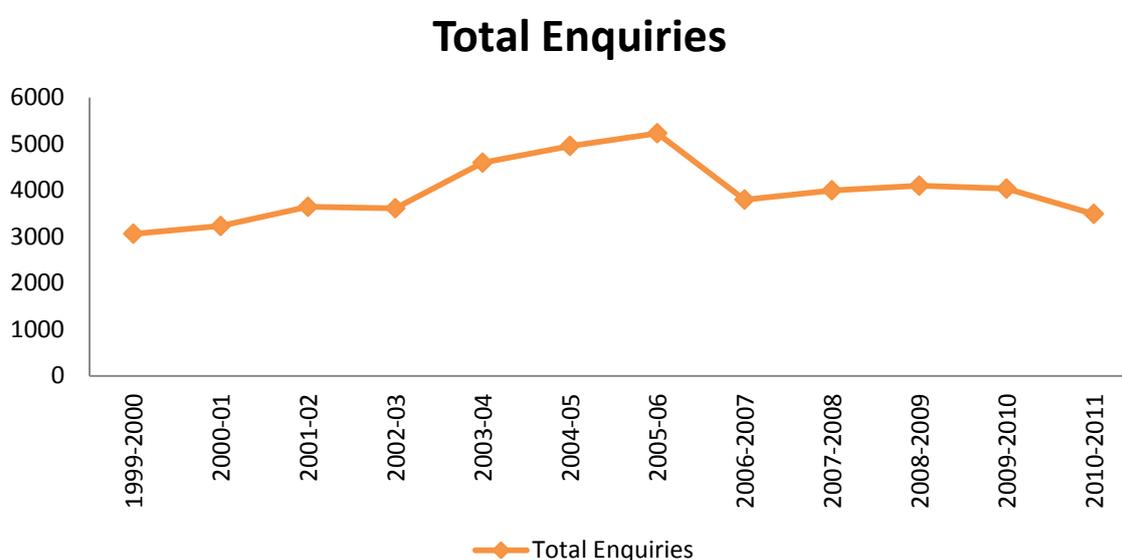


Figure B25: Number of enquiry episodes July 1999 to June 2011

Lack of growth in enquiry episodes over recent years may reflect improved alternative sources of information and advice from other sources, the availability of information on the OPA website and the introduction of the Guardianship Board’s own website.

Common reasons for seeking advice include requesting information about advance directives, guardianship and administration orders, Guardianship Board hearings and mental health appeals. The table below provides a breakdown of issues raised and the disability groupings recorded as part of the enquiry. An individual enquiry may raise more than one issue. Figure B26 below identifies the main issues raised in enquiries during the last reporting period; advance directives and guardianship and administration matters are the most common issues raised.

Enquiries 10 -11 Issues	Number
Mental health issues	370
Guardianship issues	1008
Administration issues	866
Advance Directives	856
Total issues raised	5012
Discrete Episodes 10-11	3490

Figure B26: Issues Raised in Enquiries

Review of Information and Advisory Service Practices, Procedures and Staffing

During 2010–2011, the OPA trialled the use of an experienced administration officer in an Information Officer role.

The incumbent took enquiries from reception and provided factual information on the various Acts and the role of the Guardianship Board, sought assistance of rostered professional staff when required to give advice to the public and, in complex matters, transferred the enquiry to senior staff.

Preliminary findings are that an experienced administrative officer with good knowledge of facts about the jurisdiction can answer some of the calls provided that there is accessible professional back-up. The Advance Care Directives reforms will likely involve the OPA in the provision of more advice and assistance in this area. An integration of the current Enquiry service and these expanded functions should allow the development of a suitable administrative/professional resourcing mix.

After Hours emergency response

OPA senior staff and experienced advocate guardians who put themselves forward to do after hours work participate in an after-hours roster on behalf of the OPA and the Guardianship Board. The roster covers 5p.m. to 9:00a.m. weekdays and 24 hours a day on weekends and public holidays. The duty worker responds to public enquiries and emergencies regarding registered clients. Approximately 40 emergency matters per month require attention after hours. These range from requests for emergency guardianship orders and consent to medical treatment to requests for a direction from a guardian. Remote access systems allow the staff member to identify current orders of the Board and recent activities in order to provide the best possible information and advice.

The work is growing each year and the OPA may need to provide a more dedicated after-hours resource in the future so that staff rostered on do not have the expectation of attending work the next day, having worked over night.

Complaints and Decision Reviews

The OPA believes that a robust guardianship-decision review system is part of the natural justice processes which should be afforded to clients of the service and to interested parties. Such a system is a way of ensuring that evidence-based decision making has occurred and that procedural fairness is implemented. Complaints also provide a source of feedback on how well the service is performing.

The OPA publishes on its website an information sheet titled *Office of the Public Advocate Complaints Policy* describing its internal complaints and review mechanisms and the availability of the Office of the Ombudsman for external complaints. In addition, an information sheet titled *Guardianship and The Public Advocate: Information for Families and Friends* is sent to key interested parties at the commencement of guardianship. This includes guidelines on how to challenge guardians' decisions.

The administrative actions and processes of the OPA are also subject to review by the State's Office of the Ombudsman.

Wherever possible, complex guardianship decisions are ratified by senior staff before they are announced to ensure that the process has been comprehensive and the decision is supportable. Some matters still involve dissatisfied parties who seek a reconsideration of decision and/or the processes used. Many of these concerns are resolved through further negotiation with the responsible staff members: however, interested parties are entitled to contact the Public Advocate to seek a formal review if these processes do not resolve their concerns.

The OPA offers several levels of review through its Senior Advocate Guardians, Assistant Public Advocates and ultimately through the Public Advocate. As there are no legislated mechanisms for external review of guardians' decisions, the Public Advocate can also apply to the Guardianship Board to seek advice and direction under the provisions of Section 74 of the Act. In this way, an independent review of current issues and decisions can be provided. If the Board issues directions, these are legally binding on the Public Advocate and his staff. Because decisions of the Board are appealable to the Administrative and Disciplinary Division of the District Court, interested parties have a right of further recourse if they are still dissatisfied.

For practical purposes, a concern about the OPA practices is recognised and registered as a formal complaint when one of the senior officers of the OPA is required to review the circumstances of a decision or concerns raised by the client or an interested party.

During this reporting period, the OPA upgraded its protocols and data collection methodology for managing complaints and formal reviews of guardianship decisions. The OPA also records requests from ministers and members of parliament, Ombudsman's requests and applications under Freedom of Information (FOI) legislation in this database. This allows monitoring of any duplication of complaints across the various complaints bodies and helps in identifying trends in issues raised. The OPA protocol is designed to ensure consistency of approach to complaints and review processes, to capture opportunities for systems improvement and to ensure feedback to the appropriate parties.

The OPA sets process benchmarks for the handling of complaints.

- The majority of complaints were formally acknowledged within the 7-day period stipulated. This acknowledgement requirement does not apply to FOI, ministerial and Ombudsman's matters as external deadlines are imposed by these bodies.
- The OPA aims to complete complaints investigations within a 3-week period or at least to advise the complainant of progress at that time. This year's data demonstrate that the OPA has had some difficulty meeting this benchmark. Further work will be undertaken to look at our processes during the next reporting period.

Part of this difficulty reflects the detailed nature of some administrative reviews. It can also reflect the delay in obtaining opinions from medical specialists, psychologists, occupational therapists or other experts. This is because some of the matters involve reviewing the professional opinions on which a decision has been based, and obtaining either a further review or second opinion to meet the concerns of the person who has asked for the review.

Activity

During 2010–2011, the OPA acted on

- 14 formal complaints/requests for decision reviews,
- 5 Freedom of Information applications, and
- 5 ministerial requests

Totalling 24 separate matters.

These related to 12 individuals — 11 were under guardianship and 1 was a request for historical information.

One matter was taken to the Guardianship Board under S74 of the Act following a series of complaints about the OPA's decisions.

- 8 of the matters raised concerns about decisions made by delegated guardians
- 5 raised communication issues
- 3 raised concerns about OPA procedures or accuracy/sufficient of information provided by OPA staff
- 2 raised concerns about the attitude of a staff member
- 5 raised a variety of other matters
- Some matters were requests for information or explanation only (e.g. FOI/ministerial)

This year's decisions about access to a protected person have been the most contentious..

Concerns have been expressed in certain instances that the Public Advocate has unreasonably limited access to a protected person by a family member who should have more access, or failed to limit access of a family member who should have access limited.

In other situations, access schedules designed so that the vulnerable person would not be exposed to conflict between family members have been the subject of concern. For example, the times allocated to each party can be challenged. Complaints are also made about decisions in

situations when the Public Advocate is joint guardian with another family member. In these situations the complaint is about joint decisions, but the Public Advocate is challenged as to whether the Office has acted appropriately in agreeing to a decision either taken by the joint private guardian and agreed to by this Office, or made jointly with the private guardian.

Responses

The response to these complaints has been to undertake detailed administrative decision reviews, examine known facts, and how they have been applied to decision making.

These reviews, mostly undertaken by Assistant Public Advocates, are thorough. Sometimes they lead to new solutions—for example, new access arrangements, so the review has been beneficial. Even when an original decision is upheld, we would hope that the stepwise consideration of the facts used, and how the decision is made will give further detail on process, even though at times one or both parties may still be dissatisfied with an outcome/decision.

Given that many of our decisions are in contested areas—where one party agrees to and wants one outcome and another party wants something different—decision reviews and complaints about decisions are an inevitable part of our jurisdiction. Our Office will continue to rely on decision review systems that escalate decisions in our Office, and then provide access to Guardianship Board advice and direction through section 74. Ultimately, a sound decision may not satisfy all the parties, but the actual process of making the decision should, as parties see a fair process, conscientiously applied. Should a party still disagree there should be opportunities for second opinions, further reviews and external scrutiny.

In the future we can see benefit in amending the *Guardianship and Administration Act 1993* to give people affected by decisions of the Public Advocate a right of review by a tribunal. We endeavour to do this currently by offering access to Guardianship Board advice and direction under s74. However, a right to tribunal review would be clearer if it enabled parties to apply for review directly. In New South Wales, a person affected by a guardianship decision made by the Public Guardian can apply to the Administrative Decisions Tribunal for a review. Although this only actually happens a few times each year, it is an important right.

With respect to our own processes, complaints are also an opportunity to test our own decisions and further improve practice. In 2012, our Office will further examine our process for making access decisions, in order to see if there are alternative ways to improve access decision making and implementation of access arrangements. Our systems will need to evolve further as these issues are likely to become more common in the future.

Freedom of Information (FOI)

This year, for the first time in many years, there were Freedom of Information (FOI) requests made for case files. The most extensive requests came from family members seeking the files of elderly relatives who were either under guardianship, or receiving advocacy assistance.

Obtaining case notes is likely to have reassured some of the applicants, but for our Office, the process has been time consuming. While a person has a right to know any information that may have been used in the making of a decision, our files will contain information given to an advocate/guardian from many different family members, friends, health professionals and lawyers. The person giving the information is usually talking to the guardian not expecting that notes of conversations might potentially be read at a future time by other parties, even if the

information has not been used as the basis for making a decision. For this reason, consultation is undertaken with third parties before information is released as part of the FOI process.

Following the release of information under FOI, there have been rare situations where other parties has been reluctant to provide further information because they are fearful of the person who might request it if it is recorded in our case notes. While the safety of a person who gives us information should be protected as part of routine FOI processes, it does take some reassurance to third parties to provide information, who are aware of the potential for FOI requests.

We have been grateful for the assistance of officers in the Attorney-General's Department who have managed FOI requests on our behalf. While our staff have had to provide advice on the significance of material, the process of sifting through records, contacting third parties, and making recommendations on the application of the *Freedom of Information Act 1991* has been undertaken by officers of this group in the Department.

The observation of our Office is that the *Freedom of Information Act 1991* provisions have generally worked well with our guardianship file — managing the interests of applicants and third parties.

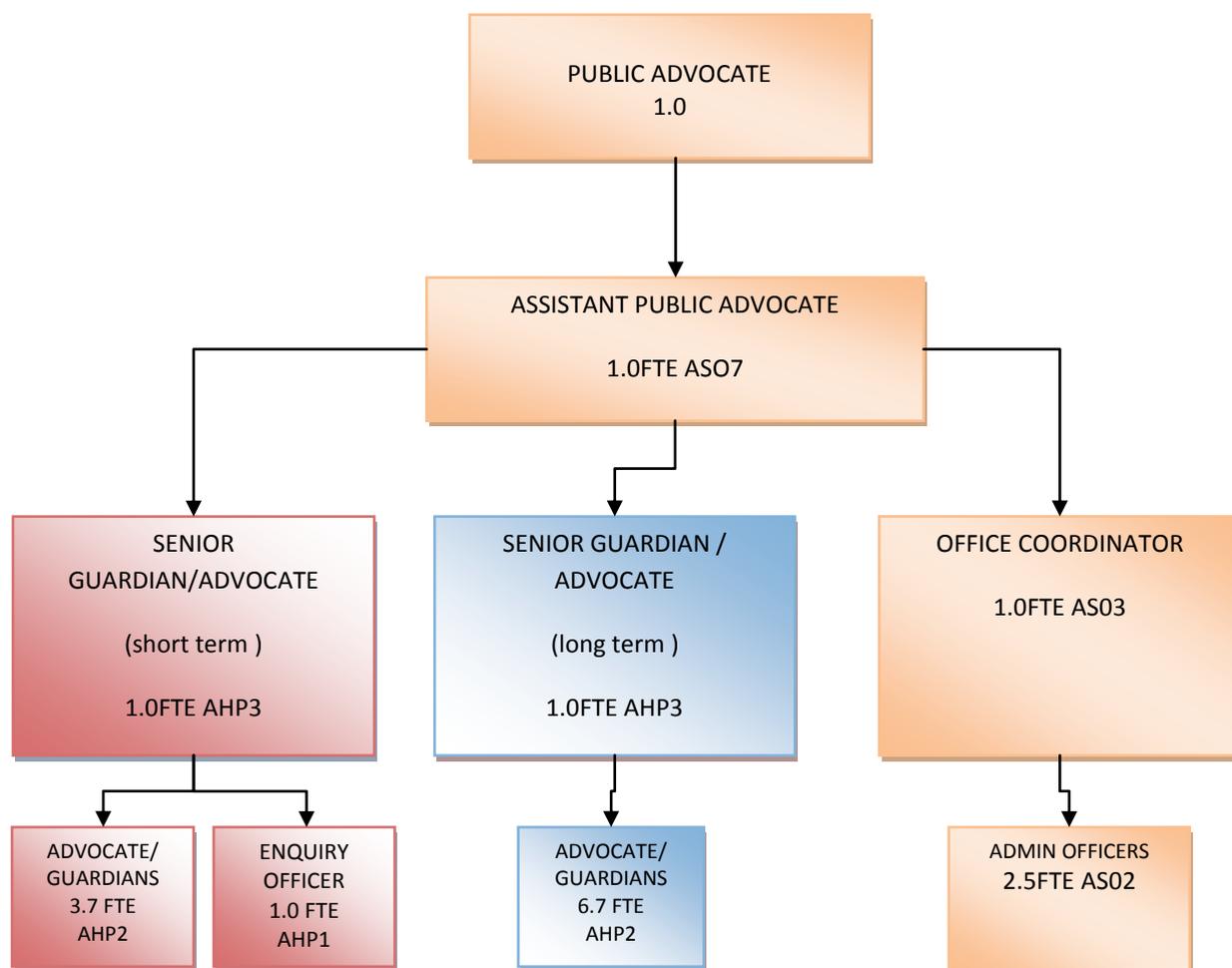
Given the emphasis that this Office places on transparency in our advocacy work, and indeed our own use of FOI requests with other government departments to assist advocacy clients, it is only proper that our Office also be subject to this transparency.

Employment and Human Resources

The OPA staffing establishment remained static during 2010-2011 at 19.3 FTE. The chart below reflects the deployment of these resources as at 30 June 2011.

Note that actual FTE this does not equate to establishment 19.3 FTE because AHP1 resources were redirected to more expensive AHP2 resources throughout the year and savings targets were also set.

Deployment of Funded positions as at 30 June 2011



Additional staffing resources

A full-time Executive funded by the Attorney-General's Department was attached to the OPA for part of the year. A Project Officer funded by the Julia Farr Ms McLeod Benevolent Fund was also temporarily employed during the year. Both positions reported directly to the Public Advocate. A Project Officer funded by the Rotary Health Research Fund was attached at the OPA for the first quarter of the year.

Staff of the OPA 2010–2011

The following is a list of staff members who worked either full-time or part-time at the Office of the Public Advocate for some time during 2010–2011.

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

Administration

Trish Bull	Office Coordinator
Cheryl Thomas	Administration Officer
Michelle Howse	Administration Officer
Aileen Vincent	Administration Officer (Part-time)
Jerusha Nicholls	Administration Officer (Part time)
Di Chartres	Executive

Advocacy, Guardianship, Investigation and Enquiries

Julie-Anne Harris	Senior Advocate /Guardian Long Term Team
Elly Nitschke	Senior Advocate/Guardian Short Term Team
David Cripps	Advocate and Guardian
Karen Bowden	Advocate and Guardian
Maria Atkins	Advocate and Guardian
Bethany Jordan	Advocate and Guardian
Margi Keville	Advocate and Guardian
Elicia White	Advocate and Guardian
Barbara Robertson	Advocate and Guardian
Rebecca Norman	Advocate and Guardian
Anna Latimer	Advocate and Guardian
Popi Amanatidis	Advocate and Guardian
Suzanne Bull	Advocate and Guardian
Tarnia White	Advocate and Guardian
Ella Nalepa	Advocate and Guardian
Mylee Edwards	Advocate and Guardian
Margaret Thompson	Advocate and Guardian

Robyn Downing	Community Enquiry Officer
Passant Ibrahim	Community Enquiry Officer
Rosemary Hillard	Community Enquiry Officer

Supported Decision Making Project

Cher Nicholson	Senior Practitioner/Senior Project Officer
Neil Nicholson	Volunteer

Rotary Mental Health Law Project

Ellie Rosenfeld	Senior Project Officer, Rotary Mental Health Law Project
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Occupational health, safety and injury management

OPA was guided by the policies and best practice principles of the Attorney-General's Department in relation to occupational health and safety and injury management. Practical assistance was provided by the AGD on request, and OPA uses the department's Workplace Health and Safety Division when required. OPA participates in the AGD policy reviews and audits.

OPA has an elected, trained OHS representative and First Aid Officer. OHS matters are routinely discussed in OPA staff meetings.

There was one incident in a community location which led to a staff member injury and associated time off.

The OPA is monitoring closely incidents of threat and aggression towards staff and will be working on improved protocols during the 2011–2012 period.

Financial Information

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

During 2010– 2011 the core program expenditure of **the OPA** was as follows:

Income	
Grants	\$ 113,636.35*
Recoveries:	\$ 4,842.98
Total Revenue:	\$ 118,479.33
Expenditure:	
Employee entitlements	\$2,027,705,5.00
Supplies and Services	\$ 400,837.08
Depreciation	\$ 32,335.63
Total Expenditure	\$ 2,460,928.49

*Included funding from the Department for Families and Communities for the Vulnerable Adults Project.

Three other grant-funded time-limited projects have been operating within the Office of the Public Advocate during 2010–2011 – the Rotary Mental Health Law Project (project officer employed until October 2010), the Supported Decision Making Project (funded until late 2012), and the Private Guardians Survey (commenced during 2010-2011 and still underway). Expenditure of funds is managed in a separate cost centre through the Attorney General's Department and reports given to grant funders.

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