

Office of the Public Advocate
South Australia



Submission to the
Social Development Committee,
South Australian Parliament,
Co-morbidity Inquiry

Office of the Public Advocate
PO Box 213,
Prospect, SA 5082.
Telephone: (08) 8342 8200
Facsimile: (08) 8342 8250
E-mail: opa@agd.sa.gov.au
Web: opa.sa.gov.au

Contact Person about this submission:
John Brayley
Public Advocate

1. Introduction - Office of the Public Advocate

- 1.1. The general functions of the Public Advocate are established under the *Guardianship and Administration Act 1993* (the 'GAA') s21. They include reviewing programs designed to meet the needs of mentally incapacitated people, identifying areas of unmet needs and inappropriately met needs, and making recommendations to the Minister.
- 1.2. The Office provides individual and systems advocacy, and under the provisions of the GAA s29 can be appointed adult guardian of last resort.
- 1.3. The Public Advocate is supported by an Office of 24 staff, 17 of whom act as Advocate/Guardians, providing services to over 1000 people for whom the Public Advocate has been appointed guardian. Staff in the Office also operate an enquiries service, a Dispute Resolution Service, and conduct investigations for the Guardianship Board.
- 1.4. It is common in undertaking these roles to assist people who experience a co-morbidity, and may have difficulty getting services through gaps in services, and difficulty finding an appropriate service.

2. Summary

- 2.1. This submission reviews the prevalence of co-morbidity. The rate of co-morbidity is significant and can be predicted, and because of its frequency responding to co-morbidity should be the core business for disability, mental health, drug and alcohol sectors. For example the rate of mental disorder in people with intellectual disability has been estimated to be 32% compared to 11% of the general population, and 48% of people who experience a traumatic brain injury develop a psychiatric illness over the long term.
- 2.2. This can be planned for so that clients can access assessment and evidence based therapies and rehabilitation. All mental health services, drug and alcohol services and disability services should offer a 'first level' response to a client with co-morbidity without needing to cross refer. To do this requires all workers in these fields to have co-morbidity training as part of their professional education or ongoing professional development.
- 2.3. When specialist back-up is needed this should be readily available, and provided through contracts and agreements between services. Some people with complex needs require integrated teams providing specialist mental health, disability and drug and alcohol expertise in the same team structure. This is already the case in homelessness responses and this approach could be expanded.
- 2.4. The National Disability Insurance Scheme (NDIS) will offer support for people who have a permanent disability and this will include people with a chronic mental illness. The NDIS will deliver one source of funding for people's support needs. This is positive, but our Office is also concerned that people with chronic and complex needs may fall through the gaps of an insurance model if they are unable or unwilling to make a claim on the NDIS for services. These people will need proactive engagement. The State as a stakeholder and funder of the NDIS will need to ensure that this group is properly served, because otherwise there is a risk that these people may receive inappropriate and expensive interventions through hospital services, Corrections and homelessness services that may have been avoided if disability services were used.
- 2.5. This submission considers the role of existing legislation, and identifies the need for new State legislation when the NDIS comes into operation. The current *Disability Services Act 1993*, will become redundant when the State no longer funds disability services. A new Act could establish legislative guidance to ensure that people with a disability have equal

access to mainstream State Government services as the general population, for example in education, training, health and mental health services.

- 2.6. This submission raises ideas, and refers to existing reviews and recommendations and how they might assist people with a co-morbidity. The basis of these ideas is explained in the text. The ideas for consideration are summarised below:

List of ideas raised for consideration in this submission, linked to terms of reference

Facilities in South Australia currently treating people with a dual diagnosis including the Margaret Tobin Centre and James Nash House

- **A new forensic disability facility.** A separate forensic disability facility be established with at least 10 beds. These beds should be additional to the existing forensic mental health bed number at James Nash House. (To read more see sections 5.6.12 onward of this submission.)
- **Transfer of some forensic responsibility to the Minister for Disability from Minister for Mental Health.** Linked to the establishment of a forensic disability facility, the *Criminal Law Consolidation Act 1935* be amended so that the Minister for Disability is responsible for the custody, care and supervision of defendants who are forensic disability clients, rather than giving this responsibility to the Minister for Mental Health as is currently the case. This will deliver better specialist disability care and improve continuity. Defendants with co-morbidity should only be in the custody of the Mental Health Minister when psychiatric care is required for an episode of illness and then returned to the custody of the Minister for Disability for ongoing supervision and care. (To read more see section 5.6.)
- **Establish a short term emergency facility for behavioural emergencies (non-forensic disability clients).** A new short term transitional facility be developed and operated by Disability Services to provide emergency care following a behavioural incident. This would be for short periods while new accommodation arrangements are put in place and be instead of waiting inappropriately in emergency departments, hospital wards or remand prison. (To read more see sections 4.2.1 onwards.)
- **NDIS to continue its funding to forensic clients in custody:** The NDIS be asked to continue its funding to eligible forensic disability and forensic mental health clients. Such clients currently remain eligible for Centrelink benefits, and should continue to receive NDIS support. (To read more see section 6.15 onwards.)
- **A new State Disability Act to provide statutory guidance to mainstream services:** An Act can require the development of guidelines for how services are developed and delivered by mainstream programs to people with disabilities. This would assist people with co-morbidity access appropriate health and mental health services either as community clients, hospital outpatients or inpatients. (To read more see section 7.)
- **The existing *Disability Services Act 1993* be amended to include restrictive practices provisions and recognise the Senior Practitioner:** Definitions of restrictive practices, requirements for assessment and positive behaviour support to be included in legislation, along with the establishment of the Senior Practitioner role. This relates to the use of restrictive practices in disability facilities. (To read more see section 5.10 onwards.)

The level of training offered to general practitioners, psychologists, psychiatrists and other relevant professionals in the area of dual diagnosis and possible measures to enhance that training

- **Training requirements to be described in statutory guidelines in a new Disability Act:** All staff in the key sectors of mental health, disability and drug and alcohol should receive education and ongoing training in co-morbidity. (To read more see section 7.)
- **Existing South Australian experts in this area be commissioned to lead the development and delivery of training:** Examples include members of the 'Triple D' interest group across brain injury, mental health and drug and alcohol services (see section 3.17); staff at the Centre for Disability Health, including Churchill Fellow in this area, and former College of Psychiatry National President, Dr Maria Tomasic, and members of the Management Assessment Panels of the Exceptional Needs Unit

Information given to individuals and carers on how to manage a dual diagnosis;
Supports to aid individuals and carers in managing and living with a dual diagnosis

- **Consumer and carer information and involvement in care to be part of statutory guidelines.** Education would be a key element of any care plan, and could be a requirement of any statutory guidelines established in this area. (To read more see section 7.)

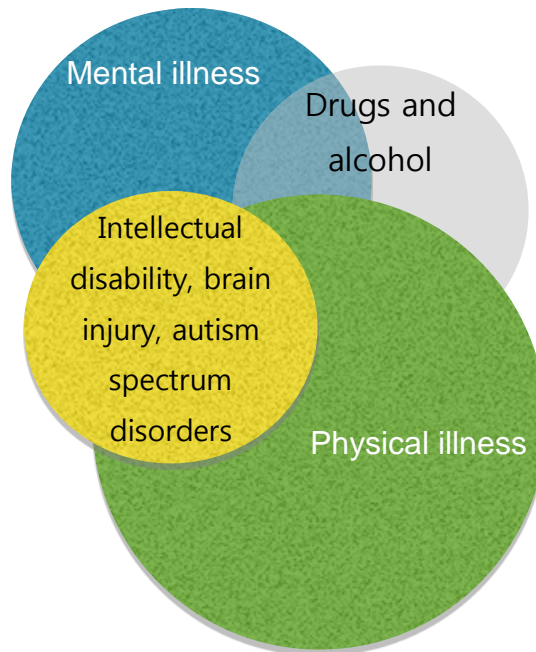
Any other related matter

- **Not exclude personality disorder from the CLCA provisions:** The Sentencing Council is currently considering the amendment of the definition of mental incompetence in the *Criminal Law Consolidation Act 1935* (the CLCA) to exclude personality disorder. Our Office is concerned that if such a proposed amendment were supported it would adversely affect the future access to forensic care for some people with a comorbidity - in particular people with cognitive disability who also have a personality disorder. (To read more see section 5.6.4 of this submission onwards.)
- **Mental Health Act 2009 amendments to consider decision making incapacity:** The Review of the *Mental Health Act* by the Chief Psychiatrist proposes that the *Mental Health Act* be amended to include decision making capacity criteria for making orders or administering involuntary treatment. Such a proposal will better protect the rights of people with mental illness, but also deliver consistency in involuntary care to people with comorbidity who can be subject to both the *Mental Health Act* (currently not capacity based) and the GAA (capacity based). (To read more see section 5.7.1 onwards.)
- **Modernise the GAA:** The GAA be amended to use definitions of impaired decision making that are consistent with the *Advance Care Directives Act 2013* and recent amendments to the *Consent to Medical Treatment and Palliative Care Act 1995*. The Act should also recognise supported decision making consistent with the Victorian *Guardianship and Administration Bill 2014* currently before that State's Parliament. These changes would protect the rights and deliver better outcomes to people generally, including those people with a co-morbidity. (To read more see section 5.9.)
- **Supported Residential Facilities Act 1992 should consider comorbidity:** Any review of the *Supported Residential Facilities Act 1992*, consider the needs of people with comorbidity. This could be done by requiring standards in this area, expecting reciprocal links between SRFs and relevant services, and expecting co-morbidity if present to be addressed in care plans. (To read more see section 5.11.)

- **New Drug and Alcohol legislation for those at risk of death due to substance use:** South Australia should consider legislation similar to the NSW *Drug and Alcohol Treatment Act 2007* or the Victoria *Severe Substance Dependence Treatment Act 2010*. While this would be new coercive legislation, it may better protect people's rights compared to taking measures to address life threatening substance use, using other legislation not intended for this purpose, such as the Guardianship and Mental Health legislation. (To read more see section 5.8.)

3. Identification of co-morbidity in research studies and in local clinical practice

- 3.1. Co-morbidity by definition refers to the coexistence of two or more conditions. The Committee reference refers to a dual diagnosis of intellectual disability and/or acquired brain injury with either mental illness, or chronic substance abuse.
- 3.2. This overlap as it applies to this reference is illustrated diagrammatically below.



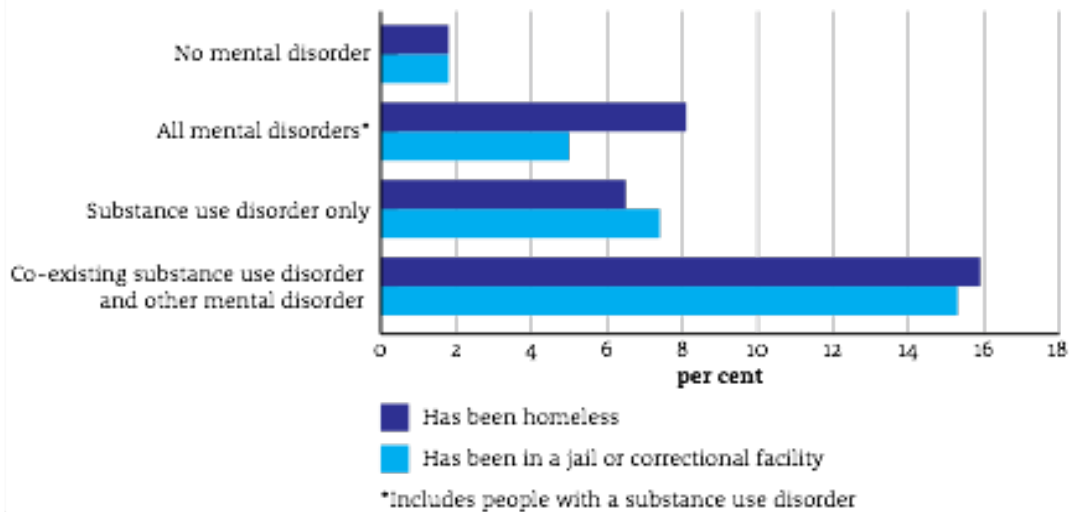
- 3.3. In considering facilities (reference 1), access to trained staff (reference 2) and the provision of support (reference 4) it is necessary to undertake some form of population planning to determine need. It is reasonable to extrapolate rates from peer reviewed literature and reports commissioned by Australian Governments.
- 3.4. Co-morbidity rates depend on how a population to be studied is identified. For example whether existing diagnoses are relied on which may in some conditions be an underestimate of the prevalence of conditions, or whether specific screening has occurred.
- 3.5. People with **intellectual disability** had higher rates of mental disorder (32.2%) compared to the general population (11%) in a Welsh study, and a Dutch study demonstrated that they also are more likely to have physical illness and need visits to GPs (Kwok and Cheng, 2007). This pattern would apply in Australia.
- 3.6. A further complication, is that up to 26% of people with an intellectual disability will also experience epilepsy. Seizures can affect cognition and be linked to disruptive behaviour. Anticonvulsant medication may also stabilise mood, but can cause somnolence, worsen cognition and sometimes behaviour (Kwok and Cheng, 2007).
- 3.7. Challenging behaviour by people with intellectual disabilities is not a psychiatric disorder as such, unless a co-morbid psychiatric illness has been properly diagnosed. Behaviour can be either independent of mental illness, or it can be secondary to a mental illness such as depression, anxiety, mania or psychosis (Allen and Davies, 2007). Mental illnesses can present in an atypical way for people with a disability, compared to the

general population. For this reason a psychiatrist or psychologist needs to be experienced and/or knowledgeable in assessing people who have a disability to make an accurate diagnosis to ensure an illness is not missed.

- 3.8. A lack of accurate diagnosis for a person with an intellectual disability can lead to a lack of care or inappropriate care: A person with an undiagnosed illness may not receive necessary community or inpatient mental health care, and a person who has behaviours due to a disability who has been incorrectly labelled as mentally ill, may have psychotropic medication incorrectly commenced instead of using a non-drug positive behaviour support plan.
- 3.9. Overwhelmingly recent concern has centred on the misdiagnosis of mental illness, leading to avoidable chemical restraint that may not be needed if positive behaviour support is provided. A related concern is the accurate recognition of mental illnesses such as depression and anxiety disorders, which require specific treatments, avoiding the use of antipsychotic medication prescribed in a non-specific way as chemical restraint.
- 3.10. It is our observation in South Australia, that our services need greater access to professional staff who can accurately identify and diagnose co-morbidity for people with intellectual disability. This is a common problem nationally. The ability to respond to dual diagnosis in a disability system is inextricably linked to how effectively a system can provide professional staff with expertise to assess and manage challenging behaviours by people with intellectual disability so as to avoid the use of restrictive practices such as restraint and seclusion.
- 3.11. There are well regarded practitioners in specialist units in South Australia who can assess and manage challenging behaviour. These include staff of the Positive Behaviour Support Unit operated by DCSI and the Centre for Disability Health, once again operated by DCSI from Modbury Hospital. Beyond this there are practitioners attached to the larger NGOs and in private practice who are well regarded who are sought out by providers on a fee for service basis. The DCSI Management Assessment Panel, which is part of their Exceptional Needs Unit provides high level skills in service planning.
- 3.12. Once co-morbidity has been identified for people with exceptional needs there are a number of non-Government organisations that can provide services, examples include Community Living Options, the Exceptional Needs division of Anglicare and Life Without Barriers.
- 3.13. However with respect to initial recognition and response there are two significant problems across our services that need to be overcome. First there is a need to develop capacity within services (disability, health and mental health services) to deliver a first line response to co-morbidity without needing to call in other agencies for common co-morbidity issues. This is already present to some degree but is variable. Second there is a lack of specialist staff with necessary skills to back up front line staff. This includes psychologists, psychiatrists and developmental educators with necessary training and experience in positive behaviour support, and identifying psychiatric illness in the presence of intellectual disability.
- 3.14. Our Office has not quantified the size of this unmet need gap in service provision, but the task of doing this should be a relatively straightforward although it may take time to do. Estimates could be based on knowledge from the literature about the prevalence of dual diagnosis associated with intellectual disability which could be used to identify the number of people needing services when planning staff numbers and training, it should be possible to use other jurisdictions as a benchmark who have better responded to the problem (in particular the UK).

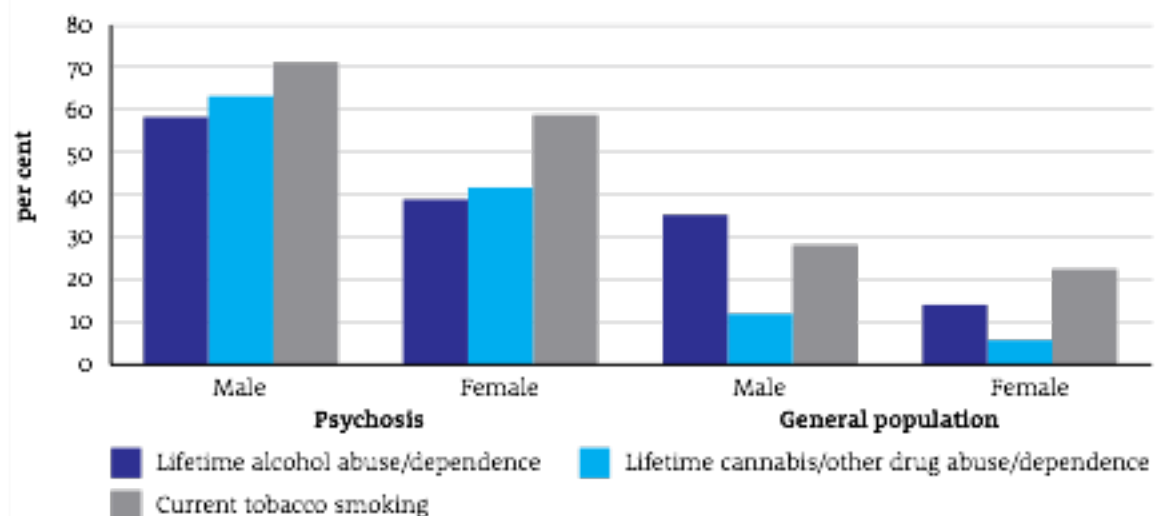
- 3.15. People with **traumatic brain injury** are also at greater risk of mental illness. A 30 year follow-up study demonstrated that 48% of people developed a clinical psychiatric illness after brain injury. The most common disorders were major depression (26.7%), alcohol abuse or dependence (11.7%), panic disorder (8.3%), a specific phobia (8.3%) and psychotic disorders (6.7%).
- 3.16. Once again skilled diagnosis is required to separate behaviour due to the direct effects of the injury, and that related to a superimposed psychiatric illness. For example people with brain injury can experience impaired concentration and apathy. Apathy - a lack of spontaneity and goal directed behaviour - can be due to damage to specific brain regions. It can also be a symptom of superimposed depressive illness (Arnould et al, 2013). Similarly disinhibition may be due to frontal lobe damage, or could be a symptom of developing mania or psychosis.
- 3.17. An increasing recent focus has been on people with “triple morbidity”: brain injury, mental illness and a substance use disorder, requiring an effective interface between brain injury rehabilitation services, disability services, mental health, and drug and alcohol practitioners.
- 3.18. Frontline staff have taken an interest in this area with the formation of a South Australian ‘Triple D’ interest group for professionals working with individuals with multiple disabilities spanning drug and alcohol, brain injury, disability and mental health sectors. This group links professionals and arranges monthly meetings. If new resources become available for co-morbidity training then this existing interest group would be a good vehicle to deliver training in this area.
- 3.19. People with **autism spectrum disorders (ASD)** are also at greater risk of mental illness. A recent review by Italian authors cites the rate of psychosis experienced by people with ASD ranging between 4.4% and 18%. Anxiety disorders and depressive disorders are frequently reported. In one study 56% of the people assessed had at least one anxiety disorder. Obsessive compulsive disorder manifestations range from 7% to 35% of people with ASD (Vannucchi et al, 2014a). The evidence for increased rates of bipolar disorder (6% to 21.4%) has also been reviewed (Vannucchi et al, 2014b).
- 3.20. The Office of the Public Advocate has previously advocated for the development of a State Autism Plan bringing together responses from disability, education, vocational training, health, mental health, child protection and justice (Office of the Public Advocate, 2012, page 16.)
- 3.21. The link between **mental illness** and **substance use disorders** has been reviewed by the National Mental Health Commission in its 2013 National Mental Health Report Card. The Commission notes that only 7% of people with this co-morbidity receive support for both problems even though it estimates that 70% of people attending mental health services or drug and alcohol services will have both problems.
- 3.22. Graphs from the National Mental Health Report are reproduced below. The first (figure 1) demonstrates the high rates of co-morbidity in homeless and correction populations, where co-existing substance use disorder and mental disorder is more frequent than either alone.

Figure 1: Percentage of people who have ever been homeless or in a correctional facility, by mental health status



- 3.23. The second graph (figure 2) demonstrates the high rate of drug use for people living with psychosis.

Figure 2: Drug use by people living with a psychotic illness compared with the general population



- 3.24. Co-morbidity in **homeless populations** can be associated with an increased risk of death. Homeless people die at 3-4 times the rate of the general population, and individuals with trimorbidity - a combination of substance use, chronic mental illness and chronic medical illness are particularly at risk (Brayley, 2008; O'Connell, 2005).
- 3.25. The increased risk of mental illness and disability in **criminal justice populations** has been linked. A British survey reported a rate of 7.1% of prisoners with an IQ <70 and a further 23.6% in the borderline range of 70-79 (Hayes et al, 2007).
- 3.26. Similar rates have been documented in a survey of people presenting to the NSW Magistrates Court. Ten percent had a score on the Kaufman Brief Intelligence Test of below 70 and a further 20% were in the borderline 70-80 range (Vanny et al, 2009).
- 3.27. The prevalence of mental illness was greater in the defendants who had an intellectual disability: 46% of those with an intellectual disability vs 36% of those without.
- 3.28. Similarly there are high rates of reported brain injury in prisoners. In a NSW study of 200 prisoners, 65% of prisoners endorsed a history of a traumatic brain injury with a loss of consciousness (Schofield et al, 2006a). Past traumatic brain injury amongst prisoners is highly associated with increased rates of major mental illness. (Schofield et al, 2006b.)
- 3.29. This is in the context of a high rate of mental illness in prisoners: A 2001 NSW study demonstrated that 39% of male prisoners and 61% of women prisoners met the criteria for a mental illness.
- 3.30. In NSW Eileen Baldry's team has modelled the cost of care for people with co-morbidities; people who have life circumstances not dissimilar to high needs clients in South Australia.
- 3.31. Her group had studied 2731 people in prison in NSW between 2000 and 2008 who had a mental illness and/or cognitive disability. 1463 had a cognitive disability, 680 of these had an intellectual disability and 783 a borderline intellectual disability. 66% of this group had either co-morbidity and multiple mental, physical and cognitive disabilities (Baldry et al, 2012a.)
- 3.32. Her group concluded that people with cognitive disability and mental health or alcohol and other drug disorders were more likely to have ongoing intense police, juvenile justice, court, and corrections episodes and events (Baldry et al, 2012a.)
- 3.33. When the total Government costs were analysed for 11 people who were the subject of more in depth financial case studies, lifetime costs across Government services for people aged between 23 and 55, ranged between \$900,000 to \$5.5M. The highest cost was for a young woman who experienced intellectual disability and borderline personality disorder and was the youngest person studied (age 23) (Baldry et al, 2012b.)
- 3.34. Prevalence Conclusions
 - 3.34.1 Co-morbidity of some form is common, and in some settings is the norm rather than the exception. Addressing co-morbidity is essential in providing an effective service response for an individual.
 - 3.34.2 Because the number of people affected by co-morbidity is known, at least from research on similar populations interstate and overseas, it is then possible to use this information to plan service delivery using a population based response. Similarly the requirement for staff with particular training to provide initial interventions to people with a co-morbid disorder can be determined, along with access to other specialist services for referral and support.

- 3.34.3 There is a particular need to provide effective coordinated interventions to people in the justice system, including prisoners and forensic patients, and to people who are homeless.
- 3.34.4 The costs of not addressing co-morbidity when analysed can be extreme, and therefore even without new money allocated, new service responses could be funded with savings of money inappropriately spent. However this takes some work to identify these savings across health, justice and disability services.

4. Service Planning: silos and gaps

4.1 Historical Background

- 4.1.1. Historically (prior to 30-40 years ago) psychiatric hospitals in Australia not only provided services for people with mental illness but also for people with intellectual disabilities, substance use disorders and alcohol related brain injuries. The services offered were limited in availability, lacked integration with primary care, did not provide local community follow-up, and institutionalised services were at times unable to keep their clients safe from abuse or neglect, and could lack respect for human rights.
- 4.1.2. In spite of these shortcomings services were under one governance, so conflicts over funding and responsibility were less likely to occur as the mental health system at the time, as limited as it was, had a broader sense of its responsibility and role.
- 4.1.3. Since then, both nationally and internationally, there has been specialisation in disability service provision, and a separation of drug and alcohol services from mental health services. This specialisation overall can be seen to be positive, and ensures that people receive skilled services dedicated to the specific therapy, treatment, rehabilitation and support requirements of consumers in each of these sectors. However this division has created new gaps in the delivery of clinical services and rehabilitation to people with co-morbid conditions.

4.2. Consequences of gaps in service provision

- 4.2.1. These gaps have significant consequences for the individual who misses out on necessary therapies and rehabilitation, and because of this may be at risk of homelessness, unnecessary hospitalisation in acute medical and psychiatric wards, and imprisonment if behavioural disturbances lead to incarceration. In some instances not addressing co-morbidity, will increase the risk of suicide.
- 4.2.2. Apart from the humanitarian and moral obligation to assist people who experience co-morbidity, this Office considers that there are likely to be significant financial savings in planning services to meet these predictable needs, compared to not meeting these needs and requiring more crisis responses. This is illustrated by the NSW data quoted in the previous section.
- 4.2.3. When major behavioural incidents occur in accommodation, such as assaults on staff, and property damage including arson our Office has been impressed with the commitment of Government disability services to find and then fund alternative accommodation for people with high needs. Prompt assistance in arranging and funding alternatives comes from both frontline staff and executives at DCSI any time during the day or night. Because of this people who need accommodation can get prompt help.
- 4.2.4. However, these crisis situations aside, there can be a limitation in what can be delivered quickly, and it can take time for a new option to be developed for clients with high needs. Access to funding is not the issue as people in this group can have significant packages allocated to them, with annual packages over \$100,000 in value. Also people in this group have often already received extensive psychological and positive behaviour support prior to an incident, so these interventions alone are unlikely to offer a quick solution in a crisis.

- 4.2.5. We observe the challenge for Government disability coordinators is one of finding a supported accommodation provider who has a suitable vacancy and skilled staff to manage behaviour, rather than a challenge of finding funds to pay for it.
- 4.2.6. Sometimes suitable accommodation can be found relatively quickly - a most recent matter was resolved within 4 days, when a new respite place was created for a client who had high needs and had already been moved from two previous providers, although this client needed to wait in a hospital emergency department over a weekend for the vacancy to be created.
- 4.2.7. Yet in other situations it can also take a long period of time. Another client with an intellectual disability will have had to wait nearly four months for a new house with staff to be established for him, spending that time in a hospital medical ward and psychiatric ward.
- 4.2.8. Other clients have been charged by the police because of their behaviour and the Remand Centre provides the "crisis" accommodation. When behaviour is difficult to manage in prison such clients can occasionally be moved to 22 hour per day solitary confinement. Usually they stay in prison custody until a new placement can be offered to them.
- 4.2.9. It is our view that emergency accommodation should be available to support people in these circumstances. It could be conjugate accommodation with highly skilled staff.
- 4.2.10. Using the wrong crisis accommodation - emergency departments, mental health wards or prison can be harmful to the client, and also more costly to deliver. Clients in emergency departments can be mechanically restrained which would not occur in a disability setting, and people with disability who are imprisoned may be at risk in this environment because of their behaviour.
- 4.2.11. In the distant past, Strathmont would sometimes take on this emergency role. We are not advocating re-establishing Strathmont. We have seen the significant improvement for many clients who leave institutions and move into community housing.
- 4.2.12. Yet there needs to be readily available crisis accommodation for people who have difficult behaviour, but do not clinically require psychiatric admission, and by virtue of their disability should not be imprisoned but cared for. This accommodation should be staffed with adequate numbers of skilled disability staff. A centre with flexible capacity up to 8-10 beds might take on this short term function until new medium to longer term arrangements can be found for clients.
- 4.2.13. The NDIS will also need to have clear responses to such emergencies (see the section in this submission on the NDIS).

4.3 Silos in Government Structures:

Core Government funded and operated services are planned and funded in such a way, to separate the delivery of services into disparate streams related to disability services, mental health services and drug and alcohol services, which are delivered in this way not only by Government providers but also through NGO funding which is separated along the same line. A simple table of departments and funding streams illustrates this.

	Disability	Mental Health	Drug and Alcohol
Department	Department of Communities and Social Inclusion (DCSI)	SA Health	SA Health
Government Service Provider	Disability Services (Government provided services) http://bit.ly/DCSIDisServ	State Government Specialist Mental Services http://bit.ly/SAHealthMentalHealth	State Government Drug and Alcohol Services (DASSA) http://bit.ly/SAHealthDASSA
Peak body for Non-Government service providers	National Disability Services - South Australia http://www.nds.org.au/	Mental Health Coalition http://mhcsa.org.au/	South Australian Network of Drug and Alcohol Services http://www.sandas.org.a u

- 4.4 Government and non-Government service provision becomes “siloed” in its funding and operation. In many situations the same non-Government organisation can be funded by different Government departments or programs for different services to one of the three sectors, each funded service having distinct aims aligned with its funding source, and separate reporting requirements. While the leaders of these systems endeavour to work across boundaries, a high demand for services and unmet needs reinforce eligibility criteria.
- 4.5 Over many years there have been multiple initiatives across Government that have sought to improve systems to work across these silos. Examples include homelessness initiatives such as the Street to Home team model, pioneered in Australia in this State, and now copied elsewhere, that provides a team that has skills in responding to mental illness, drug and alcohol use, and meeting housing needs.
- 4.6 In South Australia Mental Health and Drug and Alcohol Services are under one directorate in SA Health, and mental health wards, and drug and alcohol residential treatment services are now co-located on the Glenside Campus, which should assist with collaboration.
- 4.7 Another example of an across Government initiative is the establishment of the State Government’s Management Assessment Panel which then became a part of the Exceptional Needs Unit. This program, jointly funded by SA Health and DCSI, with representatives from different Government departments sitting on its executive committee, provides case specific guidance from expert panels, and if required, can fund financial packages to deliver support and services to people with exceptional needs, many of whom in our experience have one or more co-morbidities.
- 4.8 Commonwealth Government programs also seek to address these gaps. For example the newly established Partners in Recovery program wishes to encourage collaboration, coordination and integration in the delivery of services to people with mental illness who have complex needs. This group is likely to have drug and alcohol and possibly disability co-morbidities.
- 4.9 While these Commonwealth initiatives are welcome, the provision of similar services funded by two levels of Government for the one South Australian community has resulted in gaps and duplication, and potentially greater complexity. Because demand for services is so much greater than supply, the duplication of planning and service provision has not been a major problem to date, but in the future a single population based plan will be needed to ensure that there is a rational and consistent commissioning of mental health services to meet need and the doubling up in planning and design by two levels of Government stops.

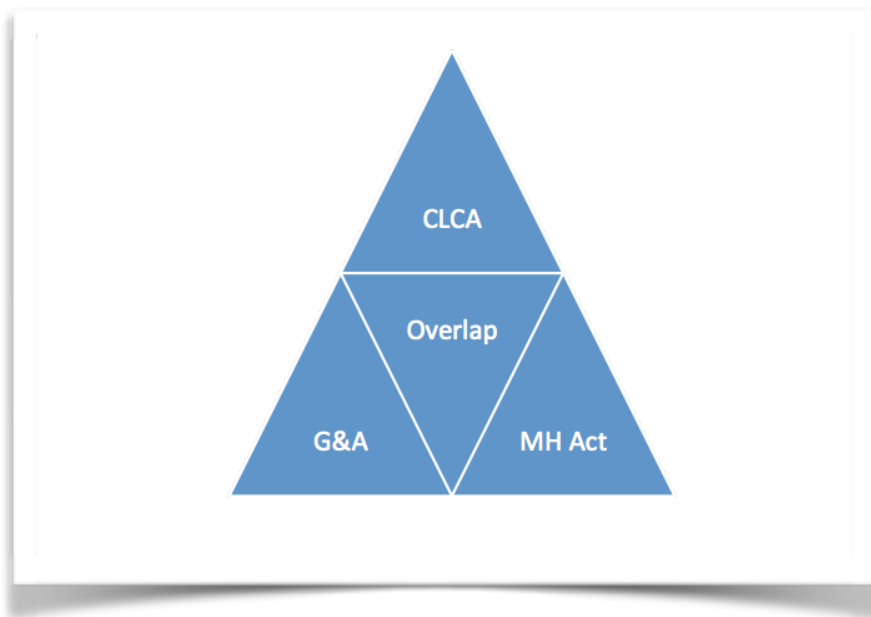
- 4.10 There is no reason why such population planning cannot occur across the disability, mental health and drug and alcohol sectors, with a recognition of the needs of people with co-morbidity. The numbers of people in each group can be estimated from the evidence of co-morbidity accumulated in the research literature, and from this the requirement to have a certain level of staffing in each sector can be predicted that can assess and respond to co-morbidity which can be planned for.
- 4.11 The current emphasis on coordination and navigation however highlights a significant flaw in service design. Ideally services should be simple to access and be so focussed on client needs that it is not necessary to have a secondary industry of coordinators and facilitators to link people to the correct service in a confusing system.
- 4.12 The strategies to address co-morbidity can be grouped as (1) strategies within a specialised service to provide first line responses to co-morbid conditions, (2) strategies for specialised services to work together to allow cross referral, (3) the development of integrated teams crossing service boundaries and (4) joint funding of supported accommodation.
- 4.13 *Within service strategies:* Each service needs to train and support staff to manage problems related to co-morbid conditions, at least at a primary care level. For example mental health staff should be able to undertake a drug and alcohol assessment and deliver a first line drug and alcohol intervention, for a person who has a mental illness and also has harmful drug and alcohol use. Applying a similar principle drug and alcohol service staff should tailor their programs to the needs of people with intellectual disability, autism, brain injury and mental illness. Disability staff should be expected to detect and respond to relapse of mental illness for clients with a co-morbid disorder as a first level of intervention even if further referral is needed. In this way straightforward needs can be met without multiple referrals.
- 4.14 *Across service strategies:* For people with higher needs, support from other services will be essential. Good relationships between providers formalised through memorandums of agreement, can help ensure that on first referral the most appropriate service will step up to take on a lead role for an individual, and that other services while not having primary responsibility, will still be available to support the lead service through access to advice, and if necessary specialist interventions. This requires a “no wrong door” approach to service provision, so that people are not turned away and told to go elsewhere, and that backup is available to the service that does accept primary responsibility from other specialist services.
- 4.15 *Integrated teams:* For population groups who have high levels of co-morbidity it makes sense for workers with different specialist expertise such as mental health, drug and alcohol and housing to work together in one functional team, even if professional links are maintained to outside specialist services. South Australian examples include the Street to Home team and the Exceptional Needs service. In the UK some council areas have Asperger’s teams that bring together the necessary disability and mental health skills to assist a person with Asperger’s Syndrome (eg Mersey Care, 2014.)
- 4.16 *Streamlined supported accommodation:* Successful tenancy in accommodation whatever its type (‘satellite accommodation’ spread throughout suburbs, ‘cluster accommodation’ delivered in groups of units or townhouses, or ‘group accommodation’ where people share a house) will always need adequate funding to deliver the required level of support. There can be disputes over eligibility and how funding will be provided, however it is possible for mental health and disability services to pool funding to provide a package that will sustain a person with high needs. For example a person who has a psychotic illness, and then subsequently developed a brain injury may require both mental health and disability services to contribute to a package of care. This occurs for Exceptional Needs clients by

virtue of the funding the program receives from two departments but may need to be organised on a one off basis for other clients.

- 4.17 While these strategies can be effective, policy level responses to develop dual diagnosis responses, has not led to a sufficient degree of change. For this reason later in this submission we suggest that there is benefit in a legislated response.

5. Use of legislation and co-morbidity

- 5.1. Silos and overlaps with respect to co-morbidity are reflected in the different laws that may be invoked in response to a person with a behavioural disturbance.



- 5.2. The diagram above illustrates the overlap between the *Mental Health Act 2009*, the GAA and *Criminal Law Consolidation Act 1935* (the CLCA). Proportions are not exact but illustrative. Multiple orders may be in place with compounding restrictions. Persons may also be subject to the provisions of the *Public Intoxication Act 1984*.
- 5.3. For example a person may be placed under a *Mental Health Act 2009* (MHA) order, when the criteria for an Inpatient Treatment Order or a Community Treatment Order are met. A person might also have a guardian or administrator appointed under the GAA (GAA). Should behaviour lead to the involvement of the criminal justice system, a person might be found guilty and sentenced, or if the person is found by the court to be unfit to plead or considered not guilty by reason of mental impairment, a limiting term might be set under the provisions of the *Criminal Law Consolidation Act 1935* Part 8A.
- 5.4. Other relevant legislation includes the *Disability Services Act 1993* which determines the funding and provision of disability services, and the *Supported Residential Facilities Act 1992* that provides for the care of people in certain facilities.
- 5.5. The use of each of these laws can be problematic for people with disability, and for people with disability who have a dual diagnosis.
- 5.6. *Criminal Law Consolidation Act 1935 Part 8A*
- 5.6.1. The *Criminal Law Consolidation Act 1935* consolidates Acts related to the criminal law, and includes Part 8 - Intoxication and Part 8A - Mental Impairment, the latter comprising s269. These provisions determine when a person may be found unfit to stand trial or not guilty by reason of mental impairment and the disposition of such persons.
- 5.6.2. The use of Part 8A provisions is currently being considered by the Sentencing Council of South Australia.

- 5.6.3. In this submission we wish to raise the application of the CLCA s269C, and s269V.
- 5.6.4. **s269C** sets the criteria to determine if a person is found to be incompetent of an offence. These criteria are as follows:

269C—Mental competence

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.

- 5.6.5. The Sentencing Council (2013) has asked if this definition should be amended to exclude personality disorder including psychopathy (Question 7 of their report).
- 5.6.6. The Office of the Public Advocate (2013) in its response to the Sentencing Council has opposed this proposition. The current criteria for the use of a mental impairment defence are based on the historical McNaghten rules, and do not depend on current trends in psychiatric diagnosis, and effectively already excludes people who only have a personality disorder, with no other condition, from using this defence without the law needing to specify the 'personality disorder' diagnosis.
- 5.6.7. Apart from our general concern about this proposal we also have a specific concern that the inclusion of such criteria could adversely affect people with a co-morbidity. These people might be eligible to use this defence by virtue of experiencing a mental illness, intellectual disability or brain injury, but if the person also has a co-morbid personality disorder this might lead to some doubt as to which condition caused offending behaviour.
- 5.6.8. It is our view that amendment is not necessary at this time.
- 5.6.9. **s269V** describes the custody, supervision and care of a person committed to detention under Part 8A.

269V—Custody, supervision and care

- (1) If a defendant is committed to detention under this Part, the defendant is in the custody of the Minister and the Minister may give directions for the custody, supervision and care of the defendant the Minister considers appropriate.

- 5.6.10. It is not our concern that a Minister has these powers, but South Australia has inadequate facilities to provide supervision and care for people who are in custody under these provisions whether the patient has a disability, mental illness or both.

- 5.6.11. At this time the Minister for Mental Health is the responsible Minister for all clients, whether the client has a primary mental illness or disability. We consider this Act should be amended so that the Minister for Disability could be responsible for clients who have primary disability.
- 5.6.12. This relates to Reference 1 of the current inquiry. South Australia does not have a standalone forensic disability service for people who have been found unfit to plead, or not guilty by reason of mental impairment, under the provisions of Part 8A of the CLCA. Forensic disability clients are either admitted to one of a limited number of forensic mental health beds, where they share wards with people who experience mental illness, or can be left in prison to wait for a mental health bed to become available because of the shortage of beds.
- 5.6.13. Notwithstanding current plans by SA Health to set aside 10 beds for disability clients in James Nash House, beds which we understand will be staffed by people with disability expertise but run by SA Health, it is our view that these beds should be separate and additional to the current forensic mental health bed number, and fall under the responsibility of the Disability Minister.
- 5.6.14. This would require amendment of the CLCA Part 8A, so that people with disability are placed under the custody, supervision and care of the Minister for Disability, and not placed in the custody, supervision and care of the Minister for Mental Health.
- 5.6.15. The operation of this Act with respect to forensic clients should mirror the best practice intended for the community with respect to co-morbidity. So for example, if a person with a disability has problem behaviours related to their disability and requires a “positive behaviour support program”, then this service should be provided in a Disability unit, under that Minister.
- 5.6.16. On the other hand if a person with a disability, also has a mental illness, and that person needs specialist mental health care, then this care should be provided on a mental health unit. A person who has recovered from an acute episode could be transferred from the custody and care of the Minister for Mental Health, back to the ongoing care and supervision in a facility under the custody and care of the Minister for Disability.
- 5.6.17. The operation of parallel Forensic Disability and Forensic Mental Health services would require close cooperation between the two services to make sure that the needs of people with a dual disability are met. We do not see the current situation in South Australia of using a mental health unit for disability purposes, as helpful to clients or staff.
- 5.6.18. These comments are focussed on people in custody, but similar principles apply to the care and supervision of forensic clients in the community on a limiting term.

5.7. *Mental Health Act 2009*

- 5.7.1. The *Mental Health Act 2009* makes provision for the treatment, care and rehabilitation of persons with serious mental illness.

- 5.7.2. The key criteria for making a Level 1 Inpatient Treatment Order (ITO) are as follows
- 5.7.3. Similar criteria apply to the making of a Level 1 Community Treatment Order (CTO).

21—Level 1 inpatient treatment orders

- (1) A medical practitioner or authorised health professional may make an order that a person receive treatment as an inpatient in a treatment centre (a ***level 1 inpatient treatment order***) if it appears to the medical practitioner or authorised health professional, after examining the person, that —
 - (a) the person has a mental illness; and
 - (b) because of the mental illness, the person requires treatment for the person's own protection from harm (including harm involved in the continuation or deterioration of the person's condition) or for the protection of others from harm; and
 - (c) there is no less restrictive means than an inpatient treatment order of ensuring appropriate treatment of the person's illness.

- 5.7.4. With respect to these criteria, *mental illness*, means any illness or disorder of the mind. This is a broad definition. It means that a person who has a co-morbidity, if at risk because of a co-morbid mental illness, can be subject to a CTO or an ITO.
- 5.7.5. Mental illness includes organic mental illness, such as delirium and dementia, and can include behaviour secondary to a brain injury. This broad definition of mental illness can ensure that people at risk can receive hospital care.
- 5.7.6. Schedule 1 of the *Mental Health Act* contains 13 statements that certain conduct does not constitute mental illness. One in particular refers to intellectual disability and another to alcohol and drug use.
 - 5.7.6.1. *A person does not have a mental illness if the person has a developmental disability of mind.* This provision ensures that people with intellectual disability are not inappropriately detained in hospital, or placed in a mental health ward which would be unsuitable for their needs. It does not preclude a person being subject to an order if the person has a co-morbid illness such as depression or psychosis.
 - 5.7.6.2. *A person does not have a mental illness if the person takes or has taken alcohol or any other drug.* There is further note that *nothing prevents the serious or permanent physiological, biochemical or psychological effects of drug taking from being regarded as an indication that a person is suffering from mental illness.* People who have developed a psychiatric condition secondary to substance use can be placed on an order.
- 5.7.7. The *Mental Health Act 2009* is currently subject to review by the Chief Psychiatrist. This review has suggested that mental capacity criteria be added to the Act. This would bring our legislation into line with current best practice. If

decision making mental capacity criteria were added to the existing criteria, a person could only be placed on an ITO or CTO if they had impaired decision making capacity to accept or refuse admission and inpatient treatment (covered by an ITO) or accept or refuse community treatment (covered by a CTO) in addition to meeting the existing criteria. Without a criteria requiring impaired decision making Mental Health legislation is discriminatory compared to Guardianship legislation, because Mental Health legislation in its current form, can allow involuntary treatment to be given even when a person has the decision making capacity to accept or refuse that treatment.

- 5.7.8. Our Office supports the addition of mental capacity criteria to the *Mental Health Act*. This will have general benefits for all people affected by the Act, but give greater consistency to how legislative provisions are applied to people who experience a disability and a mental illness, as both Guardianship legislation and Mental Health legislation will consider mental capacity.
- 5.7.9. The current exclusion of intellectual disability in Mental Health legislation is appropriate, but applying this exclusion requires considered diagnosis by practitioners to determine if at risk behaviour is related to intellectual disability (and therefore should not be subject to a *Mental Health Act* order) or to a mental illness. Otherwise there is a risk that a person with a disability might be placed on an order inappropriately, or alternatively that an order is not made when it should be. If a person has problem behaviours and is placed on an ITO because of an incorrect diagnosis of mental illness this is a problem. Such a person should be cared for by skilled disability staff using positive behaviour support and not managed in a psychiatric ward, or wait in a hospital emergency department.
- 5.7.10. Conversely if a mental health diagnosis is missed, a person may be erroneously discharged when an order should have been made and Mental Health care delivered.
- 5.7.11. Dr Maria Tomasic, a former National President of the Royal Australian and New Zealand College of Psychiatrists, has promoted further training in this area for psychiatrists and recognition of their skills and her Churchill Fellowship report is a significant resource describing service models in the UK (Tomasic, 2013).

5.8. Drug and alcohol legislation

- 5.8.1. Intoxication: The *Public Intoxication Act 1984* allows a person who is in a public place under the influence of a drug or alcohol, and unable to take proper care of himself to be apprehended by the police or an authorised officer. A person can be taken home, to a police station or a sobering up centre and then detained until the person has recovered to the point of being able to take care of him or herself, for up to 18 hours.
- 5.8.2. Our Office has not been in a position to assess the operation of this Act or the numbers of people with disability who may be subject to the Act's provisions. There is an overlap with the *Mental Health Act*, as many of the people apprehended may also have psychiatric symptoms. Other intoxicated people apprehended by this Act would have disabilities, in particular substance induced brain injury. People with intoxication are brought to emergency departments for medical or psychiatric review and may be held under the *Mental Health Act* if required to stay for psychiatric reasons and the requirements of that Act are met.
- 5.8.3. Involuntary treatment of dependence: South Australia does not have legislation to involuntarily treat substance dependence. NSW and Victoria have Acts to provide such treatment.

- 5.8.4. In NSW the *Drug and Alcohol Treatment Act 2007* has an object of providing involuntary treatment of persons with severe substance dependence with the aim of protecting their health and safety and permits the detention of people for up to 28 days in the first instance for the purpose of treatment. A person must be at risk of serious harm, be likely to benefit from treatment, and no other appropriate or less restrictive means are available to treat a person.
- 5.8.5. In Victoria the *Severe Substance Dependence Treatment Act 2010* permits the detention and compulsory treatment (up to 14 days) of people with severe alcohol and drug dependence to give the person the chance to withdraw from alcohol or drugs, recover their capacity and engage in voluntary treatment. The Act is intended for people who urgently require treatment to save their life or prevent serious damage to health, and are incapable of making a decision about their alcohol or drug use and personal health and welfare due primarily to their substance use (Department of Health (Victoria), 2014).
- 5.8.6. Our Office has not reviewed the effectiveness of this interstate legislation but at a conceptual level we can see significant benefits in having such a legislative option in South Australia. While we are concerned with any new legislation that may take away the rights of an individual, the loss of rights associated with a drug and alcohol treatment order is limited and targeted to providing a therapy for a person's substance misuse problem, and can be less restrictive than other options. Without specific legislation, orders from other Acts may be sought instead, such as guardianship orders, which can involve a greater loss of decision making rights for an individual for a longer period, or people may be placed under *Mental Health Act* orders to a mental health unit when an admission to a drug and alcohol service would be preferable. Although the making of guardianship orders for people who are substance dependent requires the presence of a mental incapacity (eg due to substance induced brain injury), and orders are generally not made to treat dependence alone, we still observe that the underlying reasons for seeking such order can be to control addiction related behaviours rather than assist with a brain injury. If a person is detained under 'special powers' in section 32 of the GAA, usually to disability housing and sometimes to stop them going to the pub, it is unlikely that they will receive the therapy provided in the NSW and Victorian schemes of detention to a therapeutic unit. Similarly some people detained to a mental health service may be better cared for in a drug and alcohol service.
- 5.8.7. It is our opinion that the implementation of the NSW and Victoria legislation should be carefully reviewed, and if evaluations of these programs suggests that they are as promising in practice as they have been in conception, then South Australia should legislate for a similar scheme.
- 5.8.8. Even if such laws are only used for a small number of individuals each year it is preferable to have rather than not have this option to use in life saving situations.
- 5.8.9. This is relevant to Reference 1 of the inquiry which refers to facilities. People with co-morbidity and life threatening substance use, may have limited insight into the need to cut down or cease their use. Such people could be admitted to a treatment facility if such an order existed. This care could possibly be provided at the Drug and Alcohol treatment services at Glenside Hospital.
- 5.8.10. If South Australia were to introduce such legislation it should have appropriate safeguards. In Victoria this includes visits by the Public Advocate to people placed on orders. In SA this could be through the Principal Community Visitor.

5.9. *Guardianship and Administration Act 1993*

- 5.9.1. The GAA exists to provide for the guardianship of persons unable to look after their own health safety or welfare or to manage their own affairs, and for the management of estates of such persons.
- 5.9.2. This Act defines mental capacity as a result of any damage to, or any illness, disorder, imperfect or delayed development, impairment or deterioration, of the brain or mind. This is a broad definition .
- 5.9.3. It is a strength of the Act that it assists people with incapacity from different causes , and people with dual diagnosis can be seen holistically.
- 5.9.4. Nevertheless the Act is dated. It is our view that definitions of impaired decision making capacity need to be modernised to correspond to definitions in the *Advance Care Directives Act 2013* and the recently amended *Consent to Medical Treatment and Palliative Care Act 1995*. This will better recognise people's autonomy and preserve rights.
- 5.9.5. Victoria's Law Reform Commission has reviewed that State's Act. In undertaking the review a few years ago, that Commission visited the South Australian Office of the Public Advocate to review our work in supported decision making. Following the Commission's report a new modern Guardianship and Administration Bill is now before the Victorian Parliament. This Bill proposes a new category of "supportive guardian" practicing supported decision making.
- 5.9.6. It is our view that South Australia needs to similarly open up this legislation for review. With respect to people with dual diagnosis, such a review would better uphold rights, but will not detract from the current strength of the Act which considers people as individuals in a holistic way, rather than placing people into silos.
- 5.9.7. It should be noted that guardianship cannot replace effective service provision. Sometimes applications for orders are made where the real incapacity is an incapacity of services to deliver necessary care, particularly supported accommodation, rather than an incapacity of the person subject of an order to make a decision about services. If the right options were available decisions could be made by the individual.
- 5.9.8. Similarly guardianship legislation cannot be the principle vehicle to reduce and eliminate restrictive practices. These are regulated under the GAA s32. Queensland and Victoria also have provisions in Disability Legislation to prevent the use of restrictive practices, and provide a check and balance for their use through a Senior Practitioner, who has a role established in legislation.
- 5.9.9. Our view is that South Australia should also include restrictive practices provisions in disability legislation and not rely on existing guardianship provisions. Ultimately responsibility for quality improvement in disability services, and preventing restriction must rest with Disability Services, and be a part of the legislation establishing Disability Services. Restrictive practices were reviewed in the 2010 OPA Annual Report (Office of the Public Advocate, 2010 pp 68-89). This is discussed further in section 5.10 of this submission.
- 5.9.10. It is also relevant to consider the interface between involuntary treatment under the GAA s32 provisions, with involuntary *Mental Health Act* inpatient care.
 - 5.9.10.1. With respect to facilities (inquiry reference 1), people with disability may have behaviour secondary to a mental illness managed in their

secure disability accommodation rather than hospital. In some instances this is unreasonable if a person requires hospital, while in other situations it enables a person to remain at their home with familiar staff which can be positive.

- 5.9.10.2. If a person with intellectual disability, autism or a brain injury has a relapse of a mental illness, that person should have access to a specialist mental health bed as would any other member of the public, and the mental health units should have skills in managing behavioural disturbance associated with dual diagnosis.
- 5.9.10.3. With respect to involuntary care, at times Disability Services will fund a disability care worker to assist nursing staff on the wards, and provide disability specific skills. This collaboration is positive.
- 5.9.10.4. We also see good practice when mental health staff provide follow-up and support to a person who has been discharged to secure disability accommodation and still needs psychiatric input.
- 5.9.10.5. However we consider that persons with disabilities should have greater access to both inpatient and community mental health services than is currently the case. With respect to involuntary care this would be under *Mental Health Act* provisions to mental health units rather than using the GAA provisions in disability accommodation.
- 5.9.11. Our anecdotal observation is that Mental Health Services can be wary of admitting clients who have a disability and have behavioural problems because of concerns that such patients may end up staying in the ward for longer than is clinically needed. This concern seems to be particularly evident if there has been a crisis with a behavioural episode leading to the eviction of a person from accommodation, new accommodation is yet to be found, and the person does not have an address to go home to.
- 5.9.12. In summary the GAA requires modernisation, and this will assist upholding the rights and delivering better outcomes to people with comorbidity. Some of the current issues with restrictive practices also requires reform of the *Disability Services Act 1993*, and other problems concerning the interface with the *Mental Health Act* in determining whether a person who has a relapse of mental illness and is at risk is detained in disability accommodation or detained in hospital, we would see as principally operational rather than legislative.

5.10. *Disability Services Act 1993*

- 5.10.1. This Act provides for the funding and provision of disability services. There were significant amendments in 2013 which included a new s3A referring to Safeguarding policies.
- 5.10.2. The notes to this section give as examples policies and procedures addressing management of care concerns, restrictive practices, supported decision making and consent, disclosure of abuse or neglect, and the reporting of critical incidents.
- 5.10.3. Based on these provisions we would expect that most services that provide care to people with a cognitive disability would have most if not all of these policies in place.

- 5.10.4. When these 2013 amendments were proposed, the Government made it clear that others could follow, and that the 2013 amendments were not intended to be comprehensive.
- 5.10.5. It is our view that further amendments to the legislation are required to better protect the rights of people subject to restrictive practices, and to seek to avoid such practices. A requirement in legislation for organisations to have a restrictive practices policy is a positive first step, however we suggest the legislation should contain specific restrictive practice provisions based on those in Victoria and Queensland disability legislation.
- 5.10.6. Such provisions would include definitions of restrictive practices, of requirements for authorising such practices, and establish the Senior Practitioner as a statutory appointment reporting directly to the Chief Executive of the relevant department (in our State the Department of Communities and Social Inclusion).
- 5.10.7. We appreciate that such measures may be time limited with the upcoming NDIS, but there are good reasons to act now. First these measures, if adopted by the State, would protect the rights of adults receiving State funded services for the next 3-4 years, possibly longer should the full implementation of the NDIS be delayed. This will benefit those people who receive this protection, or may prevent the unnecessary use of restrictive practices. Second, it gives the opportunity for the State to set best practice in this area, a standard to be maintained by the Commonwealth operated NDIS in the future.
- 5.10.8. This will benefit all clients with a disability who are subject to a restrictive practice, but in the context of the Committee's current inquiry into co-morbidity, it is particularly relevant to this group, who may be subject to restriction because of two diagnoses, restriction that is potentially avoidable with best practice.
- 5.10.9. In the next section we discuss the need for a new form of innovative State based disability legislation to take the place of the *Disability Services Act 1993* once the NDIS is fully operational, and the current State based Act is redundant and presumably repealed.

5.11. *Supported Residential Facilities Act 1992.*

- 5.11.1. This Act makes provisions in relation to the care of persons in certain residential facilities. Approximately 800 people live in Supported Residential Facilities (SRFs) half primarily experiencing a mental illness, and the remainder a primary diagnosis of disability.
- 5.11.2. Within these groups there is considerable overlap and co-morbidity, and any plans to reform the SRF sector should consider the needs of co-morbid groups. Such reform is developing from within the sector where proactive SRF operators are seeking to increase the skills and expertise offered by facilities, and by Government which we understand will review the SRF Act. There is a clear need to consider the needs of people living in SRFs who have co-morbidity.
- 5.11.3. The limitations of SRF accommodation were reviewed in this Office's 2010 Annual Report (Office of the Public Advocate, 2010 pp 44-69). Problems include a lack of privacy through the use of shared bedrooms, poor definitions in the Act of adequate heating and cooling, and dated buildings that do not support quality care. Recently the Department (DCSI) has been exploring ways to respond to concerns about the safety of women in SRFs.
- 5.11.4. SRF proprietors who accept residents who have been assessed as suitable for an SRF by DCSI's Single Entry Point, receive a supplement per resident. When

we last enquired the supplement rate was \$13.60 per day, which is in addition to the resident's own contribution of 79% of their pension.

- 5.11.5. New legislation should better reflect the care role of SRFs, and support more rehabilitation opportunities for clients.

6. National Disability Insurance Scheme

- 6.1. The advent of the National Disability Insurance Scheme (NDIS) offers hope that comorbidity due to disability and mental illness will be effectively tackled in a single scheme through the provision of one package of support spanning both areas.
- 6.2. The NDIS will provide services to people who have a permanent disability, and this includes people who have a disability that is of a chronic and episodic nature. People with chronic mental illness will be included in the scheme, so there will be one source of funding for all the needs of clients who have a disability and mental illness. This will assist the comorbidity group of people obtain funding for support services from a single source.
- 6.3. Yet at the same time the design of the scheme has led to concerns that people with complex needs with intellectual disability, autism or brain injury who may not seek out services voluntarily, may not approach the NDIS to seek services and will miss out. This group can need assertive engagement.
- 6.4. The scheme has been conceptualised as an insurance model. There is a concern that disadvantaged or socially excluded people will not make claims on this service unless assisted to do so.
- 6.5. Jim Simpson from the NSW Council of Intellectual Disabilities has prepared a guide to how the NDIS might operate for people with an intellectual disability who have contact with the criminal justice system (Simpson, 2014).
- 6.6. This guide notes the need for there to be skilled engagement of people who may have an intellectual disability, but who are reluctant to identify as having a disability or to seek out disability services. The NDIS may need to refer people to mainstream services, and provide very urgent crisis support even before a person's eligibility for the NDIS has been determined or a participant plan developed (Simpson, 2014).
- 6.7. Lawyers, advocates and workers in the justice system generally will need to be prepared to identify and refer people for NDIS support.
- 6.8. The NDIS will need to interface with a range of State Government services across health, housing, justice services, and education. There is a risk that if people who have behavioural disturbances due to disability are not engaged by the NDIS, State funded services will need to pick up their needs in hospitals and in prison by providing services that are inappropriate and should be avoided.
- 6.9. While the NDIS is a national scheme designed to take over the work of State Government disability providers, it is important to acknowledge that in other areas, State Government programs are providers of last resort and that State Government services often need to take initiatives to deal with complex services not readily delivered by Commonwealth funded programs. We see this in general health care where State Government operated public hospitals deliver many acute and complex services that privately funded operators receiving fee for service insurance payments through either Medicare or private insurers have not been able to deliver. We also see this in aged care where State Government services have initiated transition programs with Commonwealth funded partners to help move people from acute hospital beds into aged care.
- 6.10. An example from Health of the risk of low uptake of services by high needs populations in an insurance model is the low use of mainstream Medicare items by Aboriginal people with high health needs, who however use Aboriginal Health Services (Alford, 2014). There is always a risk in any insurance model that the people who should most be claiming an entitlement might fail to do so.

- 6.11. How will the NDIS respond to these situations? Clients with high needs should have the opportunity to experience the choice and personal control of services that is at the heart of the NDIS insurance model. However critical attention will need to be paid to the needs of people who may not claim their service and miss out. Funding may need to be cashed out for these groups to provide program responses, particularly to initially engage people with a disability who are homeless, facing the courts, or otherwise disempowered, and connect them to the NDIS.
- 6.12. South Australia will have an interest in ensuring that its considerable investment in the NDIS effectively assists clients with high needs who require active engagement. The national governance of the NDIS should allow robust stakeholder input from each of the Federal and State Government funders. State Governments will want to ensure that the NDIS meets its responsibilities to people with complex needs and dual diagnoses, who may otherwise be in hospital or prison.
- 6.13. The effectiveness of the NDIS response to co-morbidity should be carefully examined in evaluating the NDIS trials.
- 6.14. There could be an argument for some State NDIS money to be retained locally to operate exceptional needs responses for people with high needs who present to hospital, are homeless or are in the justice system.
- 6.15. There are similar considerations in the extension of the NDIS to forensic clients. It is the view of this Office that forensic clients should receive NDIS entitlements they would receive in the community, while they are under forensic supervision. The State should not be liable for disability support costs, which would have been paid for by the NDIS if the person had remained in the community. At the very least community funding levels paid by the NDIS should continue to be paid when the person is in forensic custody, but transferred to the forensic provider. If it costs more to fund care in custody than in the community then it is the view of this Office that while the extra funding associated with custody could be topped up by the State, NDIS funds should be available for ongoing care at least at the 'community' rate.
- 6.16. This parallels current Centrelink policies. A person will continue to receive their Disability Support Pension if they are a forensic patient in custody. In contrast a prisoner found guilty of a crime no longer receives these entitlements. It is the view of our Office that the same principle used by Centrelink should apply to NDIS entitlements for people in forensic custody - with the understanding that the allocated package is paid to the forensic provider.

7. The Future Role of Legislation in SA, after full NDIS roll out.

- 7.1. It is the view of our Office that new legislation should be considered to ensure that the needs of people with co-morbidity are addressed in mainstream services. In the past there have been policies and plans written at a Departmental or service level that have referred to co-morbidity, but these have not created sufficient change. Like the legislation underpinning the NDIS, any new legislation should have a broad definition of disability that includes psychosocial disability.
- 7.2. At the present time the *Disability Services Act 1993* exists to provide for the funding and the provision of services by the South Australian Government. This function will no longer be relevant under the NDIS when the State ceases to become a funder of services. For this reason new alternative legislation will be required.
- 7.3. It is our suggestion that a new Disability Act in State based legislation, should seek to uphold the rights of people with disability across the community, and specifically focus on what a person with disability can expect to receive from mainstream services. This is relevant to all people with disability as they access health care, mental health care, education, housing and justice services, but it is particularly important for people with dual diagnoses who will predictably need this help.
- 7.4. By having these protections in one Act, the rights of people with a dual diagnosis would be better addressed. The Act might also provide a legislative charter for the work of an Office of Disability for the State, after the NDIS is operating and the Office has a broader role, but one that does not include service funding. .
- 7.5. There are already requirements for State Government agencies to complete a Disability Access and Inclusion Plan. A proposal to establish a new Disability Act would give greater authority to this work already underway, and require more specific actions to be undertaken by agencies to ensure people with disabilities had full and equal access to a skilled service. This would specifically apply to people who have a disability and a co-morbid mental illness or drug and alcohol use disorder.
- 7.6. Our Office does not have a formed view of what State based disability legislation should contain post NDIS, however we see some precedents in legislation from overseas.
- 7.7. In particular one model would be for Parliament to enact legislation that requires the Government to issue guidance on how the needs of people with disabilities will be met by State Government services, and requires services to follow such guidance. Having this compulsory element overcomes a problem often encountered where Governments may have policies that are not followed. This strategy makes it a requirement.

- 7.8. **Statutory guidance model.** An example of statutory guidance can be seen in the UK Autism Act 2009. While this Act applies to one condition the approach could be applied more broadly across disabilities.

7.8.1. For example, the Autism Act has the following requirement.

2 Guidance by the Secretary of State

- (1) For the purpose of securing the implementation of the autism strategy, the Secretary of State must issue guidance –
- (a) to local authorities about the exercise of their social services functions within the meaning of the Local Authority Social Services Act 1970 (c. 42) (see section 1A of that Act), and
 - (b) to NHS bodies and NHS foundation trusts about the exercise of their functions concerned with the provision of relevant services.

7.8.2. The requirement of this is expanded upon as follows in the Act.

- (5) Guidance issued under this section must in particular include guidance about –
- (a) the provision of relevant services for the purpose of diagnosing autistic spectrum conditions in adults;
 - (b) the identification of adults with such conditions;
 - (c) the assessment of the needs of adults with such conditions for relevant services;
 - (d) planning in relation to the provision of relevant services to persons with autistic spectrum conditions as they move from being children to adults;
 - (e) other planning in relation to the provision of relevant services to adults with autistic spectrum conditions;
 - (f) the training of staff who provide relevant services to adults with such conditions;
 - (g) local arrangements for leadership in relation to the provision of relevant services to adults with such conditions.

- 7.8.3. An example of the statutory guidance related to training is listed below. General and specialist training is mandatory for health services (Department of Health (2010)).

- In addition to general autism awareness training for staff, local areas should develop or provide specialist training for those in key roles that have a direct impact on access to services for adults with autism – such as GPs¹² or community care assessors – and those whose career pathways focus on working with adults with autism, such as personal assistants, occupational therapists or residential care workers. The end goal of this specialist training is that, within each area, there are some staff who have clear expertise in autism.

- 7.8.4. This is an autism example, but the same approach can be applied to responding to the needs of people with disability more generally and could be used in a new Disability Act.
- 7.8.5. Such an approach would improve access to mainstream services for people with a co-morbidity.
- 7.8.6. The statutory guidance model could be applied in South Australia. An Act need not mention specific details with this model, but require 'statutory' or 'Parliamentary' guidelines to be developed and approved by either a Minister or the Governor.
- 7.8.7. As can be seen these provisions are more specific than the more general provisions in the *Equal Opportunity Act 1984*, or the *Disability Discrimination Act 1992*.

7.9. **Legislating best practice standards and linking this to funding.** In these examples a particular therapy or approach is cited in legislation or details expectations outlined by a legislature.

- 7.9.1. An Australian example of citing a professional intervention in law are the requirements in the Victorian *Disability Act 2006* for the development of a positive behaviour support plan prior to implementing a restrictive practice.
- 7.9.2. United States legislatures have been prepared to stipulate detailed requirements of service programs in law. A US State example is California Assembly Bill No. 334 of 2001 (California Assembly, 2001) which requires the State Department of Mental Health to legislate service standards and then gives specifics of what those standards should cover. Interestingly it requires standards for the provision of mental services to meet the needs of target population clients who are physically disabled, but does not have a similar requirement for intellectual disability. Nevertheless the principle of requiring the development of standards in particular areas is sound, could be applied to co-morbidity, and has similarities to the UK statutory guidance approach.
- 7.9.3. More recently Republican Congressman D Murphy has a Bill before the US Congress, Helping Families in Mental Health Crisis Act 2013 (US Congress, 2014). This is in part a funding Bill, requiring the the establishment of a Demonstration Program of Community Behavioural Health Services. This Bill

stipulates the skill of staff to be employed (including those with dual diagnosis skills) and the provision of evidence based treatments. It requires linkages and where possible formal agreements with other services.

- 7.10. In conclusion this Office sees benefit in the use of legislation to establish “statutory guidelines” as per the UK example, or legislation that require the development of standards. This approach could be used to respond to co-morbidity, but also be applied more generally to ensure that the rights of people with disability are fully upheld when seeking services from State Government operated or funded providers.

8. References

- Alford K (2014) Economic Value of Aboriginal Community Controlled Health Services, National Aboriginal Community Controlled Health Organisation, http://www.naccho.org.au/download/naccho_health_futures/Full%20Report%20-%20Economic%20Value%20%20Final%20Report.pdf#page=25&zoom=auto,-18,586
- Allen D and Davies D (2007) Challenging behaviour and psychiatric disorder in intellectual disability, *Current Opinion in Psychiatry*, 20:450-455.
- Arnould A, Rochat L, Azouvi P, Van der Linden M (2013) A Multidimensional Approach to Apathy after Traumatic Brain Injury, *Neuropsychological Review*, 23:210-233.
- Baldry E, Dowse L and Clarence M (2012) People with intellectual disability and other cognitive disability in the criminal justice system, Report for NSW Family and Community Services, Ageing, Disability and Home Care, NSW Government. Accessed from https://www.adhc.nsw.gov.au/_data/assets/file/0003/264054/Intellectual_and_cognitive_disability_in_criminal_justice_system.pdf
- Baldry E, Dowse L, McCausland R and Clarence M (2012b) Lifecourse institutional costs for homelessness for vulnerable groups, National Homelessness Research Agenda 2009-2013, Australian Government, Canberra. Accessed from <http://www.pwd.org.au/documents/pubs/adjc/Lifecourse-Institutional-Costs-of-Homelessness.pdf>
- Brayley J (2008) Preventing the Death of Homeless People, *Parity*, 2:41-42.
- California Legislative Information (2001) AB-334 Mental health funding: local grants, http://leginfo.ca.gov/faces/billNavClient.xhtml;jsessionid=3250dafb5361fe4313942246b5a7?bill_id=200120020AB334
- Department of Health (UK) (2010) Implementing "Fulfilling and rewarding lives" Statutory guidance for local authorities and NHS organizations to support implementation of the autism strategy, Department of Health, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216129/dh_122908.pdf
- Department of Health (Victoria) (2014) Severe Substance Dependence Treatment Act 2010, <http://www.health.vic.gov.au/ssdta/application/> 21 May 2014
- Hayes S, Shackell P, Mottram P and Lancaster R (2007) The prevalence of intellectual disability in a major UK prison, *British Journal of Learning Disabilities*, 35:162-167.
- Koponen S, Taiminen T, Portin R, Himanen L, Isoniemi H, Heinonen H, Hinkka S and Tenovuo O (2002) Axis I and II Psychiatric Disorders After Traumatic Brain Injury: A 30 year Follow-up Study, *American Journal of Psychiatry*, 159: 1315-1321.
- Kwok H and Cheung P (2007) Co-morbidity of psychiatric disorder and medical illness in people with intellectual disabilities, *Current Opinion in Psychiatry*, 20:443-449.
- Mersey Care NHS Trust (2014) Liverpool Asperger Team, undated publication, accessed from website 2014, http://www.merseycare.nhs.uk/Library/What_we_do/CBUs/Rebuild/Learning_Disabilities_Easy_Read/easyread_resources/liverpool_aspergers_team.pdf
- O'Connell J (2005) *Premature mortality in homeless populations: A review of the literature*, National Health Care for the Homeless Council, Nashville.
- Office of the Public Advocate (2010) Annual Report 2010, www.opa.sa.gov.au
- Office of the Public Advocate (2012) Annual Report 2012, www.opa.sa.gov.au
- Schofield P, Butler T, Hollis S, Smith N, Lee S and Kelso W (2006a) Traumatic brain injury among Australian prisoners: rates, recurrence and sequelae, *Brain Injury*, 20:499-506.
- Schofield P, Butler T, Hollis S, Smith N, Lee S and Kelso W (2006b) Neuropsychiatric correlates of traumatic brain injury (TBI) among Australian prison entrants, *Brain Injury*, 20:1409-1418.

Sentencing Council (2013) A Discussion Paper considering the operation of Part 8A of the Criminal Law Consolidation Act 1935 (SA),
<http://www.agd.sa.gov.au/sites/agd.sa.gov.au/files/documents/Initiatives%20Announcements%20and%20News/Discussion%20Paper%20-%20Part%208A%20Criminal%20Law%20Consolidation%20Act.pdf>

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

Tomasic M (2013) Service models for adults who have both an intellectual or developmental disability and mental disorder; including those within the forensic system, Winston Churchill Memorial Trust of Australia,
http://www.churchilltrust.com.au/media/fellows/FELLOWSHIP_REPORT_2013_Dr_M_Tomasic.pdf

US Congress (2014) H.R. 3717 Helping Families in Mental Health Crisis Act of 2013,
<https://beta.congress.gov/bill/113th-congress/house-bill/3717/text>

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

Vanucchi G, Masi G, Toni C, Dell'Osso L, Marazziti D and Perugi G (2014) Clinical features, developmental course, and psychiatric comorbidity of adult autism spectrum disorders, *CNS Spectrums*, 19:157-164.

Vannucchi G, Masi G, Toni C, Dell'Osso L, Erfurth A and Perugi G (2014b) Bipolar disorder in adults with Asperger's Syndrome: A systematic review, *Journal of Affective Disorders*, 168:151-160.