

OFFICE OF THE PUBLIC ADVOCATE



ANNUAL REPORT 2012

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

**South Australian Office of the Public Advocate
Annual Report 2012**

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4th January 2013

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

I have the honour to present to you the eighteenth 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 2011 to 30 June 2012. 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 2012 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.

'Rights' is a unifying thread throughout this report. A chapter on Supported Decision Making and a trial of Supported Decision Making based in our office brings together internally collected data with the outcomes of a recently completed external evaluation. This intervention gives people greater personal authority in their lives, greater control, and maintains a person's full recognition before the law, equal with others.

The section on adult protection summarises the work of the Vulnerable Adults Project. An effective adult protection system will uphold a person's right to safety, and provide freedom from exploitation and abuse. Whenever possible, an intervention will be focused and targeted, with the aim of keeping a person safe without needing to rely on removing personal decision making by guardianship unless absolutely necessary.

Sections on prisoners with mental illness and forensic patients illustrate the need for clinical services to be available so that a person can have the best possible mental health. There should be equality in the levels of service with that which is available to the rest of the community. This currently does not occur.

With these unifying themes, it is inevitable that our Office should consider the role of human rights more generally. It is not possible to advocate for the rights of vulnerable people if, as a community, we do not recognise the rights of all people. Equality with others is sought, not special treatment. A chapter on human rights argues for a human rights approach, based in administrative law, which encourages government decision makers to proactively ensure that rights are upheld as they make decisions.

This is all in the setting of increased demand for guardianship services. As an Office, we are proud of the guardianship work that we do, often in difficult situations. However, public guardianship is definitely an option of last resort. Ultimately, it is preferable in upholding the rights of individuals and families to help people make their own decisions through strategies such as supported decision making; and if substitute decision making is unavoidable, it is preferable to assist members of the community to take on this role for their family members and friends than have government take over. This year, our private guardians' survey demonstrated the need for extra support and information sought by private guardians who take on this role.

Ultimately, a rights based approach is empowering and can be relied upon to deliver better outcomes as discussed in the section of the report *Recognising Human Rights*.

Part A:

General Functions of the Public Advocate

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

Reviewing Programs and Identifying Unmet Need

Disability Services

Guardianship and Administration Act 1993

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

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

Introduction

For people who experience disabilities, 2011–2012 has been a year of great promise, with significant reforms announced in the disability sector both within South Australia and nationally. At both a state and national level, these measures aim to give people with disability choice and control in services and to fund unmet need, to meet major service gaps, and turn around a crisis-driven system.

This review recaps on these major developments, and then as this Annual Report has done each year, considers the current levels of service provision based on Productivity Commission data, and the levels of unmet need as reported by Disability Services.

Policy and Funding Developments

In October 2011, the South Australian Social Inclusion Board released its report *Strong Voices: a Blueprint to Enhance Life and Claim the Rights of People with Disability in South Australia (2012–2020)*. This reform seeks to create accessible and inclusive communities, prevent crises through early intervention, ensure that services such as education, employment and health work better for people with disabilities, provide choice through individualised funding, provide better support for carers, broaden accommodation options, close the Strathmont Centre and ensure that safeguards are in place to protect vulnerable people (Social Inclusion Board, 2011).

Recommendation

11 **Priority Action** Individualised funding must be made available to all new clients of government disability services and those on the Unmet Demand List, from July 2012. This includes housing support packages. All people receiving specialist disability services must have individualised funding by 2017, in line with the proposed National Disability Insurance Scheme rollout. All agencies administering specialist disability funds must ensure joined-up arrangements are in place, to streamline processes for people with disability, their families and carers.

Social Inclusion Board, Strong Voices

recommendations for the establishment of the National Disability Insurance Scheme (NDIS), to provide insurance cover for all Australians in the event of significant disability, and the National Injury Insurance Scheme (NIIS), to provide a federated model of state-based no-fault insurance schemes for people who have been newly affected by a catastrophic injury (Productivity Commission, 2011).

In its May 2012 Budget, The Commonwealth Government then announced new funding to establish a National Disability Transition Agency, and funded the commencement of the scheme for about 10,000 people nationally in mid-2013, increasing to 20,000 people in mid-2014 (National Disability Insurance Scheme, 2012a). A sum of \$342.5m was set aside for individually funded packages over three years, \$154.8m for local area coordinators to provide an “individualised approach,” and a further \$58.6m for assessments (Minister for Disability Reform, 2012). All up, over \$1 billion have been set aside for the launch, most of it being spent on infrastructure, staff costs and the development of systems.

In March 2012, the Government announced a new individualised funding model that would offer more than 2000 people control over their funding (Government of South Australia, 2012a).

Then in May 2012, the State Government announced in its Budget additional support service funding (an extra \$4.487m in 2011–12, increasing to an extra \$44,792m in 2015–16) and new capital money for housing totalling \$61.5m over four years, starting in 2012–13 (Government of South Australia, 2012b). This was amongst other measures that included funding of an expanded Community Visitor Scheme that will visit disability accommodation and supported residential facilities.

Nationally, the Productivity Commission’s final report into Disability Care and Support was tabled in the Australian Parliament in July 2011. It delivered

In South Australia, the State Government had provided in its 2012 Budget, \$20m over three years to fund the NDIS launch. This launch, which has children as its target population, will fund services to children aged 0–5 in July 2013, and by the third year will involve children up to 14 years, with a total of 4,800 children expected to benefit (NDIS, 2012b).

This is a time of opportunity. The success or otherwise of these reforms will depend not only on the adequacy of their funding but also on their implementation. While money is important to respond to unmet need, money alone will not be enough, as effective reform leadership will be essential to transfer power and control from government systems back to people with disabilities and their families.

Leadership will also be required to ensure that major gains are obtained in improving the safety and quality of disability services, while at the same time giving service users a choice of a wider range of potential players than ever before.

Local coordination is the change vehicle touted to refocus the system. Local area development coordinators have been suggested in *Strong Voices*, and are to be funded as part of the NDIS launch.

Yet the empowerment and community engagement goals touted for new, local coordination positions are similar to the original goals of existing disability workers. It is the work that many of these professionals wish to be doing, but because of funding shortfalls they have instead become gatekeepers and crisis managers much of the time. *Strong Voices* reform and the NDIS will need to make sure that every single planning decision considers how best to empower people with disability, as it could be very easy, even

Recommendation

23 **Priority Action** To support community engagement and mobilise local resources around people with disability, the Government must implement a place-based 'Local Development Model'. The Local Development Model will include a Family Living Initiative and a Community Living Initiative. Where local areas have significant culturally and linguistically diverse communities or a significant Aboriginal population, implementation of the model must be driven by the demographic profile.

Recommendation

24 A special and particular emphasis on the needs and strengths of Aboriginal people will be a driver for the implementation of, and recruitment to, the place-based Local Development Model.

Social Inclusion Board, Strong Voices

What it would provide?	The NDIS would provide reasonable and necessary supports across the full range of long-term disability supports currently provided by specialist providers. Services such as health, public housing, public transport and mainstream education and employment services, would remain outside the NDIS, with the NDIS providing referrals to them	The NIIS would provide lifetime care and support services broadly equivalent to those provided under the Victorian TAC and NSW Lifetime Care and Support scheme. This includes reasonable and necessary attendant care services; medical/hospital treatment and rehabilitation services; home and vehicle modifications; aids and appliances; educational support, and vocational and social rehabilitation; & domestic assistance
What would be the cost?	The scheme would cost approximately \$6.5 billion above current spending (around \$295 per Australian). Total expenditure would be around \$13.5 billion per annum	Net annual costs of a comprehensive no-fault scheme covering all catastrophic injuries could be around \$830 million (around \$35 per Australian)

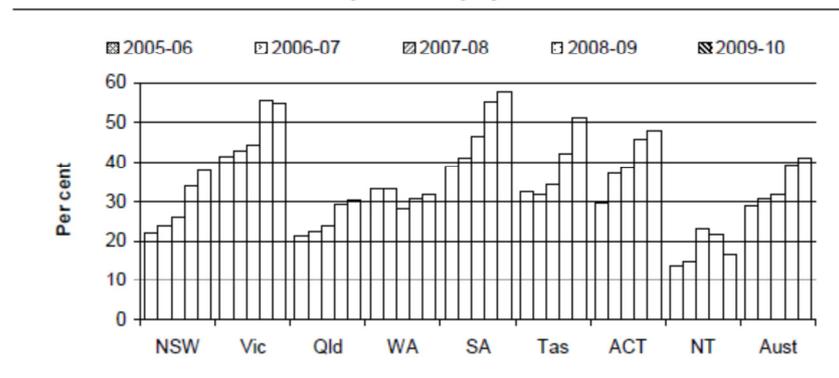
Productivity Commission: What a NDIS and NIIS would provide

with increased funds to revert to a traditional rationing and eligibility mindset, which then becomes the overriding driver to system design.

Update on service use and unmet need

The Productivity Commission’s 2012 Report describes services in 2009–2010. South Australia once again has the highest rate of access to government-funded specialist disability services. Over 55% of the potential number of users accessed a service, compared to a national figure of 41.2%. (The potential users are those people who have a severe or profound activity limitation due to their disability).

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



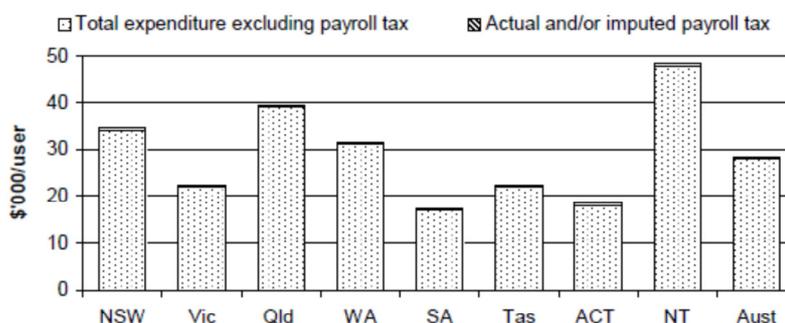
^a Potential population is calculated using the unrevised method. See section 14.7 for information on how the potential population is defined. ^b Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues. ^c For the ACT, the decreased service user rate for 2005-06 was due to incomplete data collection for therapy services.

Source: AIHW (unpublished) DS NMDS; AIHW (2011a) *Disability Support Services 2009-10: Report on services provided under the National Disability Agreement. Disability series.* Cat. no. DIS 59. Canberra; AIHW (2011b) *Disability Support Services 2008-09: Report on services provided under the Commonwealth State/Territory Disability Agreement and the National Disability Agreement.* Cat. no. DIS 58; AIHW (2010) *2007-08, 2006-07, 2005-06, 2004-05: National Data on Services Provided under the CSTDA.* Cat. no. DIS (56 and previous publications); table 14A.13.

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

The corollary statistic, of less funding per user, remains unchanged from previous years. Government expenditure per user is still reported to be lower in South Australia than in other states.

Figure 14.29 **Estimated annual government expenditure per user of NDA State and Territory administered services, 2009-10^{a, b, c, d}**



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

Source: AIHW (unpublished) DS NMDS; State and Territory governments (unpublished); table 14A.85.

Estimated annual government expenditure per user of NDA (National Disability Agreement) State and Territory Administered Services (Reproduction of Figure 14.29 of the Productivity Commission 2011)

Unmet need data

South Australia had been releasing unmet need data on a 6-monthly basis since 2008, and in 2012, this information has been released monthly. The most recent report can be read on the *Unmet need report* page at www.sa.gov.au

As of June 2012, there were 21,822 clients receiving a disability service. 2763 people were on the unmet needs list, 1190 on Category 1 and 1028 on Category 2. The definitions of urgency of need are as follows:

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).

Services described include: *Supported Accommodation* — this comprises clients who are referred to the Accommodation Placement Panel; *Personal Support* — it describes clients requiring up to a maximum 50 hours per week in-home support. If the number of hours is greater than this, the need is

Recommendation

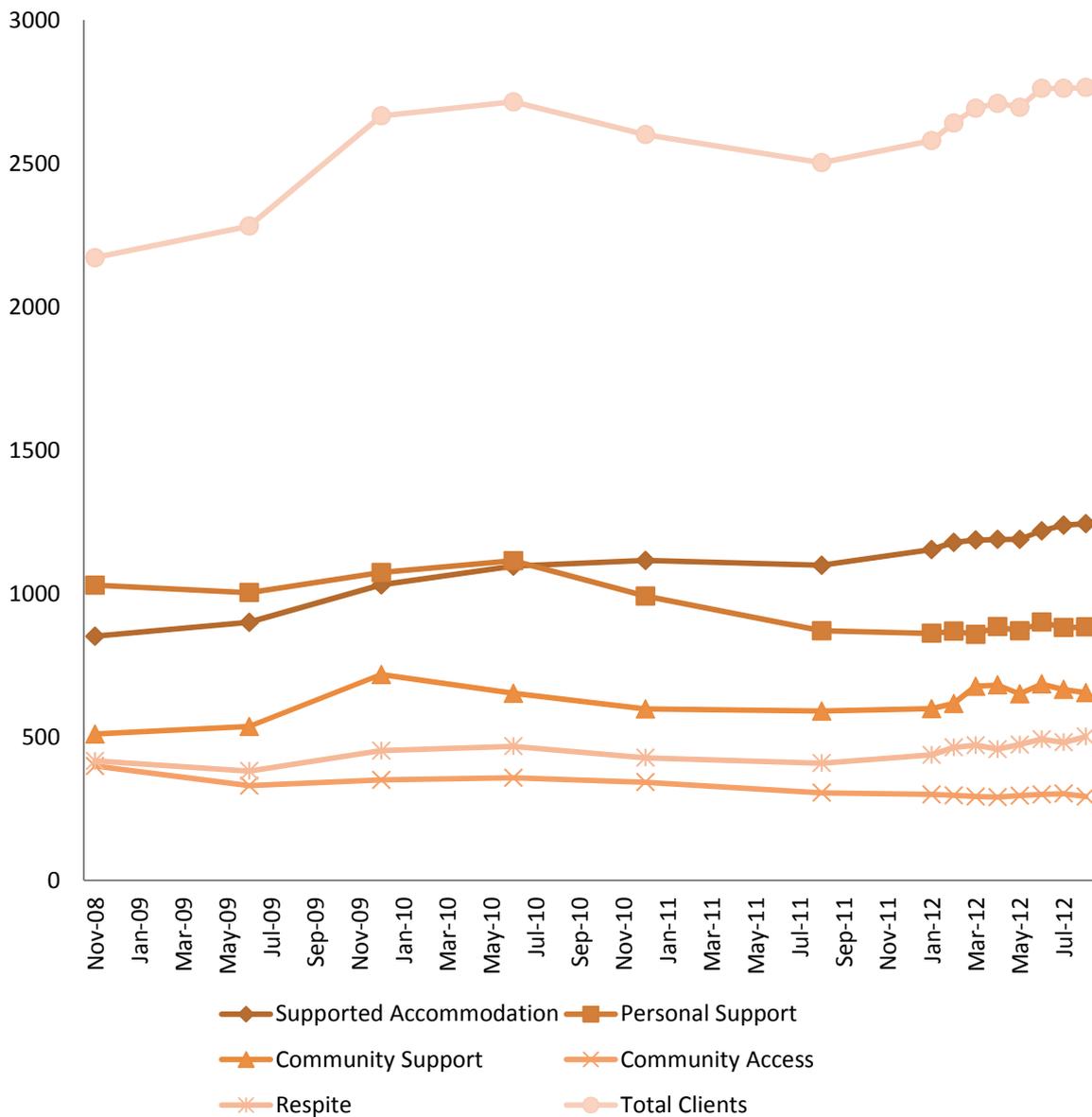
02 Priority Action To meet the immediate challenge of an under funded system, Government funding to address unmet need must be allocated as a matter of urgency to remove all 'critical and evident risk' clients from the Unmet Demand Waiting List within one budget cycle. Recurrent funding must be maintained at a level sufficient to deliver immediate and effective responses to people assessed with immediate need.

Social Inclusion Board, Strong Voices

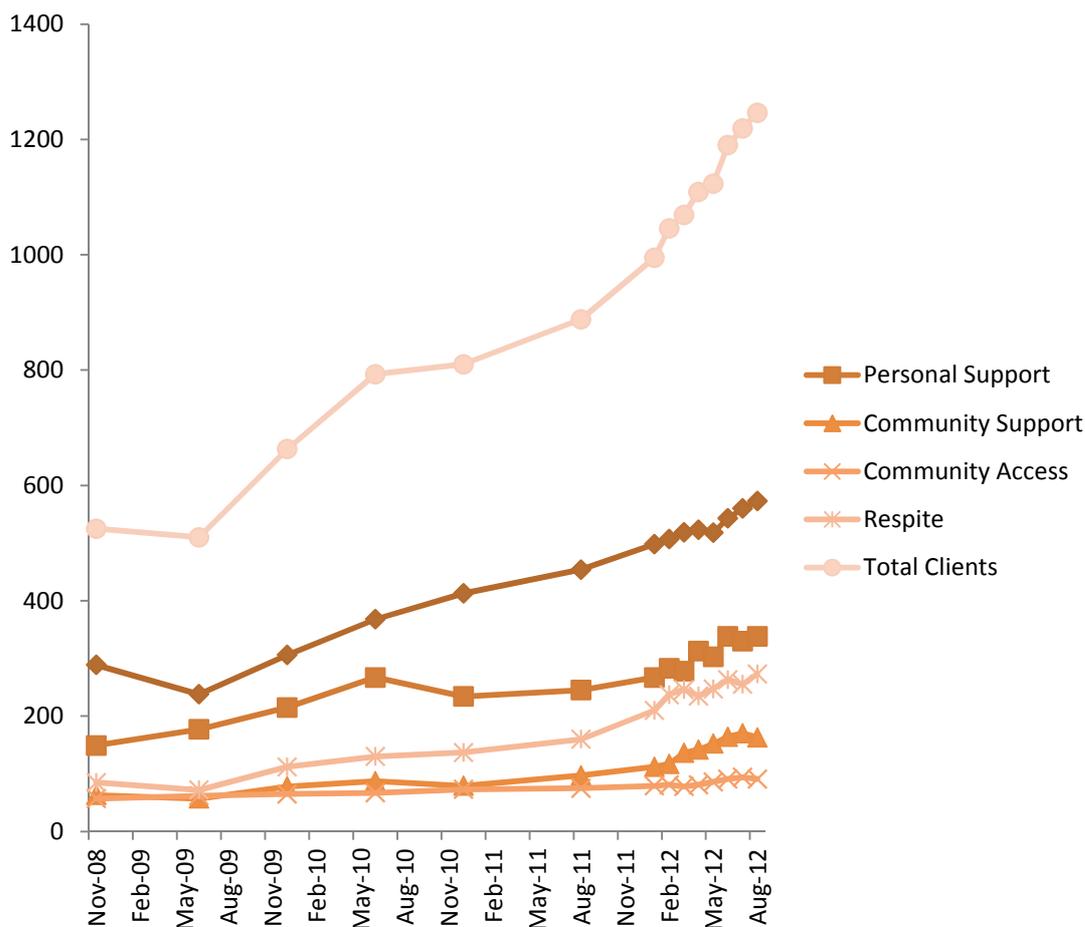
considered to be for supported accommodation; *Respite*; *Community Access* — includes day options (daytime activity), learning and life skills development, recreation and community access; and *Community Support*— includes a range of therapies and interventions.

Figure A3 charts unmet need over time for all four categories of service. There has been no substantial reduction in overall unmet need during 2011–12, with a total of 2766 clients on the overall unmet needs list in August 2012, up from 2504 clients the year before.

Figure A4 demonstrates the ongoing increase in the Category 1 unmet needs list. As of August 2012, there are 1246 clients on this list, up from 888 clients reported a year ago. A further 573 are on the Category 1 list waiting for supported accommodation, up from 454 waiting one year before, and 368 people the year before that.



Increase in unmet need list November 2008 to August 2012. For clients in all categories.



Increase in unmet need list November 2008 to August 2012. For clients in Category 1.

The recommendation of the Social Inclusion Board was that the Category 1 and 2 lists need to be funded within one budget cycle (Priority Action Recommendation 2).

The currently available data do not indicate the cost for achieving this. Recommendation 11 of *Strong Voices* is particularly relevant. If this were implemented, the individualised budget for each person on the waiting list would be known, and then it would be a simple exercise to total the cost for the Category 1 and 2 groups and fund it.

If Priority Recommendation 2 were accepted, the needs of people who have a disability who are at risk to harm to themselves or others, or who are homeless or at risk of homelessness would be met by June 2013.

This Office had hoped to present a further analysis of waiting list statistics in this Report, but additional data requested from Disability Services are not available at this time. We very much accept that their staff have been exceptionally busy preparing for individualised funding, and the NDIS.

When we do receive these data in the imminent future, we hope to better understand who is waiting, their ages, where they live, and the type of disability experienced. It is of course very helpful to know how long people are on the list, for each type of service.

Services for people who are diagnosed with autism spectrum disorders

The specific needs of people with autism spectrum disorders were reviewed in the 2011 Annual Report of this Office (pp. 24–28.)

The solution put forward was the development of a State Autism Plan, bringing together the responses from disability, education, vocational training, health, mental health, child protection, and justice. Such a plan could consider the needs of people of all ages with autism.

The 2011 review considered United Kingdom best practice, driven by their Autism Act, which led to the development of an adult autism strategy *Fulfilling and rewarding lives: the strategy for adults with autism in England*.

In June 2012, the United Kingdom National Institute of Clinical Excellence (NICE) released its clinical guidelines *Autism: recognition, referral, diagnosis and management of adults on the autism spectrum* (NICE, 2011). This is in addition to its existing guidelines for children and young people.

With respect to structures for delivering care, the guidelines recommend both a mechanism of bringing existing agencies together, along with the development of specialist multidisciplinary teams. The local autism multi-agency strategy group would have representation across government from mental health, disability, primary healthcare, education, social care, housing and employment services. Membership of local specialist autism teams would include clinical psychologists, nurses, occupational therapists, psychiatrists, social workers, speech therapists and support staff.

The NICE guidelines then describe specific evidence-based interventions including psychosocial interventions, biomedical treatments, and behaviour management.

The above is currently not the situation in South Australia. The gaps considered in our 2009 and 2011 Annual Reports continue to exist. In particular, our Office sees situations where young adults with behavioural problems miss out on a planned response linking disability and mental health services. Parents can be left to care for people who, for whatever reason, cannot be easily managed in supported accommodation. Some supported accommodation providers have attempted to provide care beyond their resources for people with high needs. Access to specialist psychology assessment can be limited, and young adults with autism spectrum disorder in crisis can still be turned away from emergency mental health services because their distress and associated behaviour are seen as related to a disability, and therefore not the responsibility of mental health services.

These are the very issues that the United Kingdom approach has sought to address through practical organisational arrangements linking mental health and disability services, and requiring the delivery of evidence-based therapies and care.

Examples

Below are some stories that illustrate our limited systems for people with autism. Cases are described in general terms to avoid identifying individuals.

Transport lacking dignity. The mother of a young man who experiences autism told our Office that she was concerned with the way her son was transported. The young man was contained within Perspex barriers to separate him from other clients transported at the same time. Her concern was that these barriers may have led him to harm himself in the confined space.

Soon afterwards, the Office was alerted by a whistleblower reporting through the South



Perspex cell in a vehicle used to transport a person who has an autism spectrum disorder.

Australian Council of Intellectual Disability, that a van for persons with disabilities was seen refuelling at a service station, with a Perspex 'cell'. This was restrictive and lacked dignity. This of course turned out to be the same matter.

Following further assessment by the provider and Disability Services, it was concluded that the Perspex barrier was not needed but the person was best to travel alone as a passenger. The need to reduce stimulation from others is not uncommon for people with autism. It has now been possible to remove the Perspex 'cell'. The vehicle now has a simple Perspex barrier for the driver, similar to that used by taxis in some overseas cities, which does not look remarkable.

A residual advocacy problem remains to be resolved.

While there are staff to accompany this client as well as other residents if they should need to travel at the same time, only one vehicle is available, affecting the scheduling of trips.

Overcrowding leading to behavioural incidents. The Office was notified by a whistleblower that there was a house used by a disability service, which had an unusually high level of security and a resident might be detained without authority.

With the permission of the Chief Executive of the organisation, the house was visited with minimal notice, in the late afternoon when most residents were present (the house and an attached unit could accommodate up to seven people).

It was evident that the house was overcrowded. It had a custodial ambience, and internal fixtures were damaged. While the residents and staff appeared to have a positive relationship, the house was crowded and residents intruded on each other.

These issues affected residents who had a number of different disabilities. However, there was a particular impact for clients who had autism, both in terms of effectively preventing escalation of behaviour, and clients becoming agitated by the noise in the house.

This visit raised other issues with respect to the prevention of restrictive practices and their appropriate authorisation.

In response to the concerns raised, the number of clients in the house was reduced by removing two bedrooms, creating four good-size rooms as well as the rear unit. Repairs have been made to the building, and one client has an extra staff member allocated overnight.

As a result of these measures and the use of behavioural planning, the staff of the house were able to report improvement in their clients, and a zero critical incident rate over a number of months. This was an excellent outcome.

The organisation involved had in fact been proactive in the area of restrictive practices prior to this matter being raised. It had put in place its own restrictive practices policy and had employed a developmental educator who would assist at this house. Also the house had previously been visited by many government workers including staff from our own Office to meet with individual clients.

However, what this illustrated was the benefit of a visit to check on all clients in a house, at a time when they would all be there, and for checking on the physical environment. This of course will occur regularly when the new Disability Community Visitor Scheme, announced in the May 2012 Budget, is established.

The solutions were also illustrative of actions that can be taken which improve the quality of life for clients and increase staff safety — reduction in overcrowding, thoughtful physical modifications to a building, the use of behaviour support plans, and where necessary, ensuring that there are enough staff present to prevent behavioural problems.

Overcrowding worsening anxiety. A young man with an autism spectrum disorder and intellectual disability lives in duplex accommodation. The duplex is owned by Housing SA and is used by an NGO as disability accommodation. His unit is the home of three residents, who share a small communal lounge area onto which their bedrooms directly open. The result is limited space and overcrowding inside so that residents and staff can get in each other's way. Access to the back yard is limited because a unit for a fourth resident has been placed in that space.

This lad likes to walk. He can modulate the level of stimulation he receives by doing this. However, in his current housing it is very difficult for him to do this. Inside space is minimal, he does not have access to the back yard much of the time, as this space is used by another resident. The result is that he has had worsening anxiety and depression, problems commonly associated with autism spectrum disorders. His family have been actively advocating for him, and although a solution is yet to be found, the need for more suitable housing has been acknowledged by Disability Services who are now looking for a solution that will be more suited to his needs.

Inability to live in group accommodation. A young man who has Asperger's syndrome and associated depression and anxiety is unable to cope with living in a boarding house and group accommodation and these services have been unable to effectively provide care for him. He has been back with his parents for a lengthy period. He is still waiting for suitable supported accommodation that can provide a low stimulus environment and personal space

Prison accommodation. The risk to people with autism in prison is well known. People with a disability can be held in prison even though they have been found not guilty due to mental impairment, because of a lack of forensic facilities. People can then be held in protection areas with sex offenders. More details of a specific matter will not be provided for fear of identifying a client, but these risks are very real.

In conclusion, these are examples of a major gap in service provision for adults with autism spectrum disorders, both in providing integrated disability and mental health care, as well as suitable accommodation that through the use of space prevents rather than triggers behavioural problems.

Community Visitor Scheme

The State Government announced the extension of the mental health community visitor scheme to disability accommodation in the May 2012 Budget. This will be phased in over two years from 2012–13.

In 2012, the Office of the Public Advocate was asked to provide a visiting service to a disability provider. This requirement was included in the provider's service agreement with Disability Services. Both announced and unannounced visits were undertaken on a monthly basis.

Other matters

Disability Client Trust Fund

This matter was reported in our 2011 Annual Report. A savings measure that was announced in the 2010 State Budget was the planned closure of the Client Trust Fund operated by the Department for Families and Communities (to become the Department for Communities and Social Inclusion). This was due to occur on 30 June 2012 but this decision was reversed in the May 2012 Budget. Those people receiving the service as at 1 April 2011 will continue to do so. It is also available to those people who transferred from the trust fund to another administrator, who were receiving the trust fund service as at 20 September 2010 (Government of South Australia, 2012b).

For the reasons outlined in last year's Annual Report as to why this fund should continue to operate, this is a positive development. A valued service to a vulnerable group will now be retained.

As the fund continues to operate, the effectiveness of conflict of interest safeguards will need to be reviewed, particularly with respect to the purchase of equipment with private funds. This is likely to occur as part of ongoing auditing of the fund by the Auditor-General.

Strathmont Food

The 2011 Annual Report described problems with the quality of food delivered to Strathmont Centre. Work had been undertaken by the Department for Communities and Social Inclusion (DCSI) to improve the food. However, the final step of replacing the old system of transporting hot cooked food from Highgate to Strathmont with a more effective cook–chill system had yet to occur.

This final step occurred in 2012. Reviews by the Department of the quality of the food have been positive.

Reviewing Programs and Identifying Unmet Need

Forensic Mental Health Services

Introduction: Correctional services — our other mental health system

In 2006, White and Whiteford published an editorial in the *Medical Journal of Australia* with the title “Prisons: mental health institutions of the 21st Century?” Their paper reviewed the high rates of mental illness in prisons, and alluded to the debate about the cause — is it a reflection of the deinstitutionalisation of psychiatric hospitals, or is there better detection? They noted that Australian remand centres often contained more seriously ill people than general mental health inpatient units.

Forensic mental health services are inadequate to meet this demand and in need of urgent development. This is the case Australia-wide, but the situation in South Australia is even more critical. The lack of forensic mental health services has been covered in the annual reports of 2009 (p.66 onward) and 2010 (p. 97 onwards) of the Office of the Public Advocate. Gaps have existed in the access to forensic mental health inpatient beds, to prison in-reach services, and community follow-up. People can enter the forensic system due to failure to access sufficient general community mental-health care or alcohol and drug services.

In 2012, the Australian Institute of Health and Welfare published results of the 2010 National Prisoner Census, focusing on the mental health of prison entrants. This survey demonstrated that 31% of prison entrants reported that they had been told by a doctor, psychiatrist, psychologist or nurse that they had a mental disorder (including drug and alcohol abuse) in their lifetime and 16% were prescribed medication for a mental disorder (AIHW, 2012). Female prisoners were more likely to have a mental illness than males (41% to 30%) and to present very high levels of distress.

It is also relevant to note a South Australian report of screening prisoners for drug use prior to admission, which revealed that half had used injectable drugs in the preceding three months (Holmwood et al., 2008).

Rates of mental illness in prison have been recorded at even higher levels when the entire prison population is surveyed, not just new entrants. Butler et al. (2005), using a diagnostic instrument employed in community surveys in Australia, reported a rate of 43% of prisoners screened having a diagnosis of psychosis, anxiety disorder or mood disorders. In this study of NSW prisoners, the rate of psychiatric illness in women was 61% compared to 39% in men (Butler et al., 2005). Aboriginal women in particular are at greater risk. Compared to non-Aboriginal women, they are more likely to screen positive for symptoms of psychosis in the preceding 12 months and have higher prevalence of mood disorder and psychological distress (Butler et al., 2007).

The pattern applies to both sentenced prisoners and remandees. White et al. (2006) screened 621 remandees in Queensland for psychosis: 61 screened positive, and 81% of these had no treatment at the time of the offence. Thirty-five per cent of the remandees with psychosis had been homeless for an average of 32 weeks in the past year (White et al., 2006). With respect to homeless men with psychosis who are remanded, White et al. (2006) saw the need for flexible, preventative, management and accommodation services. This of course is the type of mental health supported-accommodation service that is significantly lacking in Australia.

Correctional systems, as never before, now have to take on a mental health role. While this will always be part of their role, some of this need is preventable. Improved mental health and supported accommodation services, as well as better responses to homelessness may keep people out of the arms of the law. In other situations when people have come to the attention of police and the courts, better recognition of mental illness and increased referrals to diversion courts can ensure that people receive treatment and clinical supervision, rather than a correctional response — actions that ultimately will deliver a better outcome for the individual and address the conditions that have led to offending behaviour. It is also important that whenever possible, if people have offended due to illness, the need for a mental impairment defence is recognised, and an appropriate limiting term applied by the Court. The benefits of appropriate diversion and support are listed in the following diagram in this document from the national group of National Justice Chief Executives.

Figure 4.2 Individual, systemic and community objectives of diversion and support

Individual objectives	Systemic objectives	Community objectives
<i>Objectives focused on outcomes for each individual with mental illness in contact with the criminal justice system</i>	<i>Objectives focused on the appropriateness, efficiency and effectiveness of system responses to mental illness</i>	<i>Objectives focused on the interests and expectations of the community as a whole</i>
<ul style="list-style-type: none"> • increasing human rights protections afforded to individuals with mental illness • increasing access to treatment services for individuals with complex mental health and related problems • improving clinical outcomes for individuals with a mental illness in contact with the criminal justice system • improving quality of life for individuals with a mental illness in contact with the criminal justice system • reducing contact with the criminal justice system by addressing each individual's health and criminogenic needs 	<ul style="list-style-type: none"> • improving the early identification and assessment of people with mental illness within the criminal justice system • increasing coordination and efficiency at the interface of criminal justice, health and human services systems • reducing the use of criminal justice sanctions for offending attributable to mental illness and cognitive impairment • reducing the intensity, seriousness and frequency of re-offending by people with a mental illness 	<ul style="list-style-type: none"> • improving community compliance with human rights obligations relating to treatment of people with mental illness • increasing community safety by addressing mental illness and related problems that contribute to repeated offending behaviour • reducing the total social cost of processing offenders in the criminal justice system whose repeat offending is attributable to mental illness and related problems • strengthening protective factors that reduce the likelihood of offending

Objectives of Diversion and Support. (National Justice Chief Executives and Victorian Department of Justice, 2011)

Use of Forensic Provisions

The *Criminal Law Consolidation Act (CLCA) 1935 s269C* defines mental incompetence:

A person is mentally incompetent to commit an offence if, at the time of the conduct alleged to give rise to the offence, the person is suffering from a mental impairment and, in consequence of the mental impairment—

- (a) does not know the nature and quality of the conduct; or*
- (b) does not know that the conduct is wrong; or*
- (c) is unable to control the conduct.*

A person found not guilty on grounds of mentally incompetence is then liable to a supervision order under s2690. The court fixes a limiting term equivalent to the period of imprisonment or supervision that in the court's opinion would have been set if the defendant had been convicted of that offence.

This supervision order can be varied or revoked on application. For example, a person might initially be treated in a secure inpatient unit but with improvement in their condition, be able to spend time in the community.

A defendant with a mental impairment is placed in the custody of the Minister for Mental Health and Substance Abuse. This applies regardless of the nature of the mental impairment; so, the Mental Health Minister is not only responsible for the care of people who have a mental illness, but also people with other disabilities such as intellectual disability, brain injury, or autism.

Under the provisions of s269V, the Minister can make a direction that a defendant be kept in custody in prison, if there is no practicable alternative to this. This is a non-delegable duty of the Minister, and such directions are usually given by the Minister when there are no forensic beds available at James Nash House. There are 40 forensic beds in the state. Each time that our Office enquires about these beds, there are usually at least 20 people on the waiting list — people who are either in prison or at another hospital in a mental health bed intended for general community use, awaiting a forensic bed to become available.

A person may also be mentally unfit to stand trial. This is defined by *CLCA* s269H. If the Court is satisfied beyond reasonable doubt that the objective elements of an offence are established, and finds on the balance of probabilities that the person is mentally unfit to stand trial, then this person is also liable to a supervision order.

The term “forensic patient” is used to describe both groups of people under supervision as described above — those found mentally incompetent and those found unfit to stand trial.

There can be a cross over — a person might be convicted on one occasion and become a prisoner, but on a different occasion be found not guilty by reason of mental impairment.

When should a mental impairment defence be used

In March 2012, the Attorney-General referred the use of the mental incompetence defence to the newly created Sentencing Council, chaired by retired Supreme Court Justice Kevin Duggan. The Council has been asked to consider whether the threshold for offenders who seek to use this defence is set too low. Our Office has met with Justice Duggan.

OPA clients include people on forensic orders, and prisoners with mental illness and disability. Examples in both groups include young women with intellectual disability and personality disorders, men with autism spectrum disorders, Aboriginal people with substance-use brain injury, and men and women with psychosis.

The use of forensic supervision orders, as opposed to punishment, for our advocacy and guardianship clients has been appropriate.

If there are instances where it is considered that a mental impairment defence has been used inappropriately, our Office does not become involved in these situations. Our concern is that our vulnerable and needy clients are not inadvertently caught up in a legislative change to address a problem that they are not a part of.

Having said this, the comprehensive and thorough process that will be followed by the Sentencing Council is impressive, and this will take in our concerns.

During 2011–12, we also met with Chief Magistrate Elizabeth Bolton to discuss concerns that there were instances in the Magistrates Court where people with a disability or mental illness were not being recognised. For example, there have been instances where a person has been found unfit to plea in one court, but this has not been raised when the person has been subsequently charged with a similar offence in a different court.

There are two issues to explain. First: this is about people with disabilities who have an ongoing incapacity. It would not be expected that the person's ability to understand or respond to a charge would improve significantly over a period of months or a few years. (In contrast, this can happen when a person with mental illness receives treatment and their condition improves.) Second: many people with intellectual disability are reluctant to display their disability, and have developed ways of dealing with encounters, particularly brief ones, so as to appear to understand what is happening, even though they do not.

A further meeting was held with Police Prosecutions, to put forward the case that information on the prosecutor's file about the previous use of s269 provisions, or court diversion, could be routinely provided to the court or to defence lawyers. In undertaking this work, we were grateful for the assistance of a solicitor from the Legal Services Commission who has extensive experience of disability and the criminal law, who raised these concerns with us and participated in meetings. This solicitor also represents many of our clients appearing before the courts.

Gaps in community mental health service provision and offending behaviour

The relationship between offending behaviour and gaps in mental health service delivery is generally acknowledged.

A person offends, an illness is detected and treated, and then at-risk behaviour is better controlled. This occurs whether an offence is minor or major. For example, in an evaluation of the Magistrates Court Diversion Program, 157 offending clients were compared in the 12 months prior to undertaking the program and in the 12 months after. There were particularly strong decreases in the rate of non-aggravated assaults, thefts (motor and other), retail theft, fraud, property damage and offensive behaviour/disorderly conduct (Skrzypiec et al., 2004). However, in this evaluation there were no changes in the level of burglary/break-and-enter offences or driving and traffic offences.

Even greater access to diversion could help reduce the imprisonment of people with mental illness, or reliance on s269 measures.

Ideally, people should have access to clinical services before offending. This may not always be possible, as the first time a person offends may be the occasion when an illness is detected, but on the other hand, many other people have had an illness recognised previously and are only properly connected with a service after they commit an offence.

This is most evident for forensic patients who are diagnosed and treated, and then improve.

A case example

The Office was approached by the family of a forensic patient. The family considered that their family member had been let down by mental health services. They contended that because of this, he committed a very serious offence while psychotic, which might have been prevented if he had received treatment. The family want to ensure that in future, other people do not have to go through this experience whether it be the potential victim, the victim's families, as well as people with mental illness and their families.

Before the critical incident, the family sought help for their family member through emergency mental-health telephone triage services on a number of occasions but it was not provided. This happened a few years ago. The family's concern is that such events can still happen now to people who might seek help for a behavioural problem and not be provided the specialist mental health care they need.

Using case notes, our Office created a timeline of this man's illness and treatment. He had been in and out of both prison and hospital many times over a period of almost 20 years prior to the critical incident that led to a court finding him not guilty by reason of mental impairment.

Unfortunately, it was not possible to look at what services had or had not been provided by telephone mental-health emergency triage services. This is because the case-note entries that would have recorded these calls could not be found by mental health services, and neither could the complete case notes from a key hospital admission. (We sought assistance from the Ombudsman's Office when case notes could not be produced by a Freedom of Information request. The Ombudsman's proactive efforts led to some other records being located but not the telephone records.)

In the years since this incident, the mental health service has established a central mental health telephone emergency service. This service now has standardised record keeping, and makes audio recordings of calls made to it, so this particular difficulty should not occur now.

Even without access to the missing notes, it was possible for this Office to describe the following patterns.

Limitations in communication and community mental health follow-up

Diagnosis

- Senior psychiatrists who saw the person in prison or in hospital, often over a long period of time, were more likely to make a specific diagnosis, recommend a psychotherapy, or prescribe medications including mood stabilisers and antipsychotic medication.
- In contrast, in the community, where the person was usually seen by a less senior clinician in an emergency service, it was more likely that behaviour problems were attributed to personality disorder or drug use, and ongoing mental health care was not provided.

Lack of transfer of information

- There was no evidence that the mental health clinicians providing emergency assessments in the community had access to the opinions of the senior forensic psychiatrists who saw the person in prison.
- Conversely, at one point during the year prior to the critical incident, important observations at Glenside Hospital that formed the basis of a new diagnosis of probable schizophrenia were not available to prison psychiatrists where the person was subsequently incarcerated again.

Regular community follow-up vs. relying on emergency services

- The person received regular mental health reviews by psychiatrists in prison but in the community, this did not usually occur — perhaps reflecting in part the differences in diagnoses.
- If specialist case management in the community had been provided, then it would not have been necessary to rely on telephone emergency service triage to respond or not respond.
- Community follow-up was indicated given the diagnosis of psychosis, the assessments made in prison and hospital, and the need for ongoing supervision of medication.
- A related issue that emerged was the effectiveness of the system to follow up missed mental health appointments of parolees when this is a condition of parole.

Model of forensic mental health care for prisoners

- Most forensic mental health care in prison is provided directly by psychiatrists, without the back up of in-reach forensic mental health workers. For this reason, psychiatrists conduct relatively frequent but short reviews of their patients. If they were more readily available, such workers could undertake routine reviews, permitting psychiatrists to schedule longer sessions for assessment and advice.

Future improvements.

Further discussions are likely to occur between this Office and SA Heath about this person's situation, and the lessons that might be learned.

In their initial response, SA Health cited important developments in the use of information technology, and consideration of the provision of forensic mental health in-reach services to prisons.

- The new electronic medical record, the Enterprise Patient Information System (EPAS), would immediately solve some of the issues that affected this person.

In particular, entries made by mental health staff in prison would be available to staff in the community and vice versa. An electronic medical record will aid the transfer of information when a person is released from prison.

Such information is now not accessible by computer. The current situation is a little better than it was when the problem occurred for this person, but information availability is still limited. Forensic mental health staff who see a patient now in prison do not have direct access to the existing mental-health information system called the Community Based Information System. Limited information from prison consultations is uploaded, so that community staff may now see on their screen that a consultation has occurred but not be able to read the detail of what happened at the consultation. Information can then be manually requested from forensic mental health services.

- A forensic mental health in-reach service is being considered. These mental health workers could provide continuity, coordination, and assist with linking people to community services for accommodation when they leave prison.

However, there is potentially a far more fundamental change in management that could make a difference to people with similar presentation as this person: that is, the recognition of the need for engagement and retention in mental health services of people who experience psychosis (RANZCP Clinical Practice Guidelines Team, 2005).

As indicated above, this person was treated a few years ago. Even with the knowledge at the time, ongoing mental health care could have been provided given the person's diagnosis, and the need for ongoing care in prison suggesting the need for community follow-up. However, with greater appreciation of the benefits of early intervention, it is easy now to look even further back in the constructed timeline of this person's care to an earlier time when this person might have been engaged and retained.

The knowledge about early intervention is not new — it has been promulgated for over 15 years but the work to ensure that early intervention is readily available has only occurred in recent times. Past annual reports have highlighted this gap in South Australia. Funding was announced by the Commonwealth Government in 2011 (see our Annual Report 2011, p. 43) and we now anxiously wait to see what South Australia will receive in the next round of allocation of these funds.

In the introduction to this case review, it was noted that the family were concerned that the events relating to their family member could recur today. In fact, our Office does receive calls from families of young adults with recent onset of illness where a person has been seen in an emergency department of a hospital, and sent home with limited follow-up (e.g., a GP appointment, or a referral to a group therapy program).

When this happens, just like in the case example, symptoms (including psychotic symptoms) have been attributed to personality or substance use and specialist mental health services have not seen that they have an ongoing case management role, even though the person may be treated with psychiatric medication that has been started by the service.

In these situations, best practice is that people who are at high risk of psychosis with pre-psychotic symptoms, or have a first episode of psychotic symptoms should be followed up. As in the case example above, an eventual diagnosis may only become apparent over time. At the beginning of a person's illness, diagnosis may not be clear, illness may be undifferentiated, but a

person should be engaged with a service, be monitored, receive education and if necessary, low dose trials of antipsychotic medication prescribed. Treatment can be indicated when there is violence and aggression, or a risk to others. Substance misuse also needs to be actively identified and treated (International Early Psychosis Association Writing Group, 2005).

So, if critical incidents can be prevented in the future, it may be through: offering early intervention services when diagnosis is not clear; the provision of 'dual diagnosis' — mental health and alcohol and drug misuse — services for people whose illness relapses with drug use; and providing greater access to ongoing community mental health follow-up for people who in the past were referred back to GPs or other services due to the workload constraints of specialist services. (This of course requires extra resources of the type allocated by the Commonwealth in 2011, and charted in our Annual Report of that year (p. 43)).

However, in situations where diagnoses are unclear, it is still likely to be the reviews by senior psychiatrists, either in hospital or prison, that will help provide clarity. It is still all too possible that valuable clinical information will sit in a paper file at a different location, inaccessible to clinicians who need to respond to an emergency. This is why a record system such as EPAS, if such technology were available a few years ago, may have prevented a tragic outcome. Of course, it exists now and it will be imperative in the roll-out, that people in mental health facilities and prisons are covered by this system.

Prisoner Mental Health

If prison is fast becoming an alternative mental health system, then what can a person with mental illness who is in custody expect?

First, fundamental rights must be upheld. With respect to civil rights, Articles 7 and 10 of the International Covenant on Civil and Political Rights (ICCPR) are relevant, which require that no one be subject to cruel, inhuman and degrading treatment or punishment, and that the inherent dignity of all humans be respected. The latter requires that an essential aim of the treatment of prisoners be reformation and social rehabilitation. General Comment 21 relevant to these rights recognises that persons deprived of their liberty will enjoy all rights set forth in the covenant subject to the restrictions that are unavoidable in a closed environment.

It is unlikely that a mentally unwell prisoner can be treated in a respectful and humane way, if necessary treatment is not provided to manage both personal distress and behavioural problems using an informed clinical and therapeutic approach. Similarly, offending behaviour linked to a mental illness is unlikely to be addressed prior to release from prison, if symptoms are ignored or behaviour is contained through restrictive practices without providing suitable therapy programs.

With respect to the Convention on Economic, Social and Cultural Rights (CESCR), Article 12 recognises the right of everyone to the enjoyment of the highest standard of physical and mental health. This also applies to prisoners. More specifically, the UN Principles on the Protection of People with Mental Illness and the Improvement of Mental Health Care articulate standards of care and rights with respect to treatment, amongst other rights.

In Australia, a key guiding document is the National Statement of Principles for Forensic Mental Health, prepared by Australia's Health Ministers (Australian Health Ministers Conference, 2002). The first seven principles are summarised in the next Table. These principles reflect broad system factors, and an assessment by this Office has been made based on the experience of our clients, our observations of the system, and information provided to us by practitioners and workers.

As can be seen, it is our view that the current arrangements for both men and women do not meet key national forensic mental health principles. While this is a national issue, the problems in South Australia are significant, and other states, most notably Victoria, have worked to improve practices that would better uphold these principles.

Note that only principles 1–7 are reported on. The remaining principles 8–11 are those that are related to direct service provision. They are: 8 — staff, knowledge, attitude and skills; 9 — individualised care; 10 — quality and effectiveness; and 11 — transparency and accountability. These principles would require a more specific assessment than we have undertaken. However, our overall impressions is one of skilled, dedicated practitioners, doing good work in the face of significant service capacity limitations in all the areas of assessment, treatment, rehabilitation, in-reach, and community care that the forensic service is involved in.

Outline of National Forensic Mental Health Principles 1–7, as applied to Prisoner Mental Health

Principle	Some key features related to prisons (see AHMC, 2002 for a full description of the features related to each principle).	SA Performance : system observations by the Office of the Public Advocate
1. Equivalence to the non-offender	Same rights to availability, access and quality of mental health care as the general population	NOT MET. Serious shortages of prison in-reach services and access to psychiatric beds (as few as 3 forensic beds for prisoners)
2. Safe and secure treatment	Treatment provided in a safe and secure environment compatible with treatment needs	NOT MET. Prisoners who should be transferred to a forensic bed can be cared for instead in prison in a non-mental health setting. Maximum security can be used as an intensive care ward
3. Responsibilities health/justice system	The provision of mental health care for offenders is the joint responsibility of Health and Justice to be addressed in partnership	PARTIALLY MET. This partnership can be tested because of the lack of forensic mental health resources and the demands then placed on correctional staff to manage clinical problems
4. Access and early intervention	Custodial facilities should have capacity to assess and treat and refer to specialist mental health services	NOT MET. Limitation on access to sufficient primary care in some prisons, and very limited access to specialist mental health services
5. Comprehensive forensic mental health services	Functions defined	PARTIALLY MET. Comprehensive service exists but is limited in the volume of clinical work it can manage
6. Integration and linkages	Linkages with other services defined	PARTIALLY MET. Linkages exist. Limited by work volume demand on forensic services as well as demands by partners such as drug and alcohol services and community mental health
7. Ethical issues	Highest ethical standards demanded	NOT MET IN ALL CIRCUMSTANCES. For example, Ombudsman’s report on the shackling of prisoners in general hospitals (included mentally ill prisoners)

It is acknowledged that newly funded initiatives will better address these principles. For example, the establishment of 10 extra forensic mental health beds will help our system respond better to principles 1 and 2, and providing a 10-person forensic step-down service will better address principles 5 and 6. However, while an improvement, such measures alone are unlikely to ensure that these principles are upheld with respect to prisoner mental health. Other steps will also be needed, including the provision of adequate prison mental health in-reach by a multidisciplinary team, and the establishment of at least 10 additional forensic mental health beds (based on our 2008 target of 60 beds, which itself may need to be reviewed).

Within existing resources across Corrections, Prison Health and Forensic Health, staff training and skill development will need to change to reflect the new population. For example, mental health first-aid skills and specific training on how to respond to behaviours related to mental illness can assist prison staff to support prisoners with mental illness, while being supported themselves with consultation and advice from mental health in-reach workers.



The Public Advocate (left) and the Principal Community Visitor Maurice Corcoran (right), worked together to bring attention to forensic mental health matters, both behind the scenes, as well as with the broader community through the media. Photograph by Nghiep Van Nguyen 18 June 2011.

Responding to the Needs of People with a Mental Illness in Prison

The solutions to providing an effective prison mental health service are generally well recognised.

First, the right to mental health care applies to prisoners — the services should reach equivalence to those available to the non-offender.

Second, each of the elements that are part of a community-wide mental health plan can be adapted and applied to the prisoner population — including prevention, early intervention, therapy services, rehabilitation and when required, hospitalisation.

Third, because many prisoners go in and out of prison, it is necessary to have effective continuity and follow-up, both on admission to prison and following their release.

Given the high prevalence of mental illness in prison, it is appropriate that mental health services have a permanent presence. This presence might be through an in-reach team or in some cases, the provision of mental health beds. The delivery of mental health services should be by staff responsible to the Mental Health system rather than the Corrections system, but with both groups working closely together.

To this end, some of the plans mooted for South Australia's forensic mental health system are positive. Mention has already been made of a proposed in-reach service, which could provide critical assessment, coordination and therapy services. The very presence of these services in a prison would assist prison staff prevent and respond to at-risk behaviours.

The extension of the electronic clinical record (EPAS, discussed earlier) to prisons will also be critical for people with mental illness who rotate through revolving doors of hospital, prison and sometimes homelessness. Getting the best possible information at times of an emergency could be lifesaving for this group, and it will be important that the forensic services get EPAS in the near future to enter their own assessments as well as to access information from the community.

Access to specialist mental health beds is a small but critical part of the equation. Hospital is a therapeutic environment, prison is not. However, because prison can provide close supervision, including 24-hour observation, it is possible for a person needing hospital to be held in prison for some time, in a way that would not occur if a person with a similar illness were in the community. Prison may provide this observation, but cannot provide ongoing psychiatric nursing care, and access to other health professionals. In South Australia, with only 40 forensic mental health beds, and most of those occupied by forensic patients, in 2011–12 the state was down to just three forensic mental health beds available for prisoners who were in need of acute care at any one time. At one point, it went down to just one bed for the state. Given the high rate of mental illness in the prison population, this is particularly problematic.

The provision of forensic mental health beds for women

Women prisoners, as a group, have high rates of mental illness and past experiences of trauma, either abuse as children or violence as adults. Therefore, while it is important that mental health services be readily available to prisoners and forensic patients of either sex, this need is particularly critical for women.

Over 10 years ago, the late Dr Margaret Tobin was particularly concerned about the facilities for women receiving care at James Nash House. Concerns include sexual safety, lack of privacy, and general lack of access to existing beds for psychiatrically unwell women prisoners (beds are mostly filled by men who are forensic patients), all point to the need to have a specific women-only ward or wing. This would provide safety, and also quarantine beds for women prisoners

who need treatment; the beds could not be occupied by males, who would need to be adequately catered for in a men's wing.

Victoria has specific provisions for women at both its stand-alone forensic hospital and at its prison. Acutely unwell women are cared for in a separate ward at the forensic hospital.

There is an onsite mental health presence at the women's prison, which not only directly provides services, but its presence positively affects the entire operations at the prison as staff respond to distressed or disturbed behaviour.

It is worth describing this prison unit in more detail, as it is an indicator of what can be achieved. The following is information that was collected by the Public Advocate during a visit to Victoria.

Victoria's Marmak Unit is located within the women's prison and is operated by the Health Department. The Unit has up to 20 beds, although it usually operates at about 14-bed capacity. The first impression of walking into the unit is the similarity between the communal lounge, kitchen, therapy rooms, and outside garden with those found in psychiatric units in the community; although, as all the patients are prisoners, they sleep in locked cells rather than rooms.

The Unit has been designed to foster teamwork between Corrections and Mental Health staff. The staff work-area is open plan. Corrections staff and Mental Health staff share the same office space. They act as part of one team. There is a shared handover attended by both groups — although each will then have a more detailed handover dealing with their own professional issues. Mental Health staff share risk and other relevant information at the joint handover, but other personal information is discussed at their own handover and would not be provided to Corrections staff.

Prisoners cannot be detained to the Unit. The voluntary nature of the care is an important feature in setting the ward culture. Patients need to agree to admission. The General Manager of the prison retains statutory responsibility for the prisoners and if necessary, could decide that a person needs to be housed at Marmak, but this is not usual.

The Unit aims to provide specialist mental-health treatment services to women prisoners experiencing mental health issues, including:

- Acute care for women with serious mental illness awaiting transfer to Victoria's stand-alone forensic mental health facility (the Thomas Embling Hospital);
- Sub-acute care for women in the recovery phase from an acute psychotic episode and upon return from the stand-alone hospital;
- Crisis care for women at risk of suicide or self harm;
- Psychosocial care for women with severe personality disorders;
- Care for women with age-related mental illness (e.g. dementia); and

- Multidisciplinary care, treatment and rehabilitation for women prisoners with psychiatric needs assessed as requiring assistance and integration into the mainstream prison population or the wider community upon release.

The Unit also has a comfort room to assist people who are distressed and agitated. A comfort room is an initiative regularly used in mainstream mental health wards, as part of a strategy to reduce the use of seclusion and restraint. The person is moved to the room, placed in a comfortable chair, and then provided with relaxing music, images and aromas. What works is very individual. All new patients at Marmmak receive a specialist occupational-therapy sensory assessment to determine which stimuli might be settling if the person is in crisis. Although this is a new innovation at Marmmak, there is no reason to suppose that the approach should not work in other locations, as the same strategies have been used in general psychiatric units with significant success.



Marmmak Psychiatric Unit, Victoria: Dame Phyllis Frost Centre, Melbourne. Photographs of artwork in the unit, and a recliner chair used in a 'comfort room' for distressed patients as part of a seclusion reduction initiative. Photos: Forensicare staff.

In South Australia, no such unit exists. A woman prisoner who is in crisis, is self-harming, and who for whatever reason cannot be transferred to James Nash House, might instead be managed in a maximum security cell, with a reliance on medication to control behaviour.

There are many reasons why South Australia should follow a similar approach to Victoria. First, it is effective. The alternative of relying on cells in maximum security might prevent and control behaviours but it does not address underlying treatment needs. Distress remains, and a person can continue to be a risk to themselves and others. Second, it is likely to be cheaper in the long run. If a person is unwell and at risk, a custodial approach can be expensive over the long-term, whereas a period of assessment and treatment will be cost effective, as behaviours are addressed.

South Australia is smaller than Victoria, so therefore there will be issues of scale in establishing services. Nevertheless, a specific strategy for women's care in the forensic setting could drive a range of services meeting women's needs ranging from prevention and early intervention, to the management of high-risk episodes requiring intensive specialist input.

With respect to beds, our overall forensic mental-health care bed number will increase from 40 beds to 50 beds plus 10 step-down beds. Some of the new beds could be specifically designated to meet the needs of women. Further, our Office estimated in 2008 that South Australia needs at least 60 acute beds (not including the 10 step-down beds that are additional to this) which leads to a question as to where any additional beds might be built.

Hopefully, this further expansion of forensic mental health services will be considered by the government, and plans made. If we were to have an extra 10 beds, it would be reasonable to consider operating a small number of these beds at the women's prison, staffed by both Mental Health staff and Corrections staff using the Marrmak model.

The situation for women prisoners with mental illness is critical, and needs action to address the disadvantage experienced by this group compared to male prisoners. Having said this, the situation for many male prisoners is not much better, leading to concerns in Victoria that women in that state have access to a prison-based inpatient unit, but men do not (with the exception of a small unit at the Melbourne Assessment Prison). For this reason, there are proposals in Victoria to build an extra 75 forensic mental health beds as part of a new prison development. Using a similar principle, the operation of a unit at a men's prison also merits consideration.

There are other lessons from this work in Victoria that could be applied in South Australia. There are benefits for a prison in having a mental health presence within its walls. While at Victoria's women's prison this benefit had come from an on-site inpatient unit, it is reasonable to expect that this benefit might also occur if an in-reach community forensic mental health service were operating in a prison. This is because such a service, as well as assessing and providing therapy for patients, would advise and support correctional staff and influencing practices.

Also, the 'mixed' model of having forensic mental health beds located both outside the prison at a stand-alone facility for forensic patients and unwell prisoners, as well as inside the prison for unwell prisoners, appears to have worked in Victoria. It has meant that women distressed because of personality disorders (often linked to traumas in a person's life such as child abuse and domestic violence) can access a specialist mental health service in prison, that can include a short inpatient stay, and then follow-up when a person returns to a unit located within the prison.

Conclusion

Mental health reform in South Australia has focused predominantly on services for the general community.

Forensic patients and prisoners with mental illness are mostly a vulnerable group who have difficulty asserting their rights, and are currently missing out on a level of service that meets that required by the National Forensic Mental Health Principles.

A broad forensic mental health plan, which replicates elements of a general mental health plan, including prevention, early intervention, therapy, rehabilitation and recovery, could guide the development of our services.

At this time, services for women need critical attention. However, the establishment of forensic mental health in-reach services, and the provision of a further 10 forensic mental health beds are immediate steps that could better meet current needs.

Reporting of Abuse of Children and Adults in Mental Health Settings



Former Psychiatric Hospital Ward. Google Satellite Photo.

In March 2012, concerns were raised in the media about the historical abuse of people in mental health settings.

Overall, there has been comparatively little published about this topic, possibly because the victims have been disempowered through abuse, fear of not being believed, or are unable to raise matters because they are struggling with poor health.

In the past, mental hospitals were not only the home of people with mental illness, but also institutions where children and adults who experienced a disability were placed.

When contacted by Andrew Dowdell, a journalist at *The Sunday Mail* who was writing a story about historical abuse, the Office of the Public Advocate offered to be a contact point for people who might read the article and wish to report their experiences.

Following the publication of an article titled “Mental Scars Spark Action” in the *Sunday Mail* on 25 March 2012, 14 people contacted the Office. We considered this to be a significant response from one press item.

We received responses from people who were detained as teenagers and adults as well as from their family members and staff, relating their experiences. The events occurred from the 1960s through to the late 1980s.

The majority of respondents described similar abuse experiences which included emotional, sexual and physical abuse as well as neglect. A common factor experienced by all of the respondents was the lack of respect, lack of accurate diagnosis and mismanagement of their needs at the time. Many reported exposure to distressing sights that they should not have been exposed to, particularly as teenagers.

The negative experiences had a major impact on their lives and have ongoing repercussions. Respondents reported that it had adversely affected their lives in many areas including relationship breakdown, mental health, physical health, employment prospects, and an overall lack of trust. One respondent defended Hillcrest Hospital in the 1960s and felt supported and nurtured. However, the respondent was aware of a staff member sexually exploiting child patients.

The majority of respondents want recognition from the government about what happened to them and for the government to admit they were wrong. They would like the public to be made aware of this information. They would like to see major improvements in the mental health system to include better monitoring and record-keeping. People being detained should be given a supportive and healing environment and the ongoing support they need to recover.

Respondents

A total of 14 responses were received: 13 telephone calls and one letter.

All respondents were happy for the information to be shared, and nine people were willing to be identified, with the others remaining anonymous.

Seven people reported abuse that occurred at Hillcrest Hospital from 1960 to the 1970s: one staff member, two adults and four teenagers.

Six people reported abuse at Glenside from the 1960s to the 1980s: four adults, one family member and one teenager.

One person reported a recent experience at a general hospital psychiatric unit.

Reasons for admission to a mental health institution.

Respondents were placed in mental health institutions for a number of reasons that included difficult behaviours as teenagers, attempted suicides, pattern of child and adult sexual abuse, breakdowns, postnatal psychosis and drug dependence.

A summary of abuse

A summary of experiences reported include:

- rape and sexual abuse by staff
- teenagers witnessed things they should not have: saw people who were psychotic, saw people over sedated on prescribed drugs, witnessed attempted suicide

- reports that staff played psychological games with patients — punished, threatened, laughed at and treated patients with contempt; male staff did what they liked, their attitude and behaviour did not appear to be accountable to anyone; indifference by staff; lack of care and lack of attention
- patients forced to clean up faeces from disabled children and older people
- patients witnessed other patients being treated like animals, patients throwing faeces, not wearing clothes and hosed down to remove faeces
- children and unwell adults were placed with people who were criminals, paedophiles, or were addicted to drugs
- adults with an intellectual disability placed in a caged yard and visitors on Sundays would poke a stick at them in the cage (we received more than one report of this practice of caging of people with intellectual disability)
- adults and children drugged against their will, strapped down and barely able to walk due to excessive drugs
- people being forced to participate in work programs such as cleaning car dashboards
- approached for sexual favours by other patients
- given electroconvulsive therapy without anaesthetic and then sent to work straight after the ECT
- drugs easily accessible
- people not told where they were or why they were there — no explanation given
- not provided support or appropriate therapy
- tried to report abuse but were not listened to

Impact these experiences had on respondents

Many reported a similar impact on their lives:

- don't trust anyone, don't trust doctors, won't tell anybody what happened to them, scared of government
- fearful and feeling anxious, needing to feel safe, not leaving the house, moving house, losing friends
- not able to work, changing jobs frequently, unable to keep a long-term job, living on disability support pension — poverty
- unstable life, frequent relationship breakdowns with partners and children
- no self-esteem or self-worth

- needing counselling
- never been the same since the experience
- attempted suicide
- experience triggered mental health disorder, post-traumatic stress disorder, and bipolar affective disorder
- too stressed to see a doctor — no trust.
- refuse to take any medication
- entering into abusive relationships
- major impact on physical health due to prescribed drugs over many years
- judged by others and seen as crazy
- alcohol dependence

Respondents were asked how they would like the government to respond to their situation and that of others.

Again, there were many similar responses to this question. A common theme was that the damage had been done and could not be undone.

- The mental health system needs to be addressed because it does not work, it needs better surveillance, good monitoring with checks and balances in place, better record-keeping
- people want recognition from the government about what happened to them
- people want an accurate picture presented to the public and the information to be out in the open
- the government needs to know what happened to people
- the government needs to acknowledge what happened to people, in particular to children
- the government needs to admit they were wrong
- the government needs to provide a letter of apology to people and their families
- staff who work there should be answerable
- inappropriate to put children in with adults
- inappropriate to put people in with criminals
- separate inpatient areas for vulnerable women — not mixed in with men
- appropriate assistance and therapy to be given to people during and after detention

- people should be given a supportive and healing environment while detained
- financial compensation — two people stated they would put their hands up if it was offered

Then and now

This information has been reported to the Minister of Mental Health who has noted the seriousness of the matter, the complex legal, clinical and social issues raised, and the need for further consideration, in conjunction with the Attorney General, of the appropriate means to address this matter.

A meeting was also convened with advocacy agencies in South Australia. The likelihood that this is a national abuse issue was raised. As a result of this meeting, it was felt appropriate to notify both the National Mental Health Commission and the Australian Human Rights Commission of this issue. It would be surprising if similar issues have not arisen in other states.

This area overlaps with other areas of abuse in the past and now. Insofar as this material includes reports of children who were abused, it is another example of the abuse of children in state care. The abuse of adults who are vulnerable represents similar exploitation.

Righting these past wrongs is important for so many reasons. It affords the victims the respect and value of which they were deprived in the past as fellow citizens and people with mental illness and disability.

It is also a salutary reminder about the dark side of institutions where vulnerable people were hidden away out of sight from the rest of the community. These places were founded with noble goals of ‘asylum’, the creation of a protective retreat. There were many dedicated people who worked in these understaffed settings doing good work. Some led our community in the early days of deinstitutionalisation.

Yet the places were flawed. We know that institutional cultures can create dangerous dynamics of power, control and abuse, made worse when there are insufficient resources and little transparency. People in these cultures can get desensitised to what goes on around them. This may not have happened in every ward or to every patient, but it would seem to have happened often enough in different units to lead to abuse and neglect.

In looking back, we cannot make excuses for our forebears. It is wrong to say that people did not know better. It was just as wrong to abuse and neglect people then as it is now. The perpetrators bear criminal responsibility. The providers of services did not deliver safety. As a community we collectively failed the mentally ill and disabled who were neglected or abused while hidden away.

From history, we learn for the future. The descriptions of people caged and hosed down belong to a bygone era. Yet how will people in the future look back at our current era — the early 21st century? What might retrospective inquiries conclude about the plight of people with mental illness or disability in our present time? What would be the view of our community in the future of the current overrepresentation of people with disability and mental illness in prison, the number of people with mental illness or disability who are homeless, or of the practice of

restraining people in Emergency Departments who would not be restrained if there was a proper ward bed available for their care? How will the plight of people in boarding houses be seen, or the apparent overuse of Community Treatment Orders in Australia compared to other developed nations? How will the level of effort to tackle Aboriginal mental-health care inequality be judged?

The time might now be right to consider historical abuse of people in mental hospitals, either as a topic in its own right, or as part of our community's wider response to the abuse of children and vulnerable adults.

Reviewing Programs and Identifying Unmet Need

Mental Health Services

Aboriginal Mental Health

The need for urgent action to catch up in the area of Aboriginal and Torres Strait Islander mental health was cited in our 2010 Annual Report (p. 29 onwards) and further discussed in 2011 (p. 47 onwards). It was concluded that progress in this area has been painstakingly slow. There have been good examples of excellent work at the frontline by Aboriginal mental health workers and staff in mental health services to provide culturally safe services. However, there has been little evidence of a concerted effort driven from the top, as envisioned by the Social Inclusion Board, to deliver equality of access to specialist mental health services for Aboriginal people that are also culturally safe.

This needs to be seen in the context of the major concerns of Aboriginal advocates expressed to the Social Inclusion Board five years ago, that Aboriginal people may not benefit from broad changes in mental health reform that might assist the rest of the population (Social Inclusion Board, 2007). Implementation would require strong leadership from the top, and it was expected that a leadership group would undertake strategic audits of progress against key measures and report to the Chief Executive on progress and options for improvement for Aboriginal people (Social Inclusion Board, 2007).

The need for strategic audits is the same now as it was five years ago. There is also a need for tangible measurement of what is actually being done in communities to be recognised. Given that the timeframe of the Social Inclusion Board *Stepping Up* 5-year plan has reached its end, an audit could define the work yet to do. It would be likely to show that Aboriginal people are accessing some of the 'steps' of the stepped model, such as involuntary mental health care, but there is inadequate access to other services delivering prevention, early intervention, ongoing community care and rehabilitation, which are key elements of *Stepping Up*.

An audit could be a catalyst for immediate action. Acknowledgement of history, a social justice approach and reconciliation can empower communities, and at the same time both primary and specialist services can deliver equality of access to the types of services that are available to the wider community. For this to happen, services have to not only be available but also be culturally safe so people will want to use those services. Aboriginal-controlled health organisations could have a major role in planning and delivery.

It is possible that one reason for the lack of delivery is an inherent limitation in government systems to respond effectively to complex community problems such as Aboriginal mental health. Instead of government retaining full power and only 'consulting' with communities, a genuine power sharing through working together may deliver the solutions that a more traditional government approach has not been able to provide. This is the essence of what is now described as 'co-design' and 'co-production.'

The Office of the Public Advocate has in its annual reports taken the approach of pushing for delivery of key recommendations by the Social Inclusion Board to meet service gaps. This has clearly had limited effect. Rather than simply pushing harder, it would seem that it is now better to argue for a more substantive change in the way power is shared and decisions are made in the process of policy development, implementation and funding of Aboriginal mental health initiatives.

A colleague working in Aboriginal Affairs drew the attention of the Public Advocate to a recent article on the theme “Collective Impact” (Kania & Kramer, 2011). It is a generic article addressing the need for broad cross-sector coordination for large-scale social change, in contrast to the approach of the social sector, which is to focus on isolated interventions by individual organisations.

Kania and Kramer (2011) consider the five conditions for collective success in any social change. The first is a *common agenda* that requires a common understanding of the problem, a shared vision for change and a joint approach. The second is a *common measurement system*. Kania and Kramer (2011) note “Agreement on a common agenda is illusory without agreement on the ways success will be measured and reported.” The other conditions are *mutually reinforcing activities*, *continuous communication* and a *backbone support organisation*. For this to work, funders must be prepared to let grantees steer the work, and drop their preference for short-term solutions.

These are considerations for the next phase of Aboriginal mental health planning, given that the current Social Inclusion Board plan is due to expire. There is a strong argument that catching up in Aboriginal and Torres Strait Islander mental health should be given top priority in a new mental health plan.

In the interim, to provide for equity as new mental health resources from the Commonwealth are distributed, consideration should be given to funding Aboriginal-controlled organisations to deliver services, and locating new services in places where Aboriginal people live and where gaps exist.

Progress in mental health reform

Ongoing mental health reform has been marked by successes and challenges. Successes include the ongoing benefit to consumers living in the community from non-government support, and the operation of the residential community recovery centres.

Benefits of reform

A key element of the current mental health reform has been the development of the non-government provided “Individual Psychosocial Rehabilitation and Support Services” (IPRSS). These services work alongside government clinical services. SA Health appointed Health Outcomes International to conduct an evaluation of the program.

Their report was positive about improvements in standard outcome measures, a reduction in the rate of mental health admissions by 39% and associated average length of stay by 16% (Health Outcomes International, 2011). This positive result is consistent with evidence in the literature of the benefit of such services.

In our previous annual reports, we have also described the positive benefits to clients of admission to Community Recovery Centres. These centres have been prepared to accept clients beyond their initially envisioned brief, and from our observation, effectively delivered rehabilitation.

The Housing and Support Services Program at Glenside is now open, delivering individual supported accommodation for 20 people in their own units. There have been similar positive reports of the progress of individuals in this program. A limitation is that other people in need of this 24-hour support have not been able to be admitted because of the limited numbers.

Community teams are reorganising and operating from purpose-built accommodation. Much of the mental health reform rides on the effectiveness of the community teams acting as the hub of the reform. While the new accommodation is necessary and welcome, and will no doubt assist with the delivery of care, it is still too early to know if the reorganisation of teams will deliver the necessary changes required for reform. The new community mental health model, which was intended to deliver assessment interviews to new clients, was described in our 2010 Annual Report (p. 40). It is likely that more clinical staff will be needed to provide the necessary assessment to people who request it.

Challenges: Establishing Intermediate Care Centres as an alternative to hospital

A particular challenge has been the problem of access block to acute beds, which has meant that consumers have prolonged waits in emergency departments that are not designed for their care.

During the year, access to psychiatric wards was an ongoing problem, even though additional Intermediate Care Centre (ICC) beds were available, which should have dealt with this demand. The government response to the Social Inclusion Board bed plan was reproduced in our 2009 Report (p. 32). The 252 adult acute inpatient beds would with reform become 204 acute inpatient beds and 90 intermediate care centre beds. In essence, recurrent costs associated with the closure of 48 acute beds would fund the 90 ICC beds.

Whether or not this can work depends on how ICC beds are utilised which depends in part how their role is viewed by both the community and the staff who operate them and promote their use. These non-hospital services have a different staffing structure than traditional hospital wards. This can mean that more resources can be available to employ highly trained staff to undertake therapy programs, compared to a traditional ward which often uses skilled staff to do day-to-day observations and support roles and then has insufficient resources to allocate to psychotherapy. Some cities overseas can manage most of their demand in community units and reduce their reliance on hospital beds. Such models usually need staff committed to their effectiveness. The vision for such services should be to provide a better alternative to hospital, and should not merely be seen as a 'cheap' hospital bed.

At least in the first year, this transition has not been smooth. 'Dual funding' of both existing acute beds and new ICC beds has continued for an unusually prolonged time and this increased doubts in the sector that the ICC could provide hospital substitution because the demand for beds and waits in EDs continued. The eventual closure of the acute beds occurred at the end of financial year, in mid-winter, the time of year emergency departments were also trying to manage winter demand for people with physical illness, and had little capacity to deal with increased numbers of people waiting to be seen.

Our understanding was that the different ICCs were getting up to speed, but at different rates. The end result is still to be determined, and we will not know until services have been evaluated as to whether the model has been sufficiently resourced to meet the demands expected of it.

Policy or implementation?

This also raises the questions as to whether the problem that occurred this year with the transition from acute beds to ICCS rests with the number of bed closures recommended in the original Social Inclusion Board plan — i.e. the policy is wrong, or alternatively, the policy is right but the implementation of the policy did not deliver.

This is also complicated by the fact that for the acute transition involving a bed reduction to occur properly, other parts of the stepped system also need to be properly up to speed; people might unnecessarily occupy acute beds, who would otherwise not be admitted if there was sufficient access to community packages, supported accommodation and in particular, 24-hour supported accommodation for people who have high needs. There is also a flow-on from the gaps in forensic mental health services. If acute beds are occupied by 'overflow' forensic patients that would otherwise be occupied by people admitted from emergency departments, then these community patients will be more likely to wait in a queue in the emergency department. Acute bed numbers are calculated on community need, and beds occupied by forensic patients are essentially already 'closed' for use by members of the general community.

Lack of access to acute beds can be the critical breaking point reflecting gaps in other parts of the system, not just a lack of acute bed numbers.

When too many beds are not enough

This debate needs to be seen in the setting of ongoing debates about the role of community care and hospital care. The arguments apply across all of health care. Rosen et al. (2010), in reviewing evidence for community vs. hospital care noted that community health care has been

demonstrated to be a more cost-efficient and cost-effective alternative to hospital centred care, particularly for persistent, long-term or recurrent conditions.

This year, Cunningham (2012) critiqued this, challenging the claims of Rosen et al., particularly with what he saw as the lack of benefit to people with acute conditions. In response, Rosen et al. (2012) recently published an article that particularly uses the example of mental health. Its subtitle is “when too many beds are not enough”. The article considers both the evidence for better outcomes, and the economic analysis of cost effectiveness.

The authors point out that there is inevitably a push to reinstitutionalise people, and this regressive influence can cause a loss of momentum in transforming clinical culture (Rosen et al., 2012).

The bed modelling in the Social Inclusion Board plan was not challenged when it was released but more recently, there have been arguments that the numbers used to justify the acute bed reductions must be wrong, based on the fact that people are waiting in emergency departments. While it is important that we have sufficient beds, it is also important that we do not have too many, because as resources get diverted from community care to hospital, there will be less community staff to follow up people on discharge, people will relapse, and there will be a self-perpetuating increase in demand — too many beds will indeed not be enough.

The Australian Medical Association (AMA) has called for clarification by the Minister about bed modelling, benchmarking, veterans’ beds, and confirmation of reinvestment of money saved from previous closures of psychiatric beds (Sharley, 2012). This of course is information that should be readily available. With respect to veterans’ beds, the AMA appropriately suggests that there should be a consistent national approach to veterans’ bed modelling, which in turn influences the number of community beds, depending on whether or not veterans’ beds are counted in the total number.

The Office of the Public Advocate does have a program review and unmet need function, and could review modelling and benchmarking of services for people with mental illness. This is a task we have not undertaken at this time as it would require some time to not only collect data, but also discuss their application with planners in different jurisdictions. A review would need to consider benchmarks based on number of different bed types per head of population, and the application of different population models such as the NSW Mental Health Clinical Care and Prevention Model, which is a population-based model that over the past 10 years has influenced planning in many Australian jurisdictions (NSW Health, 2010). The Social Inclusion Board relied on the analysis by Andrews et al. (2006) of the report of World Health Organization’s Collaborative Centre for Classification in Mental Health *Tolkien II*: however, the reduction in acute beds in *Stepping Up* is not as great as would be indicated in the Andrews et al. modelling.

The quality of planning varies internationally, but ideally should consider the epidemiology of illness, the best practice interventions needed to respond to it, and set resource targets (Pirkis et al., 2007). While it is appropriate that these targets should be subject to ongoing review as complex systems develop, problems that develop in implementation may not simply reflect a lack of beds, but the effectiveness of new services, and changed management practices.

While this discussion is primarily about acute beds in mental health, similar considerations apply to long-term beds. We hear calls to reinstitutionalise those with severe mental illness, often from the neighbours of people with a mental illness who have a behavioural problem. Invariably, there is a real issue that has prompted this concern — people have been discharged into isolated community settings with insufficient support and follow-up. The reinstitutionalisation response is to see the problem as a failure of policy. However, the OPA response is to see this as a failure of funding and implementation of policy rather than a failure of policy per se. When assisting with individual matters, our approach has been to advocate for more services to seek a response — to deliver for the individual what existing national and state policies intended.

The evidence base for the effectiveness of community mental health programs is strong, but when failures occur, they can be due to a lack of resource to provide sufficient community services, even though the money required for the community service is usually less than what would have been spent if the person was in hospital. Insufficient NGO support, lack of access to 24-hour care, or insufficient access to community mental health worker follow-up can all be factors.

People do have a right to live in the community, and to receive necessary clinical services and psychiatric disability support services. People with mental illness inevitably prefer community life to hospital accommodation (Craze Lateral Solutions, 2005). Community care, when resourced and delivered effectively, will work and is the choice of consumers.

If an acute relapse occurs, there is also a right to receive acute inpatient care, and to access it promptly. A person in need of such care should not experience a distressing, undignified wait in an emergency department, possibly restrained.

Both rights — the right to live in the community with support services if needed, and the right to receive acute hospital care — are important, and cannot be traded off against each other. Getting the system working requires a balanced approach.

Transformation of Older Persons Mental Health Services

Aged mental health care will be the next area to benefit from the reallocation of historical mental health funds to new areas. Long-term aged care beds at Glenside and Oakden have closed or will be closed. In our Annual Report 2010 (p.38), we described how the existing funds freed up through reform would be reinvested in older persons' mental health services. An extra indicative 50 FTE older persons' community mental health staff will be funded from money traditionally spent on older persons' mental health inpatient units (subject to the completion of a business case). In addition, freed-up funding will subsidise the care of people by non-government organisations in 24 beds in transitional care units and 40 beds in intensive care behavioural units for older people.

This expansion of older persons' community mental health will be the first significant increase in the number of community mental health staff for many years and is eagerly anticipated.

Mental Health Funding

In our 2011 Annual Report, Recommendation 11 of Stepping Up was discussed. This required that transition funding and funds freed up through the implementation of the plan be enveloped and managed carefully.

The report noted that the Public Advocate has been reassured that the enveloping and protecting of funds had occurred.

Just prior to the end of the 2011–12 financial year, the Public Advocate sought reassurance from the Chief Executive of Health that all traditional mental health recurrent funds will be spent on mental health needs, particularly those funds spent at Glenside on chronic and complex patients in the extended care adult services and the psychogeriatric services.

The Public Advocate was assured that mental health funds will be spent on mental health services. The actual mental health expenditure is well in excess of historical levels.

National Mental Health Commission

In the 2011 Annual Report, this Office put forward the benefit of a state Mental Health Commission to oversee mental health planning and monitor its implementation.

The response from the Minister in June 2012 was that as the new National Mental Health Commission's role is still being established, it will take some time to determine what sort of impact it will have upon the mental health system in South Australia. The Minister had been advised by his Department that it is not aware of any other countries that have both a National Mental Health Commission and state-based (or equivalent) jurisdictions. It would be reasonable to expect issues with duplication to emerge between a state and national commission. The Minister has asked his Department to keep him informed on the progress of the National Commission, for consideration of this matter at a different time.

While the OPA still supports the arguments put forward for a Commission in our 2011 Report, the Minister's response is very understandable. In fact, the recent work of the National Commission does suggest that it is taking a leadership role in mental health covering both state and Commonwealth services, and should hold state services accountable. Its first report card is very encouraging, recommending increased access to services, greater transparency, a reduction in the use of involuntary measures, a prioritisation of the needs of Aboriginal and Torres Strait Islander people and focusing on improving the physical health of people with mental illness, amongst other recommendations (National Mental Health Commission, 2012).

Reviewing Programs and Identifying Unmet Need

Adult Protection

Introduction

On World Elder Abuse Awareness Day in June this year, the Minister for Health and Ageing, the Hon. John Hill, launched the report of the Office of the Public Advocate's Vulnerable Older Adults Project, *Closing the Gaps*. He then tabled this work in State Parliament later than day. This report is now on the state government portal and can also be accessed using links from our own website www.opa.sa.gov.au

Minister Hill acknowledged the recommendation for the development of a policy framework for South Australia, which would enable early intervention and greater awareness of abuse among community members and service providers, and provide for a mandatory response. Minister Hill strongly supported the rights-based approach. He has forwarded the *Closing the Gaps* report to the Safe Communities and Healthy Neighbourhood Cabinet Task Force, Senior Officers' Group, to consider its recommendations.

The positive response to the report has been heartening, not only for the Office of the Public Advocate but also for practitioners who were part of the group of one hundred and thirty people from a wide range of agencies who were consulted during the project. The time, energy and expertise given was generous and inspiring, especially in a resource-stretched industry. It was very important to capture the 'on the ground' practical experience of the service providers who had significant experience in working with vulnerable older people.

Recommendations of the Report

Gaps identified in our current system must be closed to ensure that vulnerable older people at risk of abuse are offered support and protection to enable them to live their lives free of exploitation and abuse. In formulating recommendations to do this, the practitioners supported legislative reform, advocating that this was the only way to close all of the gaps in the current system and enable a consistent, coordinated, mandatory response to prevent and respond to the abuse and harm of vulnerable older people in Australia. Rather than making amendments to existing Acts, the recommendation is for a new Adult Protection Act that would specifically address the support and protection needs of adults who are vulnerable and at risk of abuse.

'It could be leading legislation for South Australia and I think it will do justice to the type of work that we've done. My support is behind strongly campaigning for a new Act, not meddling with other Acts. We need to start talking about aged rights in a way that is meaningful' (Project Participant).

While awaiting legislative reform, the practitioners agreed that the development of a rights-based policy framework would help. The practitioners endorsed the rights-based, whole-of-government policy developed by Associate Professor Wendy Lacey from the University of South Australia (this is Part B of the *Closing the Gaps* report and is also available on line), agreeing

that it would go a long way in addressing many issues in the current system. However, they emphasised that this should only be an interim measure until legislation is in place. Other recommendations included the construction of a risk assessment model and a data collection system across all government and non-government agencies to measure the incidence, causes and contributors to the abuse of older people. These data could also be used to develop a profile of those who perpetrate abuse and their relationship to the older person to enable preventative strategies to be focused most appropriately.

This Office is grateful for the financial support of the Disability, Ageing and Carers Branch of the then Department for Families and Communities which supported this work through Improving with Age — Our Ageing Plan for South Australia, and the Community Care Innovation Fund.

The work was undertaken in collaboration with the Human Rights and Security Research and Innovation Cluster at the University of South Australia, in particular with Associate Professor Wendy Lacey of the School of Law, and Professor Nicholas Proctor and Associate Professor Kay Price, both of the School of Nursing. The Project Officer for this work was Elly Nitschke of our Office.

Review of Our Actions to Prevent the Abuse of Older South Australians 2007

When launching the *Closing the Gaps* report, Minister Hill also announced that a review of *Our Actions to Prevent the Abuse of Older South Australians 2007* would be undertaken by the SA Health Office for the Ageing. The Public Advocate is pleased to have a staff representative on the Steering Committee to explore options and provide input and advice into the redrafting, launch and implementation of a comprehensive strategy to respond to and prevent the abuse of our older citizens.

Participation in a University of South Australia Research Project.

The University of South Australia's project, *Preventing the Abuse of Older People by their Family Members* has drawn to a conclusion with the final report expected soon. It has been led by Associate Professor Dale Bagshaw of the Hawke Research Institute at UniSA and funded by an Australian Research Council Linkage grant with the University's industry partners, The Office of the Public Advocate, the Office for the Ageing, Relationships Australia, Alzheimer's Australia (SA) and the Guardianship Board to develop, trial and evaluate models of older person centred family mediation to prevent the financial abuse of older people by their family members. As a project partner, the Office of the Public Advocate contributed 'in-kind' support that included the provision of a qualified mediator, experienced in mediating conflict situations involving older people and their family members and as a member of the reference group providing advice and guidance based on our experience.

Other collaborative work on this project promoted empowerment models of practice that will be very useful in informing a new dispute resolution program of the OPA. This is expected to be a function of this Office when conflict occurs with Advance Care Directives or health consent, and as provided for in the Advance Care Directives Bill tabled in parliament in late 2012.

Disability Justice Strategy for People who Experience Disability

This matter was reviewed in the 2011 Annual Report (p.52 onwards).

Many of the strategies are relevant to all people who are at risk, irrespective of age or other underlying reasons for being at risk.

The Social Inclusion Board's *Strong Voices* report recommended that the government develop a comprehensive Disability Justice Plan in consultation with people with a lived experience of disability, the Public Advocate and the Health and Community Services Complaints Commissioner.

This work has commenced, and the Public Advocate is a member of the steering committee.

Promoting Rights and Interests

Supported Decision Making

Introduction

The background to supported decision making was discussed in the 2009 Annual Report and progress regarding the South Australian Supported Decision Making Project was recorded in our 2010 and 2011 Annual Reports. This project, based at the Office of the Public Advocate and funded by the Julia Farr MS McLeod Benevolent Fund is now completed and an independent evaluation has demonstrated the effectiveness of this intervention.

It is worth recapping why the concept of supported decision making is important. It fosters autonomy. People with a disability make their own decisions rather than having decisions made by others. Providing support is a viable alternative in many situations to substitute decision making. While formal substitute decision-making is clearly recognisable (for example, a guardianship order), more commonly, substitute decision making can be 'informal' when decisions are made for a person by family, friends or professionals. Supported decision making seeks to help family or friends take on a decision-support role, rather than a substitute decision-making role.

In our model, the person who wishes to receive support decides who will deliver that support, and for how long. It is a role that cannot be undertaken by paid workers.

All too often we hear from people with a disability that they have not been expected to make decisions. Decisions are made for the person, and there has been no opportunity to acquire decision making skills and experience. Supported decision making provides such opportunities, to the extent that for some people, a supported decision-making arrangement may only be needed while a person develops new skills and confidence. It can be a short-term intervention to provide empowerment.

The United Nations Convention on the Rights of Persons with Disabilities recognises that disability is a result of environment, and not just an individual's impairment. Attitudinal and environmental barriers hinder a person's full and effective participation in society on an equal basis with others (UNCRPD, 2006). Article 12 of the Convention recognises that persons with disabilities have the right to recognition everywhere as persons before the law. States Parties are expected to take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.

This intervention is fundamentally about preserving basic human rights: equality, dignity, and freedom. Some people ask us why it is necessary to have a specific intervention labelled 'supported decision making' when what are being advocated are the traditional values of personal autonomy, the least restrictive option, and the provision of support which for all of us can occur naturally.

Unfortunately, it is all too easy to revert to traditional paternalistic responses, particularly if the rights-based, less restrictive alternative is vaguely defined and somewhat aspirational. If the more intrusive intervention of guardianship is specifically defined in legislation and provided by

the state for free, there will be little incentive to consider alternatives, particularly if the exact nature of these alternatives is uncertain. Supported decision making offers a practical strategy that can be delivered. It offers a way of helping people with their decision making without needing an order.

This discussion will reconsider the Stepped Model of Supported and Substitute Decision Making, the supported decision-making approach used in the South Australian Project, and the results of that project. While descriptions of the rationale, model and results of evaluation have already been published in a number of documents on our website over the last three years, this summary in this year's Annual Report seeks to bring together this information.

The Stepped Model

The 2012 Stepped Model is illustrated in the next figure. The South Australian Project developed from earlier versions of this Stepped Model.

We first proposed a broad Stepped Model of Supported and Substituted Decision Making in our 2009 Annual Report. This model described different interventions based on the level of autonomy retained by the individual, and the level of intervention by the state.

The aim of having such options is to avoid escalation into more intrusive interventions that may not be needed. Professor Terry Carney critiqued our original stepped model in a book chapter in 2012. He noted that "...the proposal provides a more granular range of choices in place of the more binary one of making or denying guardianship..." In his article, he goes on in a prescient way to note that new legal tools cannot rectify deficits of service provision or civil society. He says that wide spectrum tools such as the one proposed by us, can "...only be judged by how well it mobilises public or private resources (such as informal supports of civil society) in accordance with peoples' individual set of values and preferences (in this and other respects); but the point here is that agency is *realised* only to the extent that resources *exist* in the external environment" (Carney, 2012, p.17).

This turned out to be very much the case in our trial, particularly when people made accommodation or support decisions in our trial that then had to be resourced. Frequently, our facilitator needed to provide advocacy herself or link clients with advocates so that people having made a decision could see it effected. In the future, reforms such as the NDIS will be significant in addressing these current deficits so that reasonable expectations emanating from decisions will be met.

In 2010, the Stepped Model was modified in that year's annual report to provide more detail about different forms of supported decision making, to define assisted decision making as distinct from supported decision making, and incorporate co-decision making. The latter followed communication between our Office and Professor Neil Rees and his team at the Victorian Law Reform Commission who were considering co-decision making models.

This year, a minor alteration has been made in the axis label of the diagram, which is the only difference between the 2010 model and the 2012 model. The X-axis previously described "increased care and protection and increased intervention by the state" as the model described each step from autonomous decision making, through different forms of supported decision making and onto guardianship. This axis now just reads "increased intervention by the state" and no longer refers to protection. It is wrong to equate increased state intervention with

increased protection, because a person can still have extensive state involvement such as through guardianship, and still be isolated. For example, a person who has more personal control in their life through supported decision making, and more community connections through their links with supporters may be better protected than a person who is isolated and powerless. The latter can occur when a person considers they have no option but to comply with the demands of others.

It is worth recapping the distinction between assistance and support in this model. Assistance can be provided by anyone — staff at a hospital, disability providers, or people in any community organisation. It may take the form of taking time to give explanations, repeating information, and having information sheets in simple language that use diagrams. It is an obligation placed on our community to provide such assistance. Assistance is a form of reasonable accommodation, as described in Article 5 of the UNCRPD “equality and non-discrimination”.

Supported decision making, however, relies on a person asking a trusted friend or family member to regularly provide support over a particular area of decisions.

Supported Decision Making Model used in the South Australian Supported Decision Making Trial

The project facilitator established agreements between a person wanting support, and their nominated supporters. Education was provided to participants to determine if they wanted supported decision making, and to provide support in their initial key decision — whether or not to proceed with supported decision making, and choosing a supporter. The different roles are described in the following table.

Supported Decision Making — Participant Roles
The person receiving support needs to be able to:
Express a wish to receive support
Form a trusting relationship with another person(s) (supporter or monitor)
Indicate what decisions they may need support for
Indicate who they wish to receive support from for which decision
Express a wish to end support if that time comes
Be aware that they are making the final decision and not their supporter (take responsibility)

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

Assist in the expression of that decision to others if required

Supported Decision Making — Participant Roles

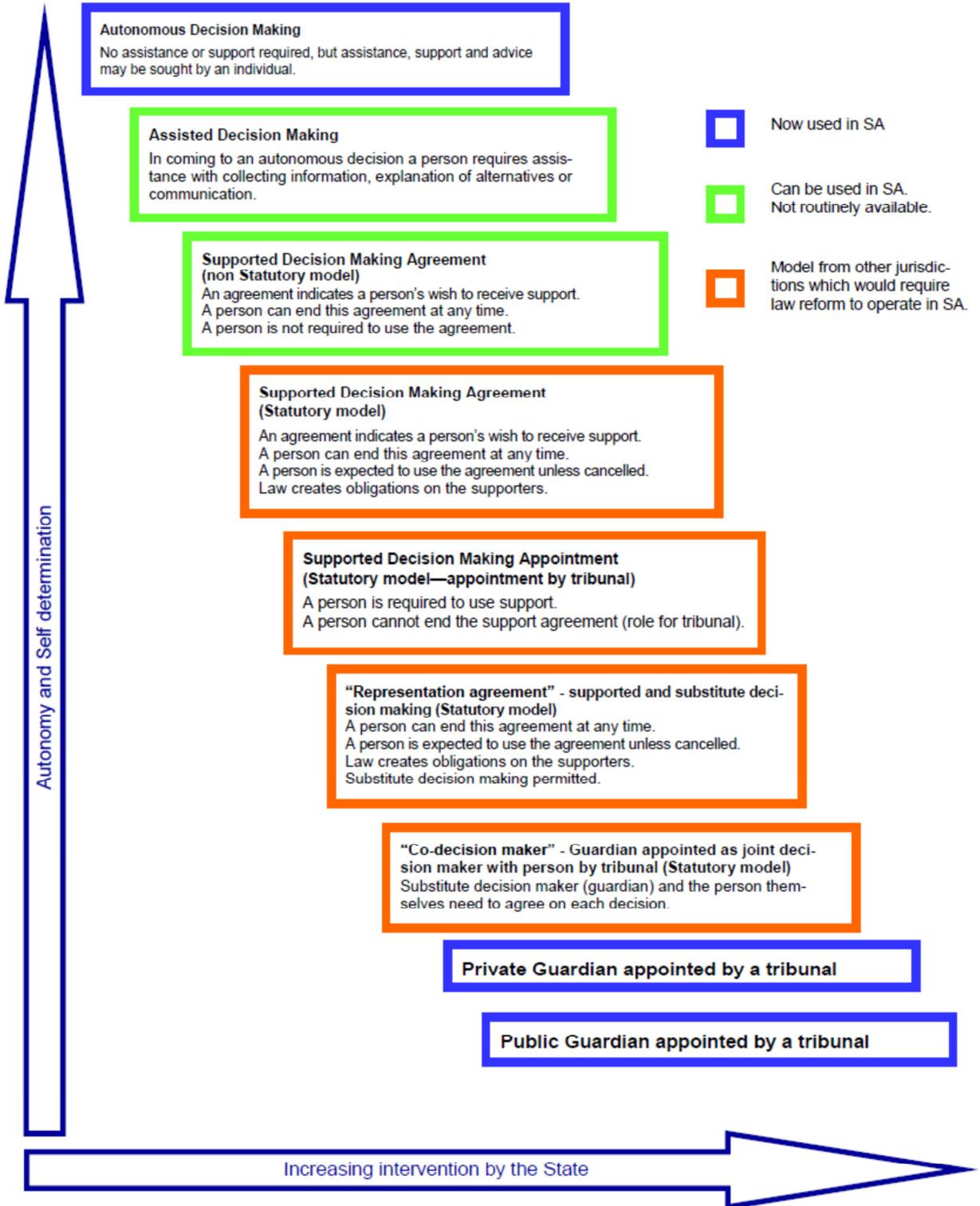
The South Australian trial involved setting up an agreement between a person with a disability and a family member or friend who would act as a decision supporter. It is a non-statutory model. Therefore, in looking at the successes of the trial, and also its weaknesses, it is important to acknowledge that this is just one form of supported decision making. For example, this trial could not accept individuals where there was significant conflict with families and friends, to the extent that some members of a family may not recognise and accept the decisions made with support. In a *statutory* model, where supported decision making, and the decisions made with this support are recognised in law, it would permit supported decision making to operate in these settings.

As a new intervention in South Australia, the project was submitted to the SA Health Human Research Ethics Committee for approval.

This project was subject to independent evaluation. Margaret Wallace of Muirgen Nominees was the successful tenderer for the evaluation — the outcomes of which are reported later in this section. The approach of using an empirical trial has not been common in guardianship law reform overseas. More often, systems are designed and then legislated for. The trial approach however, has now been adopted in other jurisdictions in Australia as a way of developing models to inform future evidence-based law reform.

Equal Recognition under the Law

A Stepped Approach to Supported and Substituted Decision Making



Participants and Decisions Made

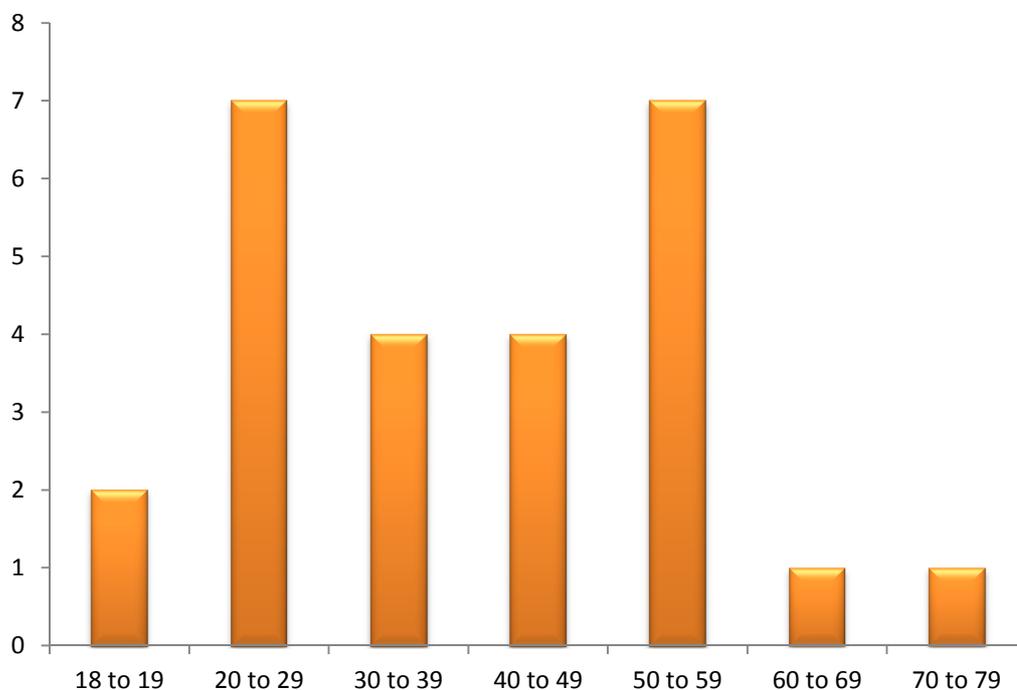
Twenty-six people who had a brain injury, intellectual disability, autism or a neurological disease affecting decision making, signed agreements with supporters. Fifty-two people had considered supported decision making, and even more had sought information. The fact that less than half proceeded to an agreement is unremarkable, because some people were isolated and did not have a family member or friend who could act as a supporter, and others were at the centre of significant conflict among family and friends.

Recruitment initially was through referrals from disability services and the Office of the Public Advocate itself. At the beginning, there were 16 referrals from non-government agencies, and up to 13 referrals from government agencies for a possible group of 10 in the first phase of the project (Wallace, 2012).

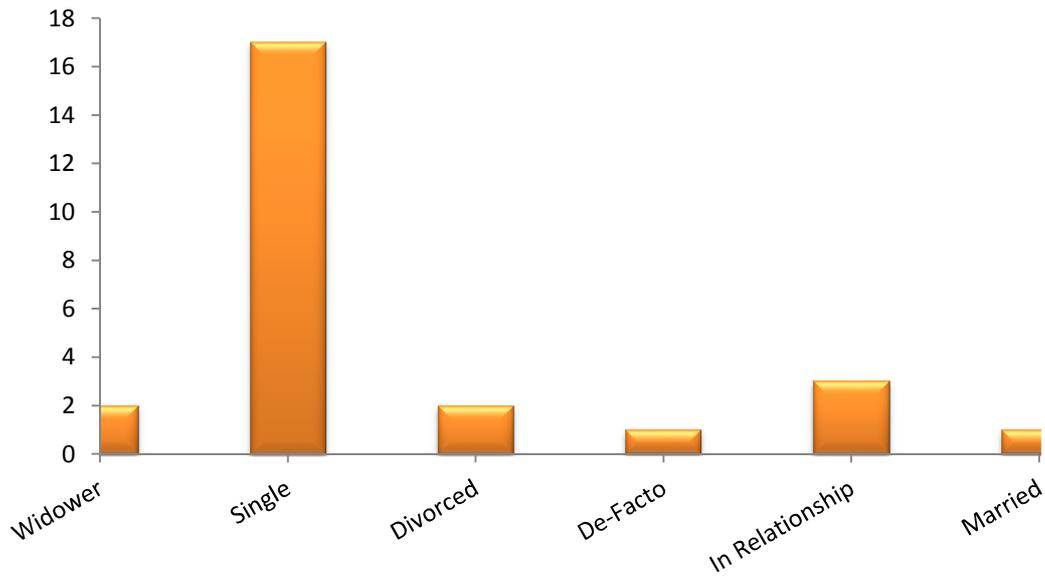
As the project expanded, people requiring early intervention were directly recruited through approaches to disability organisations. In essence, having been provided with information about the project and what it sought to do, people self-referred.

Descriptive statistics initially prepared for the 2012 International Guardianship Conference by Cher Nicholson, Senior Practitioner and Project Officer for the Supported Decision Making Project, provide a further breakdown of the overall study population. (Ms Nicholson was the practitioner who assisted the participants first to establish and then use their agreements.)

The project engaged a wide range of adult participants, from young people still in school to older people living in residential aged care. The majority of participants were not in a relationship. Details of the age and relationship status of participants are illustrated below.

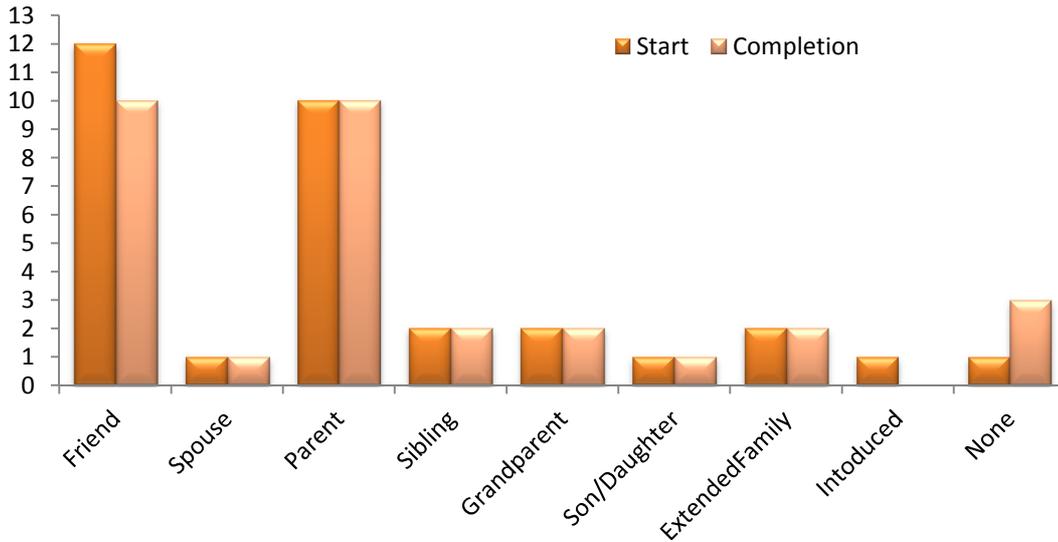


Supported Decision Making Project. Age of Participants.



Supported Decision Making Project. Relationship Status of Participants

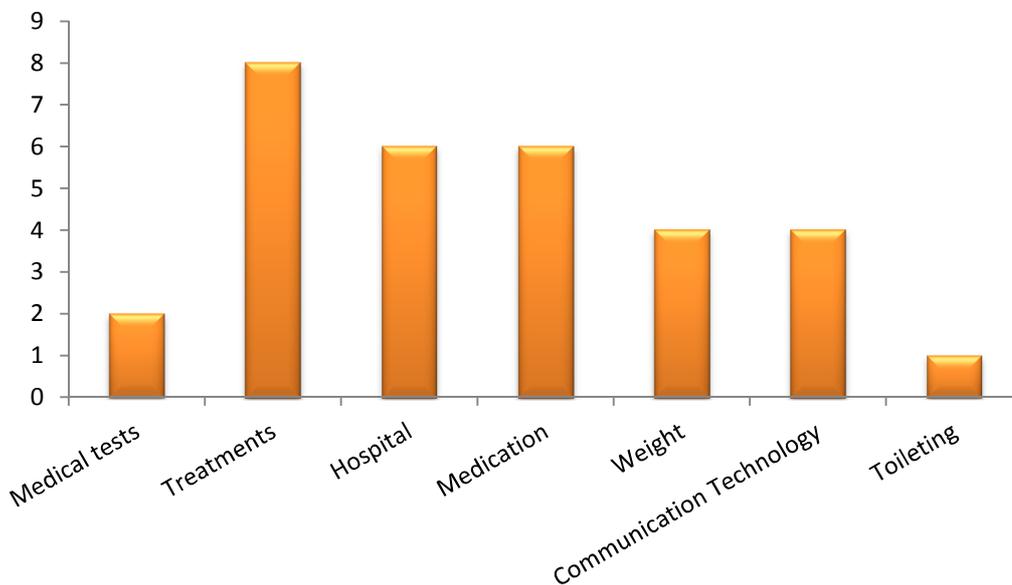
Supporters were evenly mixed between friends and a range of immediate family members. The graph below records that one person had no supporter. In this situation, the arrangement with the person's intended supporter fell through prior to commencing an agreement, so a volunteer supporter was introduced. The volunteer was unable to offer the time required, and so the project facilitator continued to offer decision support. (This was not part of the intended model for our practitioner to provide this support but it was necessary in the circumstances and data are included here for completeness.) It was possible for supporters to change during the life of the agreement. This chart describes the source of supporters, both at the beginning and at the completion of the period of the agreement.



Relationship between supported people and their supporters.

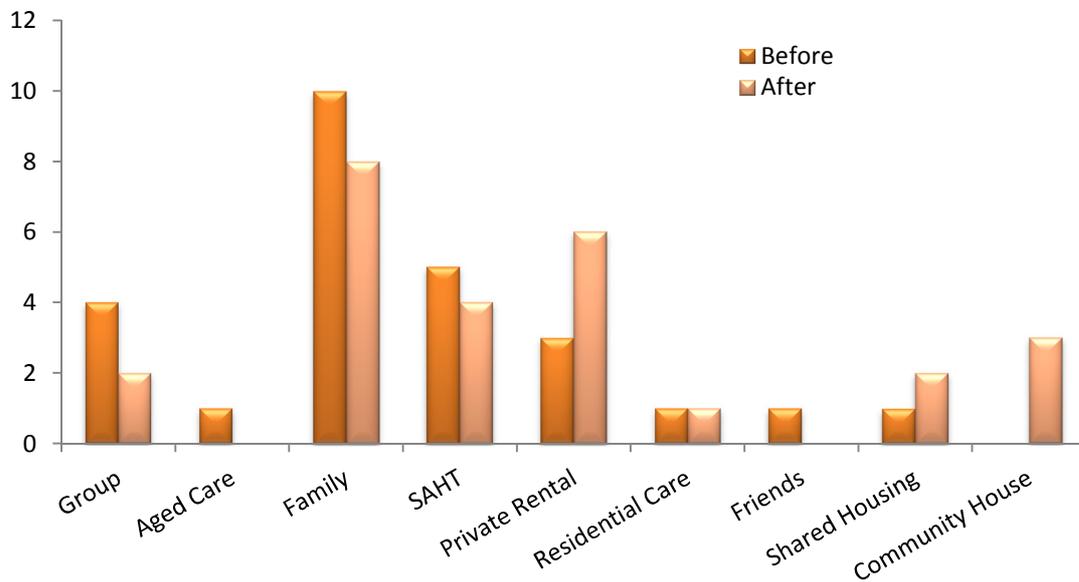
This trial considered healthcare, accommodation and lifestyle decisions.

Below is a breakdown of the health-related decisions made by participants. Because each participant made more than one decision, often across domains, the total number of decisions is greater than the number of participants.



Healthcare decisions made by participants in the Supported Decision Making Trial

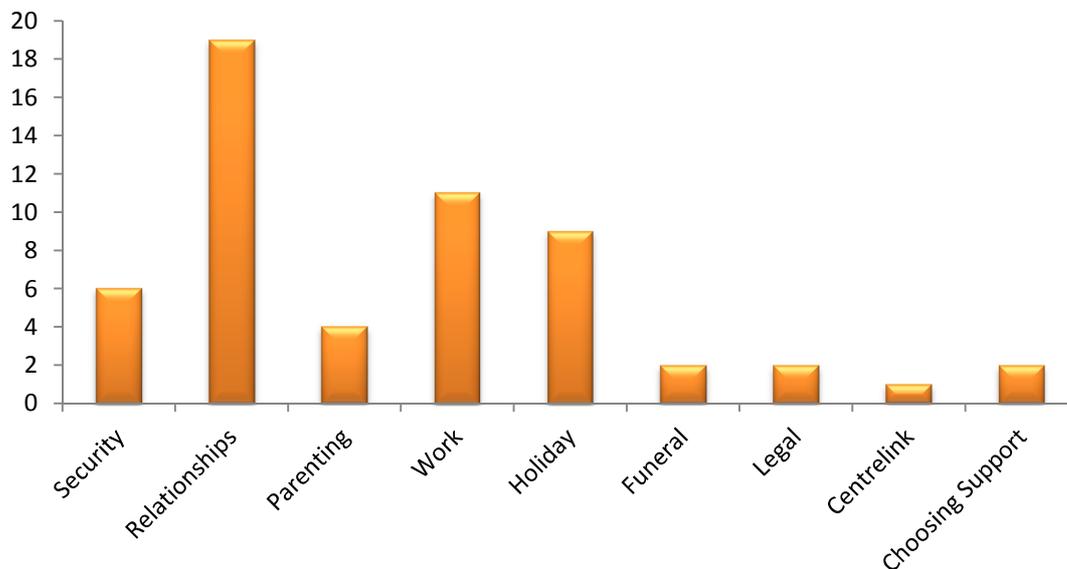
With respect to accommodation decisions, this is reflected in the changed accommodation circumstances of participants during the period of their agreement. The most notable decisions involved moves to independent accommodation with visiting disability supports. This is referred here as a 'community house', and is distinct from group home accommodation.



Changes in accommodation of participants in the Supported Decision Making trial.

Lifestyle decisions are listed below. Decisions about relationships, work and holidays were the most common lifestyle decisions made.

Breakdown of lifestyle decisions made as part of the Supported Decision Making Trial.



Outcomes of the South Australian Supported Decision Making Project

The evaluator of the project, Margaret Wallace, reported that the project had delivered specific benefits to most of the participants. Benefits included increased confidence in themselves and in their decision making. There was a growth in support networks, a feeling of greater control in the persons' lives, and increased community engagement. Supporters also reported benefits (Wallace, 2012).

Wallace (2012, p.5) reported that “the evaluation gives evidence that Supported Decision Making was both a companion process and viable alternative to substitute decision making for participants who were initially on guardianship orders.”

The evaluator collected qualitative data and used quantitative data collected by the project coordinator. She interviewed 53% of participants, 27% of supporters, and staff from three service-provider organisations.

Views of participants and service providers

The interviews revealed increased confidence, decision making skills and personal empowerment.

I make my own decisions, using pros and cons. [It is] useful with my mother. The process is working with my mum. It's different. We never talked this way before.

I have confidence to make decisions, even if [it is a] mistake.

I thought decision making would help me. I needed something to help me instead of other people making decisions for me. I like to make my own decisions on my future.

I now have people who understand, recognise and appreciate what I say and how I do things.

I have a voice, a powerful voice because of [the Agreement]. I don't have to wait on or look to other people to make the decisions.

My kids have noticed a big difference in me. [My daughter] said she is so proud of me. It made me cry.

I get my independence. I think for myself — I feel good about making decisions. It's my new life. [I have] confidence in myself that I never had before. I didn't used to speak my opinions.

However, there were problems for participants related to access to money required to achieve goals. Two people reported a mismatch between their goals and the decisions of administrators who controlled their funds, although the situation eventually changed for them.

Wallace's report (2012) describes positive observations from carers.

With respect to service providers, one reported a positive experience with a client, and another organisation with three participants in the project also had clients who derived benefit from the experience. One client was able to negotiate successfully with his family for financial independence and another used the agreement to develop a healthcare plan.

A state government agency had a mixed experience. One client had a very positive experience. Wallace (2012) reported that the workers noted that a “...a particular strength of the process from their point of view was that the SDM (supported decision making) agreement gave the participant ‘formal approval, a piece of paper, that said somebody is going to listen to me...it restores power’. However, two other people had not had a successful referral. The situation of people who were unable to participate is discussed in the next section.

Non-participants

Wallace (2012) reported that the workers, who had two referrals that did not proceed, suggested that: the vulnerability indicators that they use in their work to decide on required levels of support should be included in any decision for a person to be referred for supported decision making; and that a future program would benefit from tighter eligibility criteria to reduce inappropriate referrals.

Wallace interviewed four non-participants in the project. One wanted to be involved in the project but her brother did not agree to her request to be a supporter. Two others thought in retrospect that they did not need it. Another could not get a parent to agree. The person with a disability in this case had attended meetings with our project coordinator at an employment service, which led to a complaint to that service by the parent that the person with a disability should not be involved in activities without parental consent (Wallace, 2012).

Alternatives to Guardianship

The project design had two streams — an early intervention stream and an alternatives-to-guardianship stream. Wallace observed that the project infrastructure did not appear to be sufficiently developed to support the alternatives-to-guardianship stream to its conclusion. She said this “...points to the need for a considered process, within the processes and structures of guardianship to identify potential users of Supported Decision Making, and the need to clarify, at a public and formal level, the boundaries and intersections between Supported Decision Making and guardianship”(Wallace, 2012).

It is not possible yet to define the limits of supported decision making vs. guardianship in the population currently referred for guardianship. As indicated by the evaluator, some were organisational constraints. At the time that the Supported Decision Making Trial was underway, there was a major upsurge in guardianship appointments and demand for guardianship services. (The topic of the expanding application of guardianship was discussed in our 2011 Annual Report, p. 122.) Our intention to have advocates/guardians take on a number of supported decision-making clients as well as their guardianship was difficult to achieve in this context.

However, there were also other factors that may have limited the alternatives-to-guardianship stream. The guardianship clients were more frequently isolated and did not have family or friends who could act as supporters, compared to the early intervention stream. For this reason, ultimately, it will be necessary to have strategies to overcome this isolation — this might in the future come through the use of volunteer supporters to assist isolated clients or by linking supported decision-making initiatives to ‘Circles of Support’ that seek to connect people with disability to their community.

Also as analysed in our 2011 Annual Report, decisions relating to guardianship are not only made because of a person's impairment — often, other problems need to be solved. The person's own 'incapacity' may not be the real trigger for an order. It may be family incapacity to resolve conflict, a service incapacity to provide the necessary care and accommodation options, or a community incapacity to give at-risk people a right to safety from others through a range of adult protection and law enforcement strategies. All of these 'incapacities' can be addressed in ways that do not rely on removing a person's right to make personal decisions through guardianship, but supported decision making by itself may be insufficient. For these reasons, it would be wrong to expect that supported decision making alone can minimise guardianship, when other strategies are needed as well. (These other strategies may include offering mediation to resolve conflict, or providing better adult protection interventions.) This is further discussed in a recent conference presentation (Brayley, 2012) which argues that reduced reliance on guardianship will not necessarily occur through providing supported decision making alone, and will only be achieved by recognising the environmental issues affecting people; the solution requires addressing all parts of the UNCRPD, not just Article 12 related to decision making.

However, the evaluator did conclude that the project demonstrated that with clear criteria "...supported decision making is a viable alternative to guardianship, and can build capacity to the extent that existing Guardianship Orders were revoked." In this context, it is reasonable that supported decision making should be considered as an option each and every time that guardianship is proposed for a person with a disability. The approach can also work when an order is in place, in preparation for seeking to have an order revoked.

Net widening?

This topic was not specifically addressed in the evaluation. As already mentioned in this discussion, this was a possibility raised in Carney's report (2012) that matters addressed informally are brought up a level or two, and it was a concern raised early in the project that we may be seeking to unnecessarily formalise existing informal arrangements that were working well.

However, it was clear from our project that these informal arrangements were often not working to the satisfaction of the person with disability or their family; and clients, family or friends wanted change. Also, the informal arrangements were in fact *more* restrictive than the supported decision-making intervention in many situations, because decisions were made informally on a substitute basis by others — by family, friends or service providers.

The development of increased confidence and decision making skills will have personal benefits in the immediate term but may also assist in the future. Often, when informal decision makers are no longer available such as when parents become aged or infirm, or the informal arrangements break down due to conflict, applications for guardianship are made. It is reasonable to predict that this is less likely, if it happens to people who have learned decision making skills through supported decision making, they will be better able to make decisions for themselves now and in the future.

Supported Decision Making in the Future as a Sustainable Option

In this section, it is relevant to discuss both national and South Australian developments.

There is now significant momentum to expand supported decision making in line with the UNCRPD Article 12.

This year, the Victorian Law Reform Commission released its final report reviewing that state's guardianship legislation. It recommended that supported decision making be incorporated into that state's legislation, and made detailed recommendations on the provisions required that would make it work (Victorian Law Reform Commission, 2012, Ch. 8). These provisions would allow for both financial and personal decisions through supported decision making, give recognition to supported decisions, and describe both the powers and responsibilities of supporters. The Commission also recommended that a network of volunteers be established to act as support to those people who do not have someone in their life who can take on this role.

In New South Wales, the Office of Ageing, Disability and Home Care, along with the Public Guardian and the NSW Trustee and Guardian are commencing their own trial. This work will incorporate financial decision making, which was not a component of the South Australian work, and is an important next step. The South Australian Public Advocate is a member of their Advisory Group.

Other work is underway in the ACT and Victoria.

In South Australia, the Committee has considered future sustainability of supported decision making now that the pilot has finished. There are two key elements. First, legislative reform that could underpin the wider use of supported decision-making arrangements in the community, as well as their application in situations where non-statutory arrangements are insufficient, such as when there is conflict present. A second key element would be the provision of a small supported decision-making facilitation service, similar to the service that was operated by our Office during this project.

Our Committee is now meeting to develop recommendations for reform that will be presented to the Attorney-General for consideration. Initial discussions suggest four changes to the *Guardianship and Administration Act 1993 (GAA)*. First would be the addition of a principle acknowledging that people should be supported to enable them to make decisions as long as they can, in line with a principle of the Advance Care Directives Bill 2012. This has not proved controversial when introduced as part of that Bill, so it should be accepted as a part of the GAA. Second, when the Guardianship Board is considering an order, it should consider first if people can be assisted or supported to make their own decisions. Third, a short additional section be added recognising supported decisions, and the responsibilities of supporters. It is hoped that recommendations to the Attorney-General by the Supported Decision Making Committee will be finalised in the first quarter of 2013. The fourth change would be the addition of another section recognising supported decision-making agreements and the roles of supporters.

With respect to facilitation services, the development of individualised funding at a state level, and then the NDIS nationally, present an opportunity to establish small, supported decision-making facilitation services. There will be some form of brokerage assistance offered to service

users and carers. While this will be generally useful for people with any disability, extra steps will be needed to ensure that people with a decision making disability can take maximum advantage of the choice and control offered by the individualised funding model. Otherwise, individualised funding might empower the people around a person with a disability to make decisions on their behalf, but miss the opportunity to give power to the person with disability at every possible opportunity.

This Office has presented the need to have Supported Decision Making facilitation to the Minister for Disability and officials in the Department for Communities and Social Inclusion. There is currently significant interest and support for the goals of supported decision making that we hope might translate into the establishment of a small, sustainable Supported-Decision Making service in the future. The view of our Committee is that such a service would best sit in the non-government sector, but this would need to be with an organisation that does not already provide extensive disability services, as this could create a conflict of interest.

Supported Decision Making Committee

A Supported Decision Making Committee was established in February 2010.

It was formed under the provisions 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 contribution of the members of the committee listed below is acknowledged.

A special acknowledgement of her work is due to Cher Nicholson, the Project Coordinator and Senior Practitioner, who filled a position funded through a grant by the Julia Farr MS McLeod Benevolent Foundation.

The membership of the Committee is as follows:

John Brayley

Chair

Robbi Williams

Graham Mylett

Tiffany Bartlett

Margi Charlesworth

Ian Cummins

Dell Stagg

Margaret Brown

Ian Bidmeade

Helen Mares

Julie-Anne Harris

Elly Nitschke

Di Chartres

In attendance

Cher Nicholson

*Senior Practitioner and Project Coordinator
Supported Decision Making Project*

Heather Linton

Volunteer

Margaret Wallace

Independent Evaluator

*External reviewer
and commentator*

*John Chesterman,
Manager Policy and Education
Victorian Office of the Public Advocate*

Promoting Rights and Interests

Recognising Human Rights

Introduction

By the nature of our legislated commission, the work of our Office is to advocate for rights of the people we serve. This leads to two broad observations.

The first is that a human rights approach to legislation, policy and service provision, ostensibly will deliver the best outcomes for individuals, and bring results that are effective and efficient. Where evidence is available from other jurisdictions, solutions that are grounded in rights invariably work better than solutions that are not.

As a community we cannot go wrong by respecting the dignity, equality and freedom of all people as the basis of everything we do.

The second observation is that it is ultimately not possible to argue in a sustainable and effective way for the rights of vulnerable populations, if we first have not recognised the rights of all people in our community. If we fail to do this, then any rights-based approach to assist vulnerable people will deteriorate into a welfare approach, if vulnerable people are assisted only because they are 'special' and in need of sympathy, rather than as equals entitled to the same rights as anyone else.

Many jurisdictions around the world recognise human rights in their constitution or in Acts or Charters that give legal weight to international human rights instruments. Examples particularly relevant to us in Australia include Canada's Charter of Rights and Freedoms (1982), the United Kingdom's Human Rights Act 1998, and New Zealand's Bill of Rights Act 1990 and Human Rights Act 1993. In Australia, Victoria enacted the *Charter of Human Rights and Responsibilities*, which came into effect in 2008, and the Australian Capital Territory has enacted the *Human Rights Act 2004*, which has brought rights-based statutory officials together into a Human Rights Commission.

It is more that coincidence that we look to the rights-based jurisdictions such as Canada, the United Kingdom, New Zealand and Victoria for best practice in the areas of mental health, disability and supported decision-making service provision.



Introduction to Human Rights



In thinking about the recognition of human rights by government, there can be broad gains that can occur at little financial cost. First, with an explicitly stated charter of rights, government can consider these rights in everything it does. As policy is developed and decisions are made, the fundamental rights of citizens are considered proactively, in a way that does not happen now. This is the most important benefit of the State explicitly stating the human rights it believes in, so that a human rights culture then develops across government.

Second, there needs to be a mechanism in place for people to seek redress if their rights are not upheld. Matters might relate to a violation of any human right, including social, economic and cultural rights, as well as civil and political rights; not just complaints of discrimination as occurs now. Such a mechanism could involve a designated Human Rights Commissioner, and a tribunal that has been given powers to consider human rights matters that a commissioner cannot resolve. This does not necessarily require new resources, as a commissioner's role would likely evolve from existing statutory agencies that could be brought together. The tribunal could be one that has been established for other purposes, such as the proposed South Australian Civil and Administrative Tribunal.

In the rest of this section, the balance between positive and negative rights will be reviewed and two examples given that illustrate the benefit of a consideration of human rights. While these examples relate to areas of concern to the Office of the Public Advocate, similar uses of human rights would apply across government.

The examples include the balancing of rights in mental health policy development, and a human rights approach to elder abuse prevention and response.

Positive and Negative Rights

Fundamental to human rights are the core international conventions to which Australia is a signatory. After the horrors of World War II, the United Nations prepared the Universal Declaration of Human Rights, proclaimed in 1948. This was not binding, but it gave rise to two binding covenants adopted in 1966: the International Covenant on Civil and Political Rights, and the International Covenant on Economic, Social and Cultural Rights.

The Covenant on Civil and Political Rights describes rights that can be lost — the so-called 'negative rights' including, for example, freedom from cruel, inhuman and degrading treatment, the right to liberty of the person including liberty of movement, the right to recognition before the law, and the right to a fair trial.

The Covenant on Economic, Social and Cultural rights describes 'positive rights' such as the right to enjoyment of the highest standard of physical and mental health, the right to education, and the right to an adequate standard of living including adequate food, clothing and housing, and to the continuous improvement in living conditions.

The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), ratified by Australia in July 2008, expands on both these groups of rights as they affect people with a disability. For example, rights such as equal recognition before the law, access to justice, and liberty and security of the person are specifically defined as they might apply to a person with a

disability. Similarly, social and economic rights related to health care, rehabilitation, work, choice of residence etc., are expanded in the context of disability.

With respect to civil rights, of particular relevance is the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment adopted in 1984, and the associated Optional Protocol adopted in 2002. While the torture provisions of this Convention might be less relevant to Australia than to other places, the sections relating to cruel, inhuman or degrading treatment are needed. Australia is now in the process of ratifying the Optional Protocol, which will provide for international inspections of places of detention such as prisons, police lock-ups, psychiatric wards, and places where people with a disability are detained.

Also relevant to the work of the OPA are principles from the UN, although these documents are non-binding. The United Nations Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care, adopted by the General Assembly in 1991, have significantly influenced most current mental health legislation in Australia. Similarly, services for the elderly are influenced by the United Nations Principles for Older Persons, also adopted in 1991.

The extent to which the binding conventions are followed will depend on whether or not a country or state has legislated for these rights. This is most evident when a person seeks to make a complaint and whether or not a person can complain about a breach of rights. However, if a jurisdiction legislates for rights, it can have a positive effect in establishing a rights-basis for decision making that might proactively prevent breaches.

Currently, users of Commonwealth services have more rights protections than users of state services. For example, from the experience of our Office, if a person is detained in a Commonwealth facility, it is possible for that person to lodge a complaint with the Australian Human Rights Commission stating that either human rights have been breached or that discrimination has occurred. However, a person detained in a state facility cannot make a complaint about a loss of rights, only that discrimination has occurred.

Recognising fundamental rights in health complaints and disability legislation

While the focus in this section is on the benefits to vulnerable groups of having rights recognised broadly across the community, it is also possible for rights to be recognised and protected in specific legislation, and in the absence of broad-based recognition, this is better than nothing.

An example of this focus is the rights of healthcare users in South Australia. It is the requirement of the *Health and Community Service Complaints Act 2004*, Part 3, that a Charter of Rights be developed. This charter, which came into effect on 23 June 2011, includes a right to access services that are safe and reliable, which is aligned with a fundamental United Nations Social and Economic Right to the highest attainable standard of health.

Recommendation

- 01 Priority Action** The South Australian Parliament must enact a new Disability Act to replace the existing Disability Services Act 1993 to:
- > align with the United Nations Convention on the Rights of Persons with Disabilities and specify high level service standards such as minimising use of restrictive practices
 - > direct all State Government agencies and Local Governments to lodge Access and Inclusion Plans with the Social Inclusion Board for public release
 - > establish an integrated suite of appeal processes and safeguards
 - > establish a Community Visitors Scheme to monitor standards of disability housing and accommodation service settings.

Social Inclusion Board Strong Voices

A similar issue will arise with the recognition of the UNCRPD in the Disability Act. As can be seen from Recommendation 1 of the Social Inclusion Board's *Strong Voices* report, new legislation will 'align' with the UNCRPD. This is the opportunity for our state to legislate for compliance with the UNCRPD, which will then apply at least to the provision of services that are either funded or regulated by this disability legislation.

Similarly, *Strong Voices* has recommended an integrated set of appeal processes. Appeal mechanisms are one way to uphold a positive right to access services. It remains to be seen how a reform to the Disability Act in South Australia will tackle appeal rights. An example of how appeal rights may work can be seen in the provisions of disability legislation in Victoria. If a person in that state is refused a service by a provider because the provider believes that the person does not have a disability as defined in the Act, then that person can ask for this decision to be reviewed by the Secretary of the Department. This can

then be subject to further review by the Victorian Civil and Administrative Tribunal.

The mental health example — positive vs. negative rights

In the 2009 Annual Report of the Office of the Public Advocate, the balance of positive and negative rights as applied to the use of Community Treatment Orders (CTOs) was discussed.

A Community Treatment Order provides for the compulsory treatment of a person with a mental illness. CTOs are used extensively in Australia. In 2009, we discussed the general lack of evidence of their efficacy that leads to a loss of a 'negative' right. In contrast, the evidence for upholding positive rights through the delivery of good quality mental health services to people is comparatively strong. For example, there is good evidence for the provision of assertive community care, which seeks to maintain contact with people through regular community visits and support, and by doing this to develop a relationship, irrespective of orders. There is increasing evidence for the availability of early intervention services, which are often delivered early in the course of an illness before a person becomes so unwell that compulsion needs to be considered. Evidence has also accumulated about the benefits of providing stable housing (Office of the Public Advocate, 2009 p. 40).

Access to services is a positive right. It is not possible to consider the reduction of compulsion on one hand, without considering on the other hand the provision of services that are effective and engage with people and may prevent compulsion. CTOs have a role for the treatment of some people, but this is likely to be much less than their current use in Australia.

In May 2012, Light et al. published an incisive commentary on the 'invisibility' of CTOs in mental health policy in Australia (Light et al., 2012). They point out that both the Fourth National

Mental Health Plan (Department of Health and Ageing, 2009) and the National Mental Health Report (Department of Health and Ageing, 2010) say very little about involuntary treatment. Statistics are not reported. These documents provide a general picture of voluntary recovery-based services, and give little inkling of the comparatively high use of CTOs in this country compared to other jurisdictions, or the extensive use of inpatient detention.

The National Mental Health Plan does refer to the need for mental health legislation to meet agreed principles and facilitate the appropriate transfer of civil and forensic patients between jurisdictions. Light et al. (2012) go on to state that “Current policies give the impression that there is little involuntary community treatment in Australia and that policymakers have no role or responsibility in this area. The incorporation of CTO information — including tribunal and involuntary psychiatric service data — in mental health policies and reviews would make clear the existence, extent and utility of CTOs. This will enable the community to make informed judgements about their use and the reform of mental health services in general”.

Making visible the human rights of people with mental illness

A human rights based approach would ensure all rights are considered as policy is developed and decisions are made. Therefore, for example, the right to liberty should not just be contemplated when mental health legislation is reviewed, but also when new service policies are developed, because the successful implementation of these policies is likely to prevent future deprivation of liberty.

We do not have a Charter of Rights to apply to new mental health policies and plans. However, if a consideration of rights that are based on the UNCRPD preceded each new policy or service development, then it would be possible to consider the impact on rights such as equal recognition before the law, and liberty and security of the person on one hand, alongside other rights such as the right to live independently, to have the highest attainable standard of health, to access comprehensive rehabilitation, to access education and work, and have an adequate standard of living.

It is unlikely that a rights-based culture will become established across government unless such an approach occurs consistently as a requirement of law. In policy areas such as mental health, which requires across-government action, it is insufficient for mental health policy makers alone to think in this way, if those responsible for other services in our community that assist people with mental illness are not also operating to the same rights-based priorities.

In the opinion of this Office, a formal recognition of human rights is likely to lead to mental health policy shifts that will result in better priority setting within existing budgets, and a greater accountability for tackling the tough problems facing people with mental illness; whether it be our reliance on unsuitable accommodation options for high needs clients, acceptance of high rates of prison incarceration for people with mental illness, or permitting the use of emergency departments as mental health wards that are not designed for the purpose.

Recognition of human rights for all citizens can not only underpin policy development for mental health, but can be a driver to resolve problems that have somehow become acceptable during the implementation of deinstitutionalisation.

Ultimately, such an approach can be a powerful force to overcome stigma, which increases if people with a mental illness are left without adequate accommodation, support or services.

Rights-based elder abuse prevention and recognition policy.

In 2011–2012, our Office and the University of South Australia Human Rights and Security Cluster completed a project on enhancing elder abuse prevention and recognition (Office of the Public Advocate and the University of South Australia, 2012).

Older Persons Have the Following Rights and Freedoms:

To be treated with dignity and humanity

To exercise personal self-determination

To freedom of movement, including the right to choose their place of residence

To freedom from torture or other forms of cruel, inhuman or degrading treatment

To liberty and security of the person

To freedom from exploitation and physical, social, psychological and sexual abuse

To freedom from discrimination of all kinds

To recognition as a person before the law

To equality before the law

To life

To adequate food, clothing and shelter

To enjoy the highest attainable standards of physical and mental health

To freedom from arbitrary or unlawful interference with his/her privacy, family, home or correspondence

To family life and to have their family unit respected by others, including governments

To freedom of association

To participate in the social and cultural life of the community

To freedom of thought, conscience and religion

To freedom of opinion and expression

From the Office of the Public Advocate and the University of South Australia, 2012

This work was tabled in the South Australian Parliament in June 2012, by the Hon. John Hill, Minister for Health and Ageing. A summary of the work is also contained in the Program Review section of this Annual Report.

The purpose of this discussion is to illustrate how a policy-setting process can be determined by rights. The work defining rights and linking this to practical outcomes was led by Associate Professor Wendy Lacey of the University of South Australia, an expert in Human Rights and Administrative Law.

To do this work, it was first necessary to define the rights that older people have. Rather than simply rely on the existing non-binding United Nations Principles for Older Persons, Dr Lacey drafted a charter based on the binding international treaties to which Australia is already a signatory.

The effect of creating a charter and recognising it in legislation is discussed below:

Articulating the rights of older persons would ensure that those rights condition the policies and practices of service providers and government bodies, as well as empower older persons through the list's dissemination. However, it is important to note that, even if such rights were included in the context of legislation, the effect would not be to create a new cause of action that could form the basis of litigation. The principal effect would be to make such rights a relevant consideration in decisions of government officers or agencies affecting older persons, and any law or policy should make that expressly clear, as the Aged Care Act 1997 (Cth) does with respect to the aged care service providers which it funds (Office of the Public Advocate and the University of South

Australia, 2011).

The report recommends a legislated model of adult protection that clearly defines abuse and vulnerability, requires agencies to work together to prevent and respond to abuse based on a defined code of practice, and establishes an Adult Protection Unit to coordinate this response.

This has much in common with systems in rights-based jurisdictions such as England and Scotland.

A rights analysis leads to different policy solutions, which happen to be more targeted in addressing actual need than existing solutions, and based on overseas experience, are more effective.

The aim is to provide a response that on the one hand upholds a person's rights to safety, but on the other minimises the loss to a person's self-determination and recognition as a person before the law. Because of this, there is an emphasis on recognising and assisting people at risk of abuse on a voluntary basis whenever possible.

This is not to say that involuntary interventions cannot happen in a rights-based model. Victims of abuse can be fearful, and unwilling to accept help. The Scottish Adult Support and Protection Act 2007 does give authorities power to intervene to stop abuse, with orders for assessment of an adult suspected of being at risk, removal of an at-risk adult from a place of harm or banning from a certain place a person who might harm an at-risk person. Such interventions are targeted to a person's safety, and the balancing of different rights has been carefully considered in the law, and by the practitioners who apply the law to individual situations. The legislation provides protection without removal of decision-making rights as would occur with guardianship.

Our current approaches in Australia can fail to provide protection for many at-risk people, and can remove a person's recognition before the law through a guardianship order when other, more focused interventions may have achieved the same or better result without this loss of rights.

Conclusion

This section has considered two examples of how problems can be analysed from a human rights framework. In both examples, mental health and elder abuse, effective action requires multiple government agencies to work cooperatively. It is not enough to have a rights-based approach to planning — each of the agencies involved in implementing policies and strategies must share a rights-based culture. This can happen if services work under a common human rights charter.

Similar human rights analysis can be applied to so many different areas — the use of restrictive practices in disability settings, equal access to justice for people with disability who have been the victim of a crime, and equal access for Aboriginal people to specialist mental health and disability services that are culturally safe, to give but a few examples.

Equality, dignity and liberty are universal rights and values. To reiterate the core argument: it is not possible to argue that everyone in the groups that our Office serves be treated as equals, unless we have first as a community agreed upon the rights that we all have.

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 2011–12, the Public Advocate met with relevant ministers and Members of Parliament in an advocacy role.

The Public Advocate sought appointments with ministers to discuss a range of legislative, policy and funding issues across the law, disability, ageing and mental health. A meeting was also held with the Minister for Corrections to discuss a client matter.

In addition to the meetings with State Ministers listed below, a single meeting was also held with the Hon. Mark Butler MP, Federal Minister for Mental Health and Ageing.

Meetings with the Premier and Ministers:

Hon. Jay Weatherill MP, Premier

Hon. John Rau MP, Attorney-General

Hon. Ian Hunter MLC, Minister for Disabilities

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

Hon. Jennifer Rankine MP, Minister for Corrections

Meetings with Members of Parliament:

Hon. Stephen Wade MLC, Shadow Attorney-General

Hon. John Gardner MP, Shadow Minister for Disabilities

Hon. Martin Hamilton-Smith MP, Shadow Minister for Mental Health

Hon. Kelly Vincent, MLC

Hon. Robert Brokenshire, MLC

Section 22 Report

No matters were raised under the formal provision of Section 22 during 2011–12.

Presentation to select committees:

The Public Advocate was recalled by the Select Committee of the Legislative Council on Disability Equipment and Services to give further evidence on 12 April 2012 relating to information in the 2011 Annual Report concerning the use of clients' money held by the Disability SA Client Trust Fund to purchase equipment. The Public Advocate had previously appeared before this committee on 6 May 2011.

Give advice on legislative powers

Guardianship and Administration Act 1993

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

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

Advice about the Act was provided through:

- The enquiry service
- Education sessions

This work is reported in Part B of this Report.

Monitor Legislation

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;

Our 2011 Annual Report made the case for a rights-based approach to guardianship, as opposed to a welfare orientation. It was argued that this was Parliament’s intention. However, because of ambiguities in the Act, it could be further clarified with law reform.

The discussion also recognised that the appointment of a guardian is not just made because of the “mental incapacity” of the individual. It can also reflect systemic factors around the individual and an order may be needed for a systems problem rather than an individual’s need. The United Nations Convention on the Rights of Persons with Disabilities recognises that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others (UN Enable, 2006).

There are many and varied ‘environmental incapacities’. They can be due to a family incapacity created by conflict between members of a family. They can also be due to an incapacity of a service to deliver necessary accommodation and support options. They might reflect our community’s incapacity to offer simple assistance and support to help people make their own decisions, or in the context of abuse, to prevent it or recognise it when it occurs. Another incapacity is that of the law to provide equality of access to justice for people with a disability. Finally, people are also disadvantaged by economic incapacity, as those from low socioeconomic areas are more likely to be put under guardianship than are people from wealthier areas.

If the principal reason that a person is brought before the Board relates to one of these environmental incapacities, then it is unjust that a person with a disability should lose their decision making rights. This of course can be minimised if we have greater access to alternative interventions, whether they be mediation to respond to family conflict, advocacy to deal with service gaps, supported decision making, or practical social work assistance delivered as part of a rights-based adult protection strategy.

Private Guardians’ Survey

It is inevitable that some people will need a substitute decision maker. Ideally, this should be someone they know, who knows them well and is committed to their wellbeing.

Yet private guardians need more support. The OPA, funded by the Law Foundation, with support from key staff of the Legal Services Commission of SA and the Public Trustee, undertook a survey of private guardians. This included guardians appointed under an enduring power of

guardianship and those appointed by an order of the Guardianship Board. The actual research work was undertaken by Harrison Research on our behalf, and Helen Fischer was the principal consultant. The full report can be read from the link on our website www.opa.sa.gov.au.

There were 289 people surveyed and a focus group was run both before and after the paper/electronic survey. Of the 289 surveyed, 219 had a dual role of both guardian and financial administrator.

Many guardians indicated that they lacked the legal framework to guide them through their role. Forty-three per cent of all guardians surveyed were aware of legislative principles; however, only 35% of enduring guardians (appointed by an enduring power of guardianship) were.

Overall concerns included a lack of information for guardians, a wish and a need for more support, and also a lack of recognition of the status and responsibilities of guardians, particularly amongst medical practitioners and aged care staff; and for those who were administrators as well, by banks. Being a guardian when there is conflict can be particularly problematic. Many guardians suggested that new guardians should have a one-on-one interview with an advocate who could take them step-by-step through their role, rather than just being given written information. Fact sheets provide legal and administrative information but not a practical 'how-to' guide.

As can be seen in Part B of this Report, which considers the role of the enquiry service in our Office, at the same time that the private guardians surveyed were experiencing a lack of information and support, calls to our enquiry number were declining.

The current reform of Advance Care Directives provides an ideal opportunity for our Office to address many of these issues. The role of advance directives and the support role of our Office will be promoted, and subject to the current Bill passing, our Office will also be offering additional services such as mediation, which will assist guardians facing conflict in their role, will be able to make a declaration including the nature and scope of a substitute decision makers powers, and whether or not the person who made the advance directive is currently able to make a specific decision themselves.

In this context, with an added take-up of advance care directives expected with a new Act, our Office in many situations could take on a facilitation, education and support role for families and friends to make substitute decisions, rather than the Public Advocate being appointed to make these decisions.

Part B:

Direct Services

Provided to the Community by the Office of the Public Advocate

Public Guardian

Guardianship and Administration Act 1993

Section 29 —Guardianship orders

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

The role of guardian

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

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

Guardianship is fundamentally a role for families and friends who know a person well. That is why the Board can only appoint the Public Advocate if it is satisfied that no other order would be appropriate. A more detailed discussion on the role of guardianship can be found in the 2011 Annual Report (p.138). Current controversies with respect to welfare vs. rights based models and the growth in guardianship orders are also discussed in the same report (Office of the Public Advocate, 2011, p.122).

Guardianship Activity 2011-12

During 2011-12, the Office of the Public Advocate provided guardianship services under the *Guardianship and Administration Act 1993* on behalf of 928 people (793 in 2010-11). This represents a 17% increase over the previous year. In the previous three reporting periods, the increases were 6.7%, 9.6%, and 17%. Figure B1 illustrates the upward trend in active guardianship numbers over the past five years as well as end-of-year active caseloads.

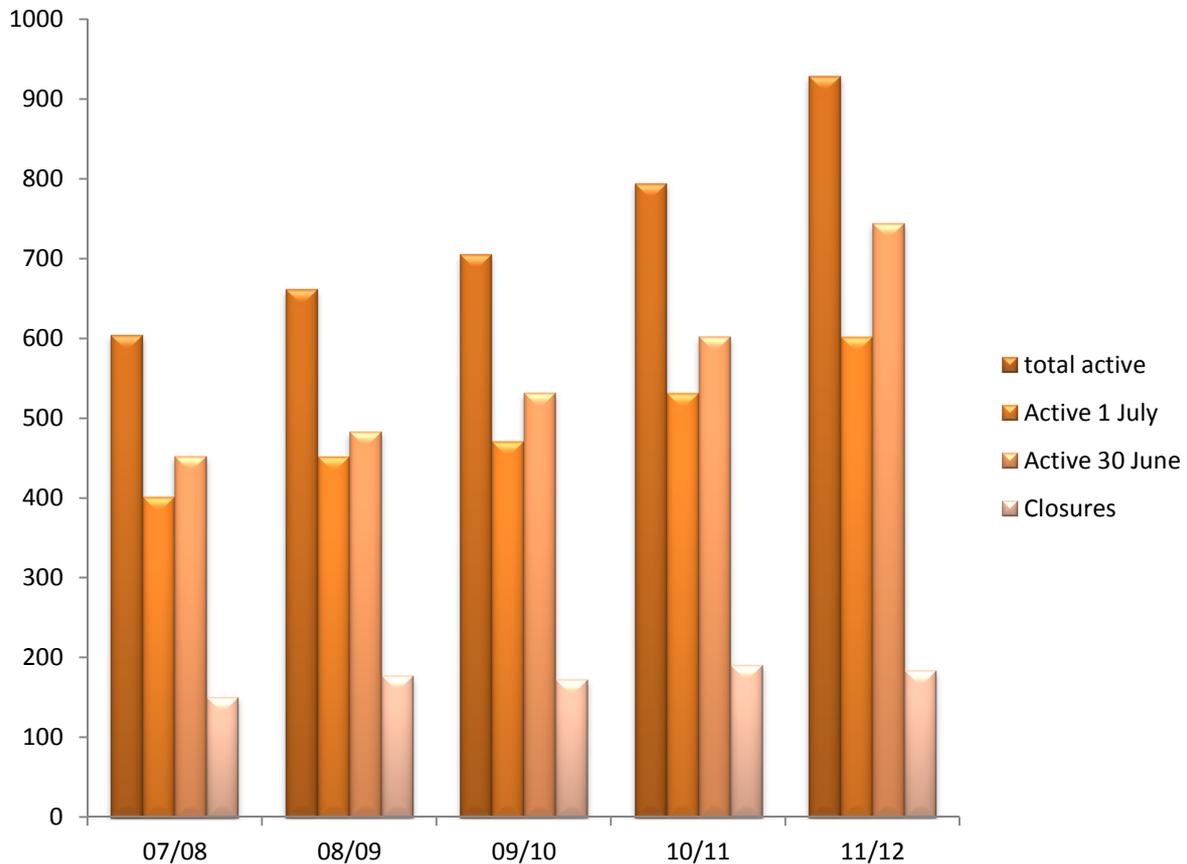


Figure B1: Guardianship Activity 2007-08 to 2011-2

The number of active cases managed by the Office continues to expand. The rate of growth each year varies. As at 30 June 2012, there were 744 active guardianship cases compared with 602 at the beginning of the financial year. This is a 23.6% increase in active cases compared with 13.4% for the previous reporting period. The OPA has experienced a 65% increase in active cases since the end of June 2008 (four years).

Despite the addition of 1.8FTE temporary staff at the end of 2011, the significant increase in active guardianship cases has been operationally challenging, affecting desired practices such as the timely allocation of new cases to a delegated guardian.

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

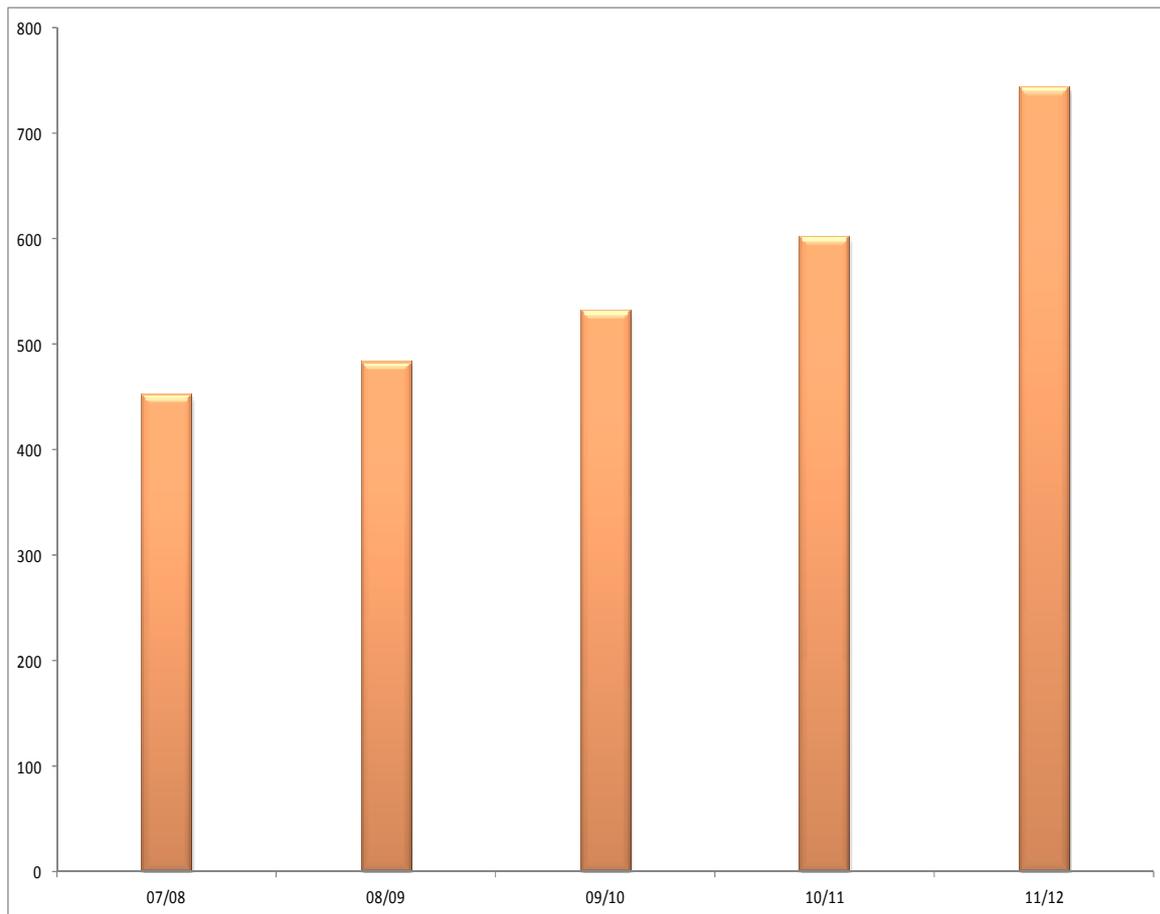


Figure B2: Comparison of Active cases as at year-end 2007–08 to 2011–12

This year, 326 new Public Advocate guardianship appointments were made, a 26.4% increase on last year’s figures (258). Figure B3 illustrates the general upward trend in number of appointments until 2009–10, and the escalation in rate over the last two years. Of the 326 new appointments, 114 were limited orders (35%) and 212 (65%) were full orders. Of these, 32 orders (10%) involved joint appointments with private guardians. Appointments were for 151 females and 175 males.

Of the 326 appointments, 89 (27%) involved an interim order. This compares with 71 (28%) of 258 cases in the last reporting period. Of the 89 interim appointments, 72 orders granted S32 powers to direct where a person would live, 40 provided authority for detention and 38 for use of reasonable force for the delivery of treatment and day-to-day care.

In 2011–12, 35% of new Public Advocate appointments were limited orders and 65% were full orders.

New guardianship cases are managed within a two-team structure and stable matters are later transferred to a monitoring category. This year, the numbers of new guardianship cases allocated to the two teams (short- and long-term) were similar. However, the short-term team has fewer staff but has the objective of more rapid throughput due to its clientele and the nature of substitute decisions required. Many of their cases transfer to the monitoring list once major decisions are made: however, some are taken back to the Board by that team for revocation.

A high proportion of this client group is elderly and in secure residential care. Recent legal advice stating that powers of compulsion under S32 of the Guardianship and Administration Act 1993 are required to provide a legal basis to care in locked facilities means that many more clients will be maintained under guardianship to their life's end. This is because they are deemed to be detained in the eyes of the law, as they do not have freedom of movement. The OPA is working with government to find alternate legal strategies to address the necessary checks and balances involved in detention of vulnerable adults. This topic was discussed in detail in our 2011 Annual Report (p.76 onwards).

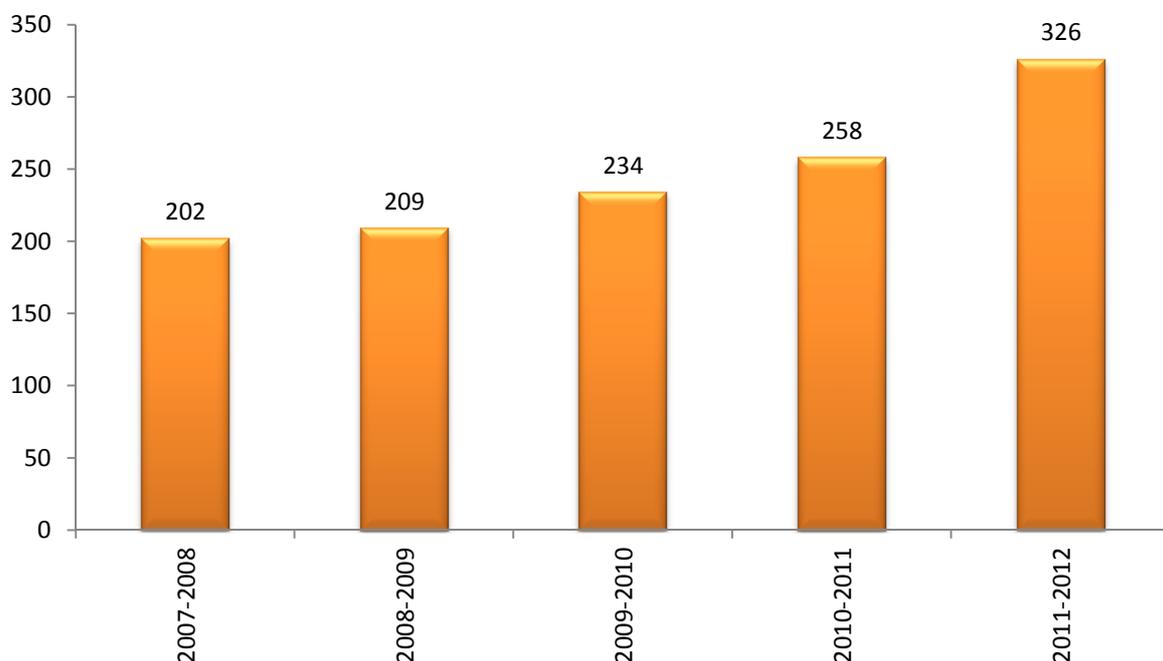


Figure B3: Comparison of new Guardianships over the past five years

The steady increase in statutory appointments over the past decade can be explained in part by demographic issues. However, other policy and practice issues impinge on the rate of appointment. In previous reports we have discussed the impact of factors such as legal interpretations of the need for guardianship, changing practices within the Guardianship Board itself and contemporary risk-management concerns of service provider organisations. In 2011-2012, policy changes have been made within the disability services, which will lead to the identification of more people in need of an independent decision maker, who are currently having decisions made by staff. This is likely to have a significant further impact on public guardianship in the next reporting periods. The Office of the Public Advocate will continue to seek to influence these trends by promoting appropriate alternatives to public guardianship where possible. However, on a day-to-day basis, the OPA is not in control of its workload as decisions about who becomes a client and when they are discharged are made by the Guardianship Board.

During 2011–12, 184 cases were closed — a decrease of 4% (7) when compared to 191 closures in 2010–11. Of the 184 closures, 84 were due to revocation of orders, 61 due to death, and 38 due to private guardians being appointed. Reasons for closure are illustrated below (Figure B4). This is analysed in more detail in the following pages.

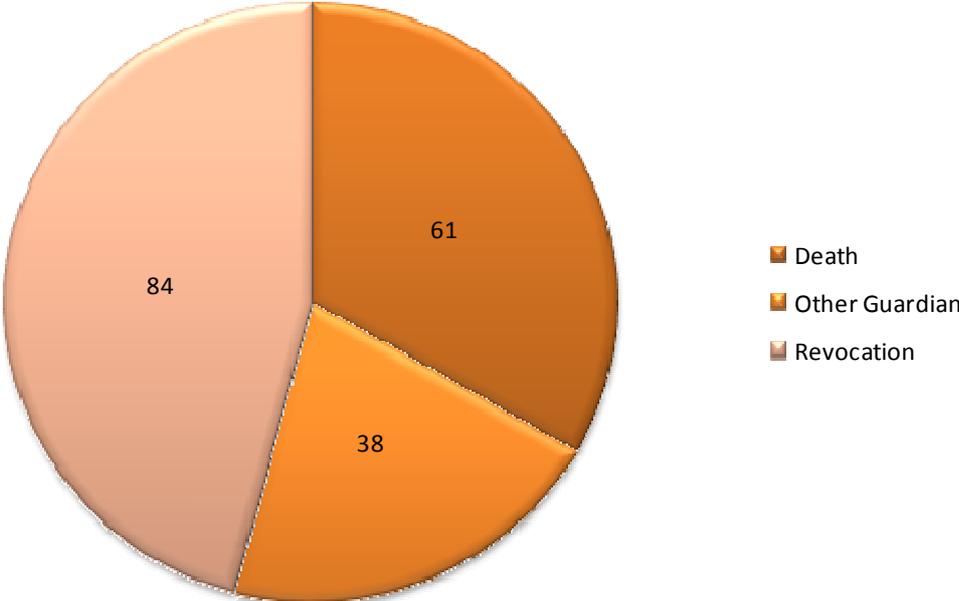


Figure B4: Reasons for closure of guardianship cases 2011-2012

The rate of closures in 2011–12 as a percentage of all orders was 19.8%. This compares to 24.1% in 2010–11 and 24.5% in 2009–10. Rates of closure for the past six years are illustrated in Figure B5. It is difficult to determine the cause of this decrease in closures. In the past, revocations of orders no longer considered necessary were readily given by the Board, often by a hearing conducted “on the papers.” Now, hearings are usually set in person to consider these requests, and as noted previously, the Board is constrained by newly recognised legal requirements that mean an order should continue in situations where in the past, an order would have been revoked (for example, an older person living in a secure nursing home, who does not want to leave, but remains a wandering risk). However, in other situations, it is the opinion of our staff attending hearings that an ongoing need for guardianship is now more likely to be identified by the Board in situations where informal arrangements would have previously been acceptable.

However, there are factors in our Office that might have also influenced this trend. As can be seen, a similar low result occurred in 2006–07. As in this reporting period, 2006-07 saw the OPA workforce under substantial pressure with high workloads affecting the service’s ability to maintain throughput. An injection of additional staffing resources in 2007 following an external staffing review conducted during that year may have contributed to an improved rate of throughput. Similar concerns arose at the beginning of this reporting period and temporary

resource increases were implemented. Additional government funding has been allocated in the May 2012 Budget for 2012–13 onwards and this may achieve similar results with respect to an increase in closure rates in the next reporting period. However, the other policy and practice issues that influence case closure will need to be addressed if throughput rates are to rise again.

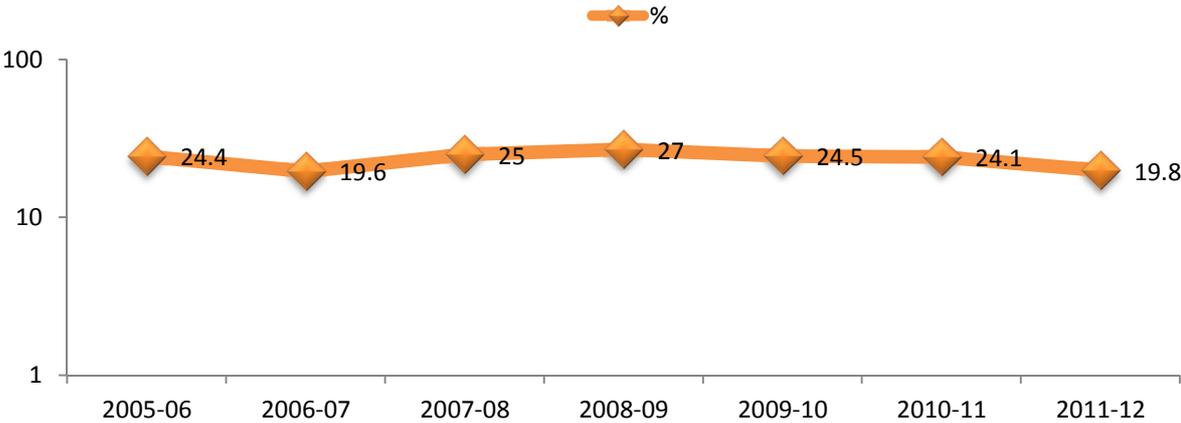


Figure B5: Rate of Guardianship closure 2005–06 to 2011–12

Figure B6 compares numbers of guardianship cases and closures over a five-year period. This reporting period represents the lowest rate of closure of the past five years.

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

Figure B6: Closures 2007–08 to 2011–12 as % of all guardianships

The next table (Figure B7) compares reasons for closure for a four-year period. Note the rise in transfers to private guardianship and the fall in revocation as an explanation for closure.

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

Figure B7: Reasons for closure 2008-09 to 2011-12

Of those clients whose guardianship orders were revoked during the year, 36% were under guardianship for less than 12 months, 78% for less than two years and 82% for less than three years. This compares with 39%, 71% and 77% respectively for the previous reporting period. While the numbers under long-term guardianship (i.e. over three years) are not diminishing, these figures suggest a small reduction in proportion of all cases in long-term guardianship (i.e., a 5% reduction). This is represented in the table below (Figure B8).

Comparison of Length of Guardianship for Closed Cases				
Length	< 12 months	< 2 years	<3 years	3 years +
2010-11	39%	71%	77%	23%
2011-12	36%	78%	82%	18%
Difference	-3%	+7%	+5%	-5%

Figure B8: Closed Cases Length of Guardianship Comparison of 2010-11 and 2011-12

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 last two years' figures with 21% of closures relating to private guardian appointments after the initial appointment of the Public Advocate. However, this shift may be largely related to the growth of the use of interim order appointments in the past two years. These usually involve the initial appointment of the Public Advocate until a full Board hearing can explore with family appropriate ongoing arrangements. The OPA staff also continue to seek out suitable family members to whom guardianship can be transferred. As discussed in our 2011 Annual Report (p.132), an education and support program for private guardians may encourage more family members to take on the role. However, there will always be those individuals who do not have suitable kin in their lives or whose family do not wish to take on the responsibility.

Figure B9 below compares the number of closures in each category over the past eight reporting periods.

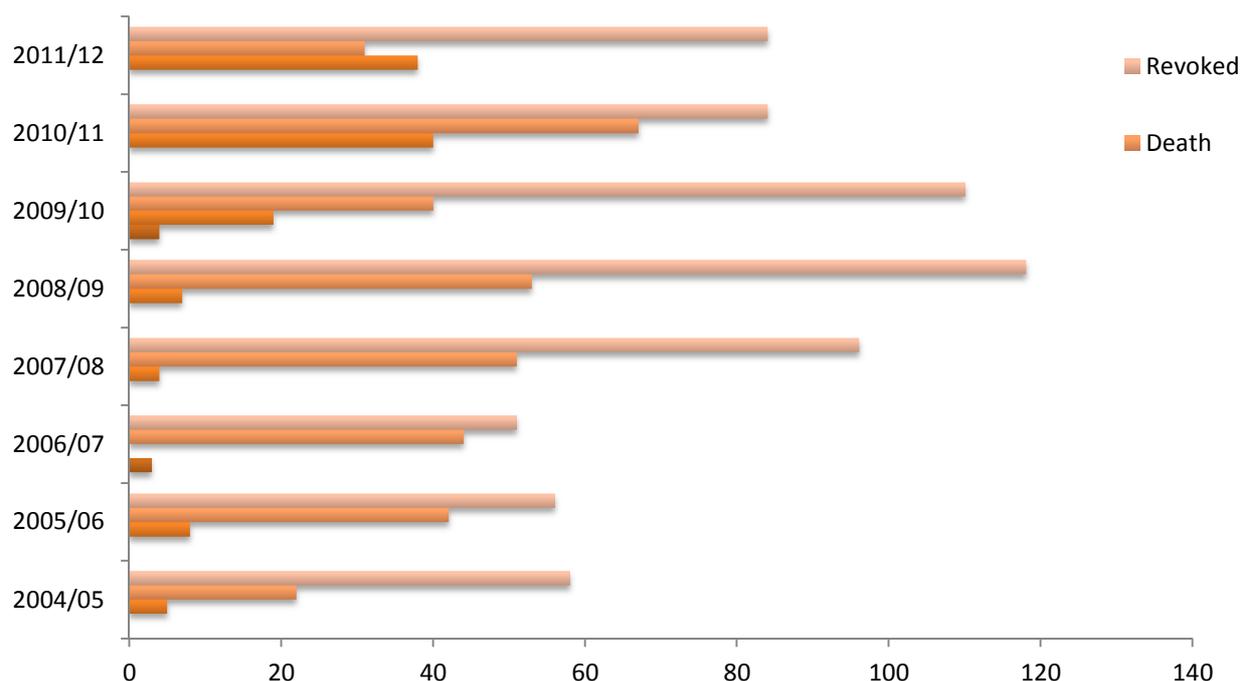


Figure B9: Guardianship Numbers by Closure type for past 8 reporting periods

The average length of guardianship for closed cases in 2011–12 was 1.72 years (median 1.1yrs). This compares with an average length of 1.75 years (median 1.2yrs) in the 2010–11 reporting period. Average and median length of guardianship have remained relatively steady over the past three reporting periods.

Figure B10 compares age groupings and diagnostic groupings with length of guardianship for those cases closed in 2011–12. In contrast with the previous reporting period, clients with an intellectual disability had a lower average length of guardianship than the other major diagnostic groupings (19 months vs. 30 months). Clients within the dementia diagnostic group had similar length of guardianship to the major groupings, whereas in the previous reporting period this was substantially lower (22 months vs. 17 months). This may reflect the impact of current approaches to the issue of detention in residential care facilities and Guardianship Board practices which promote continued external surveillance of vulnerable older people.

Length of guardianship for different age groups demonstrates a mixed picture, with the average length of guardianship changing across two reporting periods: for the under-41 years, 26 to 14 months; middle-age group from 20 to 26 months; and the 70s plus group remaining at 20 months.

Guardianship Cases Closed in 2011–2012

Diagnosis, Age and Length (months) of Guardianship

Diagnosis				Age			
	Number	Average length (months)	Median Length (months)	Age at end of Order	Number	Average Length (months)	Median Length (months)
Brain Damage	21	26	14	<41	35	14	12
Dementia	83	22	13	41<70	68	26	18
Mental Illness	29	21	18	=>70	81	20	11
Intellectual Disability	26	19	12				
Dual Diagnosis	17	22	14				
Other	9	8	8				
Total	184	21	13		184	21	13

Figure B10: Closed guardianships diagnostic and age profile

Figure 11 maps length of guardianship for closed guardianship cases over the last two reporting periods. Note that there is a similar clustering of numbers within the different periods.

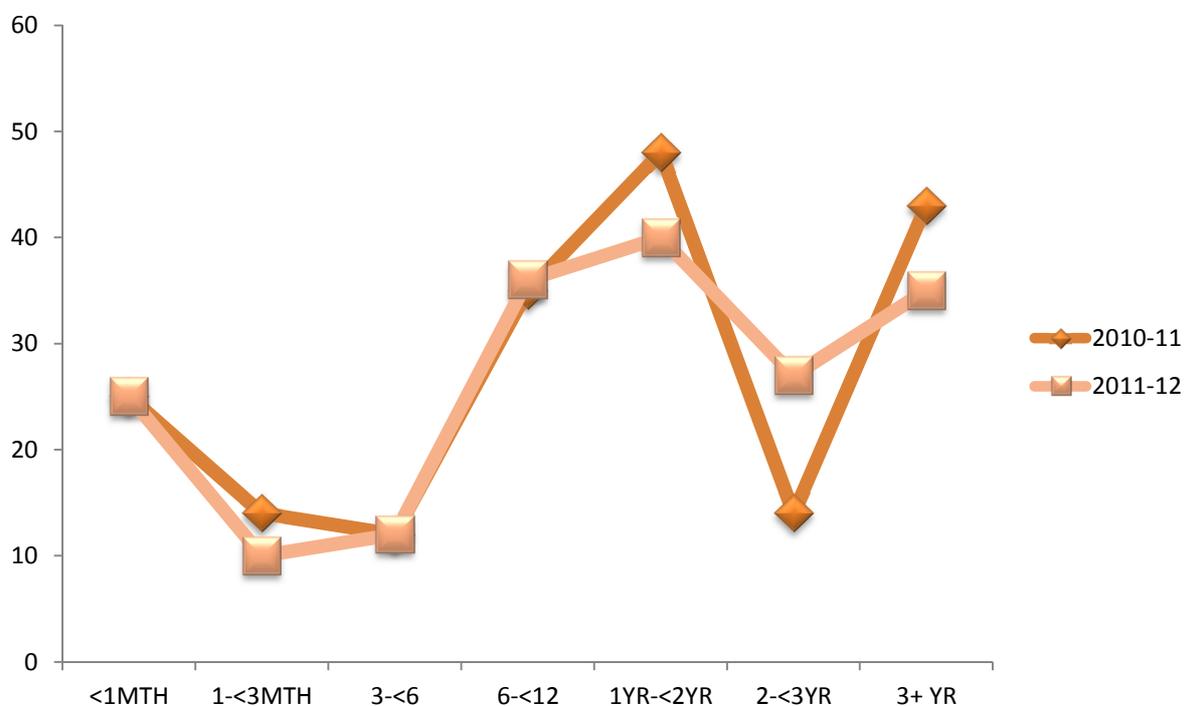


Figure B11: Number of closed cases by length of guardianship (2010–11 and 2011–12)

For the 744 guardianship cases as at 30 June 2012, the average length of time open to that date was 2.4 years (in 2010–11, it was 2.3 years) and a median length 1.6 years (the same as 2010–11).

The table below (Figure B12) compares length of guardianship for those cases open at the end of the past three reporting periods and those closed during these reporting periods.

Comparison of length of guardianship						
Comparison of length of Guardianship	Open cases 30/6/ 10	Open Cases 30 /6/11	Open Cases 30/6/12	Closed cases 2009-10	Closed Cases 2010-11	Closed Cases 2011-12
Average length (yrs)	2.3	2.4	2.4	1.7	1.8	1.7
Median length (yrs)	1.6	1.7	1.6	1.3	1.1	1.1
Proportion of cases in each time period						
Time Periods	Open cases 30/6/ 10	Open Cases 30 /6/11	Open Cases 30/6/12	Closed cases 2009-10	Closed Cases 2010-11	Closed Cases 2011-12
<12mths	36%	34%	37%	38%	45%	45%
12mths	24%	22%	20%	31%	25%	22%
< 2yrs						
2yrs to < 3yrs	14%	16%	14%	14%	7%	15%
3 years plus	26%	28%	29%	17%	23%	19%

Figure B12: Comparing length of guardianship over 3 years

The graph below (Figure B13) compares active cases as at 30 June, from June 2008 to June 2012 and the length of the orders at those dates.

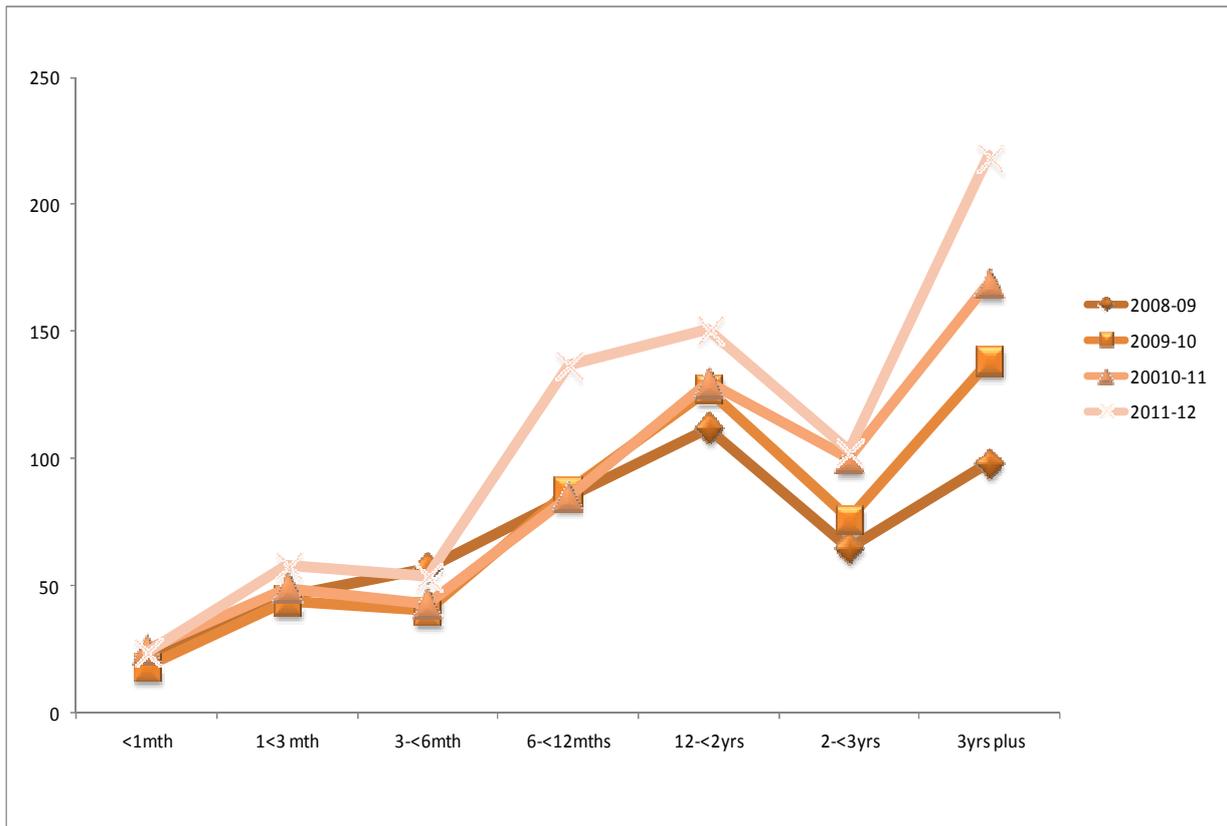


Figure B13: 5-year comparison of Length of guardianship for open cases as at 30 June each year.

The age profile of active, new and closed guardianship cases as at 30 June is compared in the table below (Figure B14). Note the fluctuations from year to year with a minor increase in the proportion of younger clients in new cases and decrease in later-life new cases.

Age Profile of Closed, Active and New Cases 2009–10 to 2011–12

Age	Closed Cases (age at closure)			Active Cases (as at 30/6)			New Cases (age at opening)		
	09-10	10-11	11-12	09-10	10-11	11-12	09-10	10-11	11-12
Age < 41 years	21%	13%	19%	29%	28%	30%	21%	24%	29%
41 to 70 years	33%	30%	37%	36%	40%	38%	35 %	18%	34%
> 70 years	46%	57%	45%	35%	32%	32%	44%	58%	37%

Figure B14: Age profile of guardianship clients 2009–2012

Diagnostic profiles of all guardianship clients active at 30/6/2011 and during this reporting period are illustrated in the following table (Figures B15).

Diagnostic Profile of Guardianship Clients				
Diagnosis	30/6/2011		2011-2012	
	Number	Percentage	Number	Percentage
Dementia	186	31	283	30
Mental Illness	127	21	197	21
Intellectual Disability	132	22	207	22
Brain Injury	56	9	76	8
Dual Diagnosis	99	16	112	12
Other	2	0	53	6

Figure B15: Diagnostic profile of all active guardianship cases this reporting period

Use of Special Powers

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

- (1) The Board, on application made by the guardian of a protected person -
- (a) may, by order, direct that the protected person reside -
 - (i) with a specified person or in a specified place; or
 - (ii) with such person or in such place as the guardian from time to time thinks 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 continued to require behavioural support plans for clients subject to restrictive practices. The background to this was described in the discussion of Restrictive Practices in the 2010 Annual Report (p.68 onwards) and the review of Deprivation of Liberty in the 2011 Annual Report (p.65 onwards).

Section 32 powers

In 2011–12, there were 312 clients who had a history of S32 orders at some time during the lifetime of guardianship (i.e. 34% of clients). This compares with 21.6% in the previous reporting period and 21% in 2009–10. As the organisation has only been collecting these data consistently over the past three years, it is difficult to interpret trends in the use of S32

powers. The increase in the proportion of cases may relate to that fact that we are now capturing a long-term picture of the use of S32 powers over the lifetime of guardianship (i.e., three years' worth of data). However, we know that from a practice perspective, the focus on restrictive practices in disability and aged care settings has led to more applications for powers under S32 and this would in part explain the rising number of cases where S32 has been applied.

Of the 312 clients with S32 powers as part of the order, their age as at 30/6/2012 was: 29.5% less than 41 years; 41% between 41 and 70 years; and 29.5% were 70 years or older. While the largest diagnostic grouping within this population is dementia (29%) it is clear that requests for powers of compulsion are significant for all populations: 23% of S32 powers applied to protected people with intellectual disabilities; 14% for those in the dual diagnosis category; 21% for clients with mental illnesses; and 14% for those protected people with other underlying diagnoses.

Another perspective is the proportion of people within different diagnostic groupings who have been subject to S32 powers during their active guardianship to date. In this interpretation, individuals with dual diagnoses have the greatest proportion (39%), followed by those with an intellectual disability (35%), those with a mental illness (32%), those with dementia (31%) and those with brain damage (28%). As individual protected persons are at different stages in the history of their guardianship, it is not possible to draw definitive conclusions from this information. A retrospective study of closed cases would enable more analysis of links between S32 powers and characteristics of the protected person population.

Regarding the nature of the 312 orders granted under S32 of the Act, for the active guardianship population during 2011–12, there were 203 directions relating to residence, 178 directions relating to detention and 135 directions relating to treatment. Due to data collection methods, it is not possible to isolate which of those were first granted during this reporting period.

Of new guardianship clients during the reporting period, 110 of the 326 clients (34%) were subject to enforcement powers under S32 of the Act which was exactly the same percentage for this population in the previous reporting period.

While the Board might grant S32 powers, these are not exercised in all cases. Individual case examination is required to identify these practices. Last year, we conducted such an analysis which indicated that guardians issued directions using s32 powers in 47% of cases when these powers were granted in association with a new guardianship order (2011 Annual Report p. 151). A similar audit of cases has not been conducted this year.

Figure B16 illustrates the breakdown of Section 32 powers for all active and new clients.



Figure B16: Breakdown of Section 32 powers 2011–2012

Rate of Appointment of Public and Private Guardians South Australia

Of the estimated 1115 applications for consideration of the appointment of a guardian received by the Guardianship Board of South Australia during the 2011–12 financial year, 326 (29%) resulted in the appointment of the Public Advocate, a slight proportional increase on the previous year (2010–11 = 26.5%) .

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

836 of the 1115 applications (75%) resulted in the appointment of a statutory or private guardian compared with 723 (74%) in 2010–11. These figures are presented for the previous six reporting periods in the table below (Figure B17).

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

Figure B17: Comparison of Applications and Guardian Appointments July 06 to June 2012

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

The graph below (Figure B18) illustrates the trends in appointment of guardians in the past six years. While the OPA numbers have increased steadily, the rise in private guardianship over the past two reporting periods is much more significant.

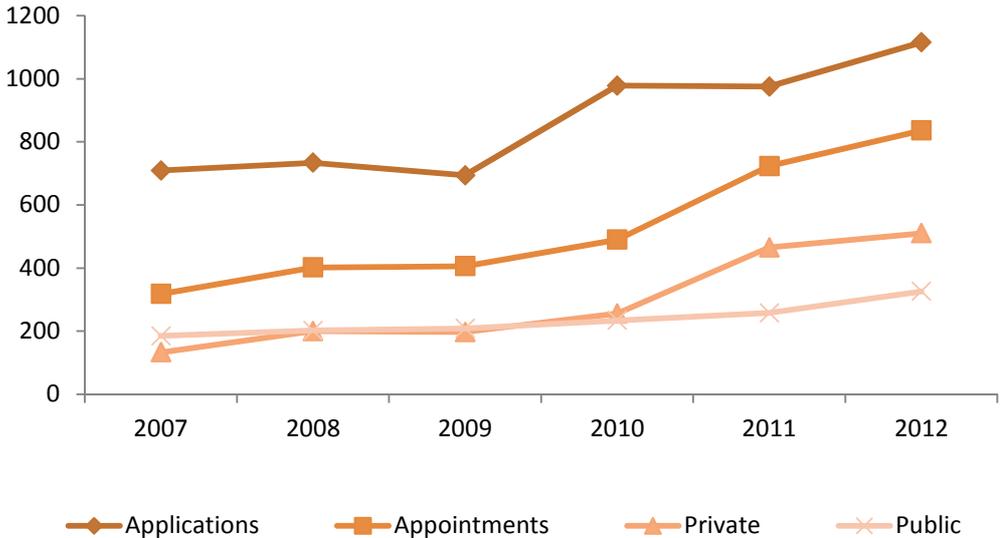


Figure B18: Numbers Guardianship Appointments July 2006 to June 2012

Prevalence of Guardianship

Figure B19 below represents the rate of South Australian public guardianship per 100,000 at the end of each financial year and the rate of change. It is notable that South Australia’s end-of-year rate of public guardianship has risen by 15.5 cases per 100,000 in the past three years. Comparative figures from other jurisdictions were not available.

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

New Guardianships in Financial Year	ABS Data SA Population (100,000)	Number of new appointments	Public Guardian Appointment Rate	Change in Rate of Public Appointments	Private Guardian appointment rate per 100,000	Guardianship Appointments per 100,000
2008-09	1632	209	12.8	-	12.1	24.9
2009-10	1633	234	14.3	+1.5	15.7	30.0
2010-11	1635	258	15.8	+1.5	28.4	44.2
2011-12	1650	326	19.7	+3.9	30.1	49.8

Figure B19: Rates of Public Guardianship 30 June 2009 to 30 June 2012

The rate of private guardianship appointments is also included in this table by way of comparison. We do not have information on the number of private guardianships which are active at the end of each financial year but would presume that the rate per 100,000 is expanding each year, probably at a rate greater than public guardianship. While new appointments for public guardianship have increased by 6.9 per 100,000, private guardianship appointments have increased by 18.0 per 100,000 over the past three reporting periods.

Responding to demand

This increased demand has presented a significant challenge for this Office. In recent years, steps had already been taken to make our operations as efficient as possible, streaming our work into short- and long-term teams, and using our data systems to predict and respond to demand.

Our Office was also given an opportunity to present our case for a more limited role of guardianship to a professional development session of the Guardianship Board, arguing that a limited rights-based application of guardianship was preferable to a broader welfare-based approach, using much of the material subsequently published in our 2011 Annual Report (p. 122). (As noted above, however, some of the increase reflects other factors beyond the Board's control).

We also considered the level of service we provided to those people under guardianship who in the past would not have been placed on an order. For example, we have considered triaging these cases differently to receive a lesser 'consent only' service. However, after careful legal analysis, there was no real option of doing this and the effectiveness to be gained was marginal. Even when the need for guardianship is debated at the time of appointment, once a client is in our service the expectation of participants is created and the time involvement of our staff will be the same.

The average caseload at year end (excluding team leaders) for the the short-term team was 45.8 cases and 49.5 for the long-term team. Thirty-six guardianship clients remained on the waiting list as at 30 June 2012.

We were able to successfully make the case to the Attorney-General's Department that all steps had been taken to efficiently manage this problem within our Office, and that the sheer demand pressure necessitated extra resources.

On this basis, the Department permitted the Office to operate over its guardian establishment by 1.8FTE from late 2011 through to June 2012. This was a temporary arrangement. This added capacity assisted us to deal with our waiting list, but the added capacity was quickly absorbed by the runaway increase in guardianship appointments and at the end of the year, a waiting list was still in operation, although at that particular time high-needs clients could still be allocated faster than before.

In May 2012, the Government announced additional funding of \$500,000 per year to the Office. This will mean in 2012–13 the temporary positions will become permanent, and some additional staff will also be employed. Given the pattern of increased guardian appointments, we were also encouraged that the Government has said of this initiative in its announcement of the Budget that it will look at the need for additional resources in the future.

In addition, in 2012–13 professional resources will be diverted from the public enquiries system to further organise and manage the large stable guardianship (monitoring) caseload which has lacked consistent coordination in recent years.

Figure B20 (below) illustrates the waiting list at the Office of the Public Advocate.

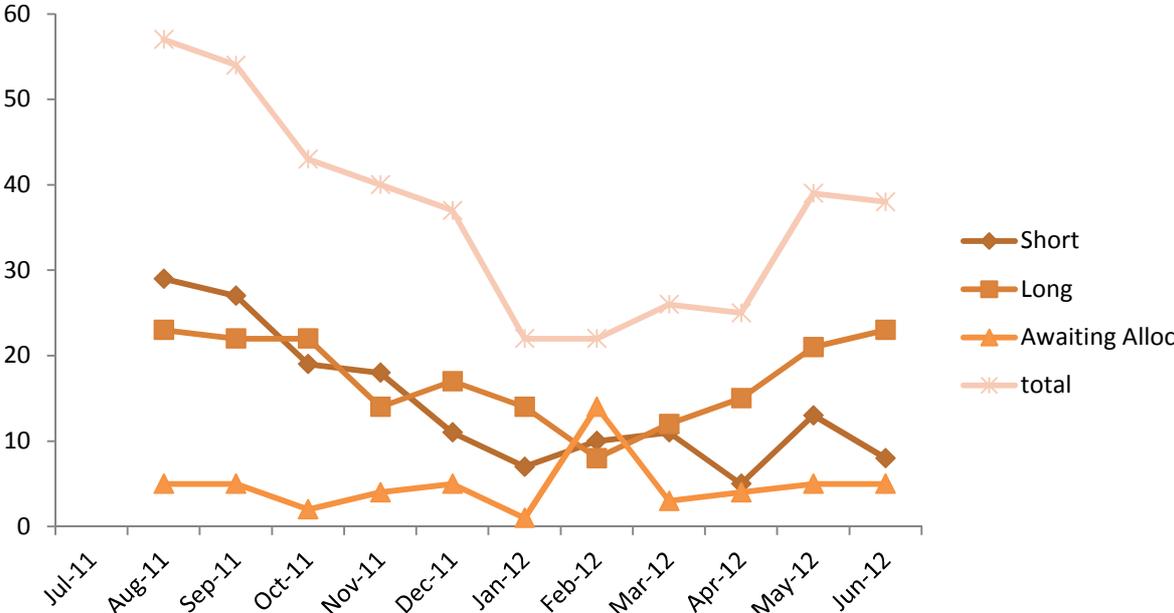


Figure: B20 Waiting lists for allocation of new cases 2011–2012

Recording of the waiting list numbers commenced in August 2011. The graph shows the list for the short-term team, the long-term team, and people who are awaiting allocation to one of the teams. The latter group is included for completeness in this graph as people are only “awaiting allocation” briefly when their appointment has just been made. The significant waits have been post-allocation for short- and long-term teams; ‘on hold’ pending allocation of a delegated guardian within a team.

While on the waiting list, clients will still receive a service either from a guardian on a duty roster within the office, or the Senior Advocate/Guardian for the respective team. However, while such an arrangement responds to the need for urgent decisions, it is not optimal, as a delegated guardian is not available.

With respect to our performance, throughput per worker is also measured and is represented in Figure B21.

Active Case throughput 2010-11 and 2011-12 Reporting Period			Monitoring	Total Cases
Team Data (Excludes seniors)	Number Opened per FTE worker	Number Closed per FTE worker*	Number of Monitoring Cases closed ***	Total Cases managed per FTE guardian worker in year
Short Term Team				
10-11 (3.7FTE)	35.9 (133 cases)	22.2 (82 cases)		
11-12 (4.8FTE)	34.6 (166 cases)	14.0* (67 cases)		
Long Term Team				
10-11 (6.7 FTE)	17.4 (117 cases)	11.8 (79 cases)		
11-12 (7.7FTE)	21.3 (164 cases)	10.9 (84 cases)		
Combined Teams				
10-11 (10.2 FTE)	25 (255 cases**)	18.7 (191 cases**)	31***	77.6 per FTE (793 cases)
11-12 (12.5FTE)	26.1 (326 cases**)	14.7 (184 cases**)	34***	74.3 per FTE (928 cases)
NB Senior Advocate Guardians and Management not counted in guardian FTE numbers *Transfers from teams to monitoring caseload not counted in closure calculations Short Term Team in particular transfers significant numbers to monitoring ** Includes management cases and monitoring cases ***No specific resource allocated to the monitoring cases for full year covered by staff from guardianship teams and senior staff. These cases are therefore counted in throughput per FTE guardian for closed cases				

Figure: B21 Comparison of Short- and Long-term Team Throughput 2011-12

As previously discussed, the OPA workload throughput is largely influenced by external factors which determine new work and closure of cases. Rate of closure per FTE within the short- and long-term teams has dropped this year. This is particularly reflected in the short-term team which has been affected by the change in practices regarding older people in aged residential care facilities. These clients residing in secure care are now transferred to the monitoring caseload rather than referred to the Board for revocation, because of the requirement to continue special powers under s32 of the *Guardianship & Administration Act 1993*. While there was an increase in staff in 2011-12, this did not occur until late 2011. This has no doubt affected the ability of the service to attend to returning matters to the Board for revocation, so the lower closure rate reflects OPA factors, as well as external factors raised before.

Optimal caseloads per FTE are benchmarked at 35 active cases per FTE and 75 cases per FTE for monitoring. At year end, the Short-term Team staff were managing an average of 45.8 cases per FTE and the Long-term Team 49.5 per FTE. With no staff formally allocated to the monitoring

caseload, at June 2012 there were 137 monitoring cases managed through duty and coordinated by a part-time Assistant Public Advocate. Some of the new resources will be specifically allocated to the needs of monitoring clients.

A new round of business improvement is planned for 2012–13 . Key discussions will revolve around the ongoing relevance of the two-team model, more efficient use of the workforce, particularly in terms of travel time, ways of managing waiting lists and throughput issues. However, these internal strategies are not the only reforms required. At the moment, guardianship remains the primary programmatic strategy for external oversight of vulnerable adults with decision making disability. There are pressing philosophical and resource reasons for building alternatives, both within and alongside of guardianship. Such alternatives should include advancing discussion on adult protection strategies, integration of supported decision-making approaches into programs that will work with vulnerable adults to help them maintain control of their own decisions, private guardian support program to enhance the quality and opportunity to use family members and friends in this role and establishing a robust community guardians’ system using volunteer resources.

Future demands for guardianship services are difficult to predict. However, we know that the workload of the Office of the Public Advocate has steadily increased since its establishment. As part of resourcing reviews, the OPA has attempted to predict future demand for guardianship services based on past performance. This is reflected graphically in figure B22. The projections made for the end of this reporting period underestimated the actual outcome of a 24 % increase in active guardianships over the 12-month period. This graphic clearly demonstrates the workload consequences of either an increase in new guardianship numbers or a reduction of numbers of case closures achieved, or both.

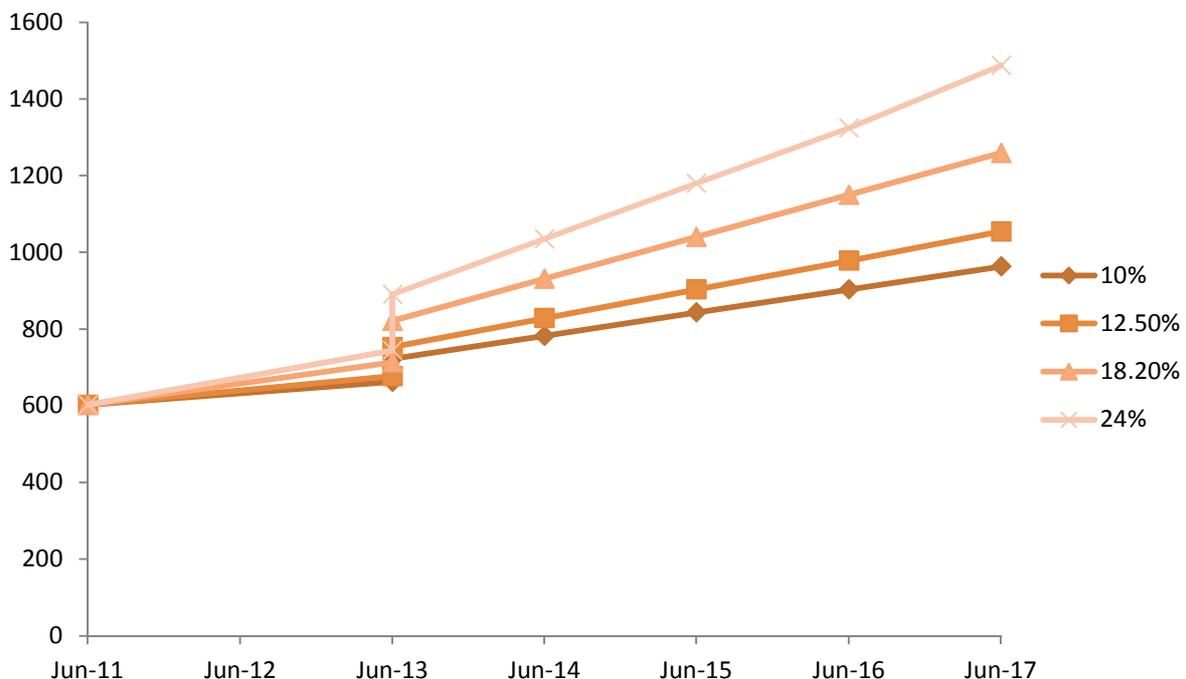


Figure B22: Projecting future demand for guardianship services

Investigations

Guardianship and Administration Act 1993

Section 28—Investigations by Public Advocate

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

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

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

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

Number of investigations 2011–2012

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

- 10 were open at the beginning of the reporting period
- 20 were opened during the year and
- 9 remained open as at 30 June 2012

Investigation training

A number of OPA staff have been participating in a training program sponsored by the Attorney-General's Department and run by TAFE to develop investigative skills relevant to a variety of government compliance-investigative roles. Staff have devoted work and their own time to participate in classroom and on-line education with the purpose of enhancing their skills in this area. This will be of benefit to the OPA in that more staff will have a formal background in the principles and practices of investigation within a legal framework.

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 whenever possible.

During 2011–2012, the OPA staff reviewed 432 applications which nominated the Public Advocate for appointment as guardian or where guardianship appeared to be part of the application but no preference for guardian was noted. In addition, some applicants do not clearly state which orders are being sought and a proportion of these applications only require an administration order. This figure compares with 321 screening matters in 2010–11, which is a 35% increase.

The OPA is sometimes appointed as guardian without prior knowledge or the screening process. This is usually when the Board changes the guardian during the review of a private guardianship order or when an emergency order is made. It is therefore not possible to make an accurate direct comparison between the number of matters attended by the OPA staff and the number of the OPA appointments made. However, it can be concluded that a maximum of 75.5% of these screenings resulted in the appointment of the Public Advocate, and that this percentage is likely to be significantly lower, as some of the 326 new guardianships during 2011–12 would not have involved this screening activity.

Combining the number of investigative activities (attendance at initial hearings as a ‘screening matter’ and formal investigations), the following picture emerges (Figure B23).

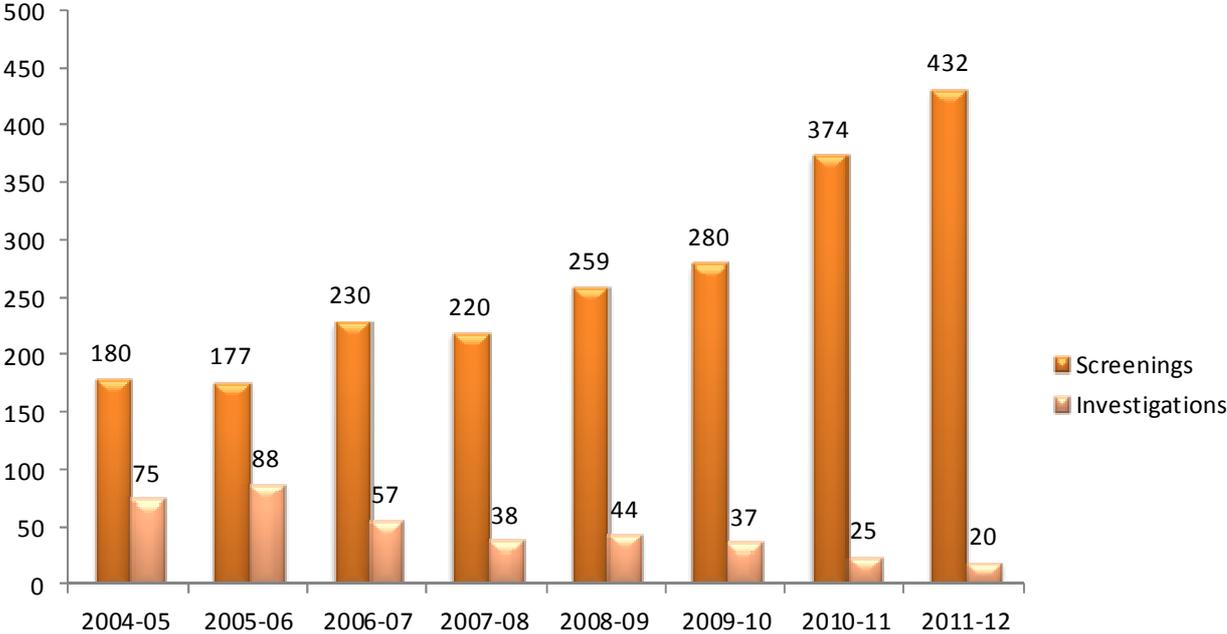


Figure B23: Number of Guardianship Applications Screened & Investigations Undertaken 2004–05 to 2011–12

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 2011–2012, 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.

The use of a warrant has been considered on occasion — usually when family or friends are concerned about a person they believe to have a mental incapacity and are having significant difficulty obtaining an appropriate assessment of incapacity due to the non-cooperation of the potential protected person. 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 advocacy for people under guardianship, as part of our information and advisory service and through taking on a small number of advocacy clients. The OPA officers will intervene on behalf of individuals who have a mental incapacity or on behalf of their carers in an attempt to ensure that they receive assistance. This can solve minor issues which might otherwise have led to guardianship or administration applications to the Board.

With respect to specific advocacy matters, there were 46 new cases in 2011–2012. Comparison of the past six years is featured below (Figure B24).

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

Figure B24: Advocacy Clients

Community Visitor Schemes

The introduction of the Community Visitor Scheme under the provisions of the *Mental Health Act 2009* has provided a valuable source of advocacy and assistance for inpatients of mental health facilities. The Principal Community Visitor and the Public Advocate have worked closely on systemic and individual issues affecting people with mental health problems. There has also been regular referral between the two programs. The Scheme has already provided valuable intelligence about the core issues which people with mental illness face during their inpatient stay.

We welcome the announcement of funding for the establishment of a Community Visitor Scheme for people with disabilities and support the proposed integration of this program with the mental health Community Visitor Scheme. The opportunities exist for expanded and ongoing collaboration on issues faced by individuals with disabilities and by their families.

Advocacy for Strathmont Residents

Planning for the closure of Strathmont Centre, a large residential facility for individuals with disabilities, has been a significant agenda for government services over several years. In line with this, a number of residents of Strathmont moved into community accommodation during

this reporting period. Disability Services approached the Public Advocate to assist clients who had limited or no family support to have their views and needs considered during the re-housing process.

Disability Services provided funding to the Attorney-General's Department for the provision of a time-limited advocacy service. Two Advocate Guardians attended individual accommodation planning meetings and met the residents before and after their accommodation changes. This process was achieved without the need to have guardians appointed to make decisions on behalf of those individuals.

The staff involved noted the improvement in the quality of life of the individuals they visited and were impressed by the respectful and individualised approach shown by Disability Services staff. The Office will continue to liaise with Disability Services regarding the final stages of planning for this closure.

Office of the Public Advocate Community Visitor Program

At the request of the Department for Communities and Social Inclusion, in 2011–12 the Public Advocate and his staff commenced a visiting program to a non-government residential service which provides accommodation and support for young men with high and complex needs, most of whom were under the guardianship of the Public Advocate. These clients have mental health, disability and forensic backgrounds and many have limited family involvement. The Department wished to establish an external monitoring process similar to what will be provided through the future Community Visitor Scheme. Monthly planned and unannounced visits have involved the Public Advocate and an Advocate/Guardian from the office visiting the facility, speaking with residents and staff and making observations about the programs provided. Regular reporting and liaison has occurred with senior representatives of DCSI over these visits.

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

Lack of routine access to advocacy services for clients appearing before the Board for both Guardianship Act and Mental Health Act matters remains an issue. This has been raised in previous reports, including our 2011 Annual Report (p. 164).

Section 14(9) of the Guardianship and Administration Act provides that a person can be represented by the Public Advocate, or a recognised advocate. In practice, our enquiry service refers people to recognised advocacy services.

This has been a long-standing gap in services provided, and it would assist to meet the need for advocacy for clients appearing before the Board if our Office were able to take on this function.

On occasion, our service is approached by people particularly hoping that we might take on this role, which we have declined to do, as it would not be possible to offer the service more generally.

Our view is that the current legal representation scheme should be extended either 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.

The OPA commenced the reporting period with seven active litigation guardianship matters. A further 11 were opened during 2011–12. Matters involved included actions in the Youth Court, the Federal Magistrates Court, and the Supreme Court and were about a range of issues, mostly the care of or contact with children.

The OPA has now finalised its internal Litigation Guardianship Protocol with the assistance of the South Australian Courts.

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.

The OPA staff have presented to a number of service providers and community groups during 2011–12 regarding Advance Directives, the Guardianship and Administration Act and the role of the Office of the Public Advocate and the Guardianship Board. The Public Advocate has also presented at a number of conferences, workshops and training programs during this period on a range of matters concerning rights for people with disability, supported decision making, prevention of abuse, and on topics related to improvements in the delivery of mental health, disability and aged care services.

In addition, the Public Advocate comments on advocacy matters and guardianship issues through radio, print and TV media when opportunities arise.

The Public Advocate and the Senior Practitioner involved in the Supported Decision Making Project have presented in a number of venues about the learnings from this project .

The Alliance for the Prevention of Elder Abuse

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

Alliance members formed an important part of the groups consulted in the Vulnerable Adults Project referred to in Part A of this Report.

Enquiry Service

During 2011–12, the OPA redirected resources from the enquiry and monitoring service to active guardianship. For most of the year, the equivalent of one person managed enquiries and the monitoring-caseload duty-worker system for action. While the demand of providing information to the public remains steady, it is not growing in the same manner as guardianship. It does require full-time availability of advice but over recent years, the method of delivery has been debated. In a previous reporting period, the OPA conducted a three-month trial of the provision of an information service by a full-time administrative officer supported by the professional staff who provided advice and follow-up.

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 2995 discrete episodes of enquiry. A comparison with previous years is graphed below (Figure B25). The substantial drop in 2006–07 coincides with a new database recording system which has improved our ability to link callers with their previous enquiries.

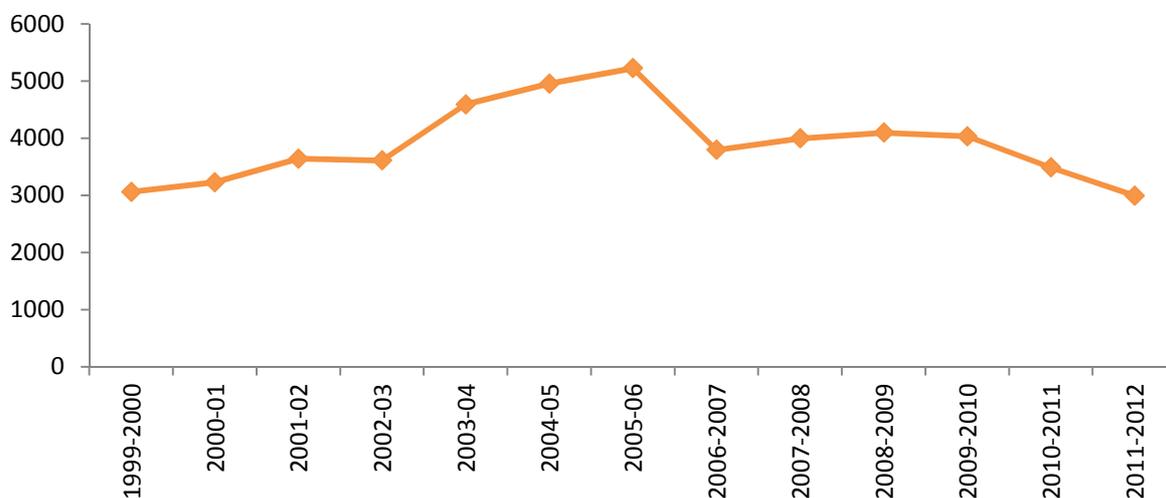


Figure B25: Number of enquiry episodes July 1999 to June 2012

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 key 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.

Main Enquiries Issues	2010-11	2011-12
Mental health issues	370	264
Guardianship issues	1008	1035
Administration issues	866	873
Advance Directives	856	737
Total issues raised	5012	4181
Discrete Episodes	3490	2995

Figure B26: Issues Raised in Enquiries

There has been a downward trend in overall numbers in the last three years which may reflect advice from other sources and improved access to alternative sources of information used by people who might otherwise make a telephone call, as well as the availability of information on the OPA website and the introduction of the Guardianship Board’s own website.

With respect to specific issues, the decline in mental health calls may reflect the availability of the Office of the Chief Psychiatrist to answer queries from practitioners, and the Community Visitor Scheme to take calls requesting visits.

The reduction in calls regarding advance directives is concerning and needs to be considered in the context of the Private Guardians Survey undertaken this year by this Office and funded by the Law Foundation (Office of the Public Advocate, 2012).

The survey highlighted a perceived lack of information available to private guardians appointed by the Board, or a family member or friend appointed through an Enduring Power of Guardianship. Information about decision making, responsibility, and the need for support were raised by the guardians themselves. A particular issue was what to do when there is family conflict over decisions. This need is exemplified by the fact that 43% of private guardians appointed by the Board were aware of the legislative principles that guide decision making, which declined to 35% amongst current enduring guardians appointed by the person. This was in spite of these guardians perceiving such information as important and wanting to know more.

The planned introduction of new advance-care directives legislation will be an opportunity to refocus our service to the needs of substitute decision makers in the community, through providing education and information, as well as assisting people to resolve conflict that might otherwise have proceeded to an application to the Board and the appointment of the Public Advocate as guardian.

After-hours emergency response

OPA senior staff and experienced advocate guardians who put themselves forward to do after-hours work participate in an after-hours roster on behalf of the OPA and the Guardianship

Board. The roster covers 5:00p.m. to 9:00a.m. on weekdays and 24 hours a day on weekends and public holidays.

Statistics for this service are not routinely generated, but rather the work is reviewed from time to time. The experience is that this after-hours work is also growing.

Complaints and Decision Reviews

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

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

With respect to decisions, the Office provides internal reviews and can request external reviews of decisions by the Guardianship Board. The administrative actions and processes of the OPA are also subject to review by the State Ombudsman.

Complex guardianship decisions are ratified by senior staff before they are implemented to ensure that the process has been comprehensive and the decision is supportable. Reviews can be undertaken at several levels in the Office by Senior Advocate Guardians, Assistant Public Advocates and ultimately through the Public Advocate. If a person is dissatisfied with a decision of the Public Advocate, they can apply to the Guardianship Board to seek advice and direction under the provisions of Section 74 of the *GAA*. Directions by the Board are legally binding, and if necessary, parties can appeal them to the Administrative and Disciplinary Division of the District Court.

Activity

During 2011–12, the OPA acted on 30 separate matters consisting of:

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

These related to 19 individuals currently or formerly under guardianship and three matters which were not about individual clients.

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

- Nine of the matters raised concerns about decisions made by delegated guardians
- One raised communication issues
- 12 raised concerns about OPA procedures or accuracy/sufficiency of information provided by OPA staff
- One raised concerns about the attitude of a staff member
- One complaint was about our responses to complaints made by others.

Some matters were requests for information or explanation only (e.g. FOI/ministerial)

The complaint about the complaint processes was a concern that fear of complaints could influence decision making. The response to this was to highlight the statutory independence of our decision making, and the access to external review if needed.

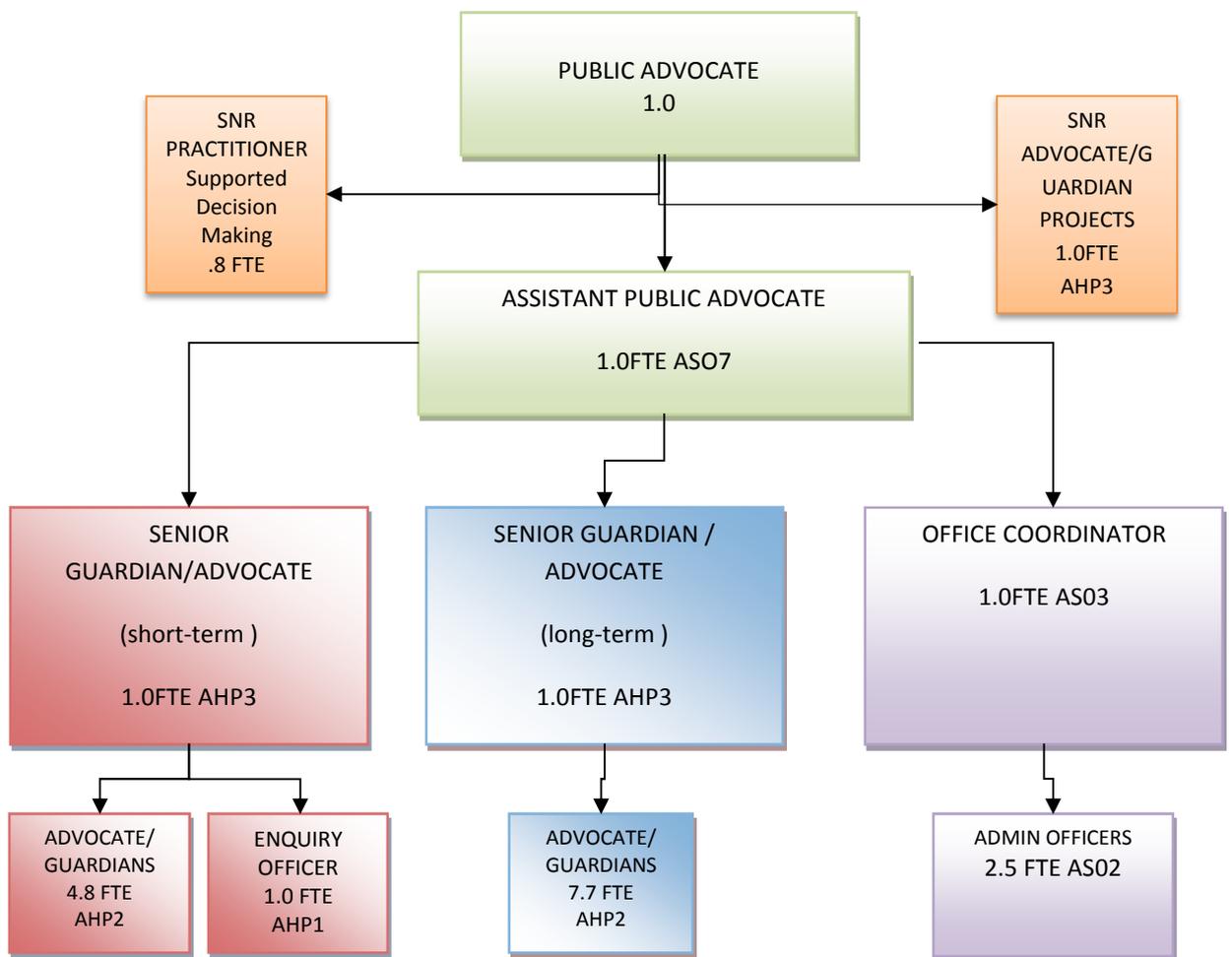
Employment and Human Resources

The OPA ongoing staffing establishment remained static during 2011–12 at 19.3 FTE. An additional 1.8FTE temporary Advocate Guardians were employed over establishment from late 2011 with the agreement of the Attorney-General’s Department in response to increasing demand.

A Senior Practitioner and part-time Peer Worker were also employed as part of the Supported Decision Making Trial funded by the Julia Farr MS McLeod Benevolent Foundation. The chart below reflects the deployment of these resources as at 30 June 2012.

Note that actual FTE does not equate to establishment 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 2012



Operational: 21.8 FTE as at 30/6/2012

Staff of the OPA 2011–2012

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 2011–2012.

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

Administration

Cheryl Thomas	Office Coordinator
Michelle Howse	Administration Officer
Aileen Vincent	Administration Officer (Part-time)
Jerusha Nicholls	Administration Officer (Part time)

Advocacy, Guardianship, Investigation and Enquiries

Julie-Anne Harris	Senior Advocate /Guardian Long Term Team
Elly Nitschke	Senior Advocate/Guardian Short Term Team
	Senior Advocate/Guardian Projects
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
Popi Amanatidis	Advocate and Guardian
Suzanne Bull	Advocate and Guardian
Tarnia White	Advocate and Guardian
Ella Nalepa	Advocate and Guardian
Andrew Sarre	Advocate and Guardian
Simone Trowbridge	Advocate and Guardian
Passant Ibrahim	Community Enquiry Officer / Advocate and Guardian
Susan Goldeband	Community Enquiry Officer / Advocate and Guardian
Barbara Ley	Monitoring Officer

Supported Decision Making Project

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

Occupational health, safety and injury management

OPA was guided by the policies and best practice principles of the Attorney-General's Department (AGD) in relation to Occupational Health and Safety (OH&S) 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 has an elected, trained OH&S representative and First Aid Officer. OH&S matters are routinely discussed in OPA staff meetings.

There were no incidents leading to loss of staff work-time during this reporting period.

Risk and Incident Monitoring

The OPA work regularly involves emotionally charged and conflictual situations which can result in behaviour which is difficult to manage. OPA staff have increased their vigilance about threats and behaviours which constitute risk using the AGD's incident reporting system and the AGD security incident report.

As a result of several matters of concern, the OPA has established a Risk Review Group involving senior staff, OH&S representative and staff involved in particular incidents. The organisation now maintains a register of incidents or situations where it has been assessed that there is a risk to staff or significant others. The Risk Review Group meets on a regular basis to monitor these individual matters.

Incidents this year have included threats to harm family of a staff member, threats to harm staff, and personal abuse of staff. In several instances, future contact between the staff member and the person making these threats has been terminated and other arrangements put in place.

It is very important to stress that the majority of threats and abuse do not come from our clients, but instead are made by the family of clients or by people who are in a relationship with clients. Most family of course are also polite and appreciative, but there are a significant minority of situations, where this is not the case.

Our Office has been grateful to the AGD Security Advisor for assistance in risk assessment and planning responses, and our on-site security staff who maintain a discreet presence at interviews when a family member has threatened staff or has a history of carrying weapons.

Equally concerning for staff is the emotional impact of dealing with protracted conflict in families when parties seek to make the OPA part of the conflict. Again, the agency seeks to offer support to staff through tandem work, transfer of client cases and defining of the scope of work relevant to the role of guardian.

We are also mindful of the ongoing Occupational Health and Safety issues faced by service providers in aged care sectors and health. It is a testament to the dedication of people working in the sector, that clients are accepted for services in such situations, even though the providers know beforehand that there will be extra work in protecting their staff from threats and abuse, and responding to complaints.

On occasion, service providers seek to use our Office as a 'buffer' between themselves and families to deal with their own OH&S issues. For example, it is not unusual to be asked if all

communication can come through a guardian. We do not agree to such requests, as whatever the family circumstances, there will be a lot of direct communication needed between facilities and families over day-to-day matters that would not involve a guardian and it would make no sense to involve our Office.

Given that we become involved in some of the most difficult conflict situations across the state, it would be unreasonable to expect our small group of staff to act as a buffer to protect workers in other systems that need to have their own responses.

Ultimately it is up to other organisations to put in their own measures to protect their staff. Many providers have systems in place that protect their staff as well as protecting the interests of clients and their rights to see their relatives. For example, a resident in an aged care facility can still see family members, but when there has been a history of threats and abuse of staff, the facility will request that visits taken place when senior staff are on duty.

Security Review and Risk Review

During 2011–12 the Public Advocate requested that the Attorney-General’s Department conduct a Security Review on behalf of the OPA following several incidents of threats and abuse towards staff. This has resulted in a number of recommendations relating to risk assessment, accommodation, security and equipment, staff training all of which will be addressed in the next reporting period. For example, a security monitoring system is to be installed in all public and interview areas.

Accommodation

Proposed expansion of staff and the need to upgrade interview and meeting facilities to enable the provision of a robust Mediation/ Family Conferencing Program requires an expansion of facilities on the 7th floor of the ABC Building in Collinswood. The accommodation fit-out is being funded from the recurrent budget of the OPA and is scheduled for completion at the end of 2012.

Financial Information

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

During 2011–2012, the core program expenditure of **the OPA** was as follows:

Income	
Grants	\$ 128,592*
Recoveries:	\$ 2,212
Total Revenue:	\$ 130,805
Expenditure:	
Employee entitlements	\$2,085,556
Supplies and Services	\$ 438,812
Depreciation	\$ 32,336
Total Expenditure	\$ 2,556,704

*Included funding from the Private Guardians Survey and the Supported Decision Making Project.

Two grant-funded time-limited projects have been operating within the Office of the Public Advocate during 2011–12: the Supported Decision Making Project (funded until late 2012 by the Julia Farr MS McLeod Foundation), and the Private Guardians Survey (commenced during 2010–11, completed in June 2012 and funded by the Law Foundation). The OPA is required to report to funding bodies on a regular basis.

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