OFFICE OF THE PUBLIC ADVOCATE

ANNUAL REPORT 2004-05

30 September 2005

The Hon Michael Atkinson MP
Attorney-General
45 Pirie Street
ADELAIDE SA 5000

Dear Mr Attorney

I have the honour to present to you the eleventh Annual Report of the Public Advocate, as required by the provisions of Section 24 of the *Guardianship and Administration Act 1993*. This report covers the period from 1 July 2004 to 30 June 2005.

This period represents our first year under your portfolio.

Yours faithfully

John Harley
PUBLIC ADVOCATE

Contents

Public Advocate's report

Organisation developments

Since my appointment as Public Advocate in early 1999 I have sought to position the Office under the auspice of the Attorney General. The intent was to achieve a greater recognition of the justice principles underpinning my role and to separate from the structures which fund service provision to people with mental incapacity. I am therefore pleased to be reporting on our first year under the Attorney General's portfolio.

Another primary objective has been to achieve a physical separation from the Guardianship Board in order to emphasise the differing roles and functions of the two organisations and in particular our independence from the Board. Work on new facilities within the ABC building is near completion and the Office will relocate in August 2005. We will have our own public contact and training areas for the first time in the Office's history. I am grateful for the assistance from the Attorney General's Department and DAIS in bringing this to fruition.

Funding provided as part of the transfer between the then Departments of Human Services and Attorney General has enabled upgrading of information technology and preliminary work on a new client management database.

The manual for private guardians "Now you are a guardian" (which was funded by a grant from the Law Foundation) was launched in April at our tenth birthday celebration hosted by the Attorney General at Parliament House. The manual has been distributed to approximately 100 private guardians between January and June 2005 as well as to service providers and enduring guardians on request.

OPA completed its Supported Residential Facility (SRF) advocacy project in January. This coincided with a slowing down of SRF closures. I remain concerned about the vulnerability of people resident within this sector, half of whom have been identified as having mental illnesses. There is an ongoing need for individual and systemic advocacy focussed on appropriate housing and support programs. I am disturbed by the uncertainty which currently surrounds ongoing funding of initiatives implemented to support residents of this sector and hope that the government does not undermine the achievements made to date by withdrawing funds previously announced as being available for this work.

Core activities

The primary roles of my staff relate to the provision of information and advice to the public and guardianship, advocacy and investigative activities surrounding the wellbeing of people with mental incapacity.

Whilst the number of new guardianship appointments dropped slightly during this year, the end of year active guardianship caseload has increased to 264 (compared with 236 at the beginning of the year). Advocacy case numbers rose as did enquiry responsibilities thus continuing the upward trend in workloads which has been evident over the history of the Office.

Due to the current workloads of the Office, resources initially intended for education, policy and project work at the time of the establishment of the Office have been diverted to direct client service.

I have now instituted a system of waiting lists for allocation of work. This gives priority to clients perceived as being at highest risk but is clearly not satisfactory in terms of providing responsive guardianship, advocacy and investigative services.

I remain amazed by the capacity and commitment of my staff to respond positively to the multiple demands on their time and to continue to treat their customers with dignity and respect, often in the face of very difficult behaviours from some clients and/or their families.

The plight of detainees

It is unusual for me to be drawn into public comment on the circumstances of an individual under my guardianship. The case of the detention of an Australian citizen however has caused me to speak out publicly on their behalf. It has also enabled me to draw to the attention of the public the significant traumas faced by immigration detainees as a result of their treatment in Australia. I can only hope that our governments and all Australians have learnt from the unfortunate circumstances of this detainee and others and that we will become more vigilant in the way in which we respect the human rights of all people and cease to denigrate those who advocate on their behalf.

Where is mental health heading in SA?

Like many others, I find myself most despondent about the state of mental health care in South Australia. Below is my submission to the Senate Enquiry into Mental Health in May 2005. I believe that this echoes the sentiments of many who work in and use the services.

"1. Introduction

Thank you for the opportunity to make submissions to the Committee.

Time and lack of resources necessitate that I limit my comments to only a few areas covered in your comprehensive terms of reference.

This submission is primarily based on my impressions and those of my staff from our day-to-day work and feedback from the community. Unfortunately we have little opportunity to systematically collate information provided to us.

2. Background to the Office of the Public Advocate ('OPA')

My position and my office which is an independent statutory office have been in existence in South Australia for over 10 years. My functions are outlined in section 21 of the Guardianship and Administration Act 1993, my primary role being to promote and protect the rights and needs of people with mental incapacity and of their carers. This is achieved primarily through our roles as:

- *statutory guardian of last resort;*
- *individual and systemic advocates;*
- *investigators; and*
- *providers of education, information and advice on the legislation*

relevant to people with mental incapacity. (The Mental Health Act, Consent to Medical Treatment and Palliative Care Act and Guardianship and Administration Act).

33% of our guardianship clients (known as "protected persons") have primarily mental health issues with a further 40% having dementia as their primary diagnosis. The picture is similar for advocacy and investigation clients. It is estimated that a further 10 % would have mental health issues as their secondary presenting diagnoses. 14% of enquiries to OPA relate to clients with identifiable mental health issues, with a further 20% relating to people with dementia. (source: Office of the Public Advocate Annual Report 2003-04)

3. Submission Summary

Despite the Burdekin Report recommendations and the National Mental Health Strategies, it is our impression that, at least in South Australia, there has been a deterioration in service availability and access, particularly for those clients who have chronic and multiple mental health problems and who now reside in the community.

We still appear to be struggling with the practical application of collaborative models of clinical and support services and lack the range of programs necessary to meet the needs of people with chronic mental health problems. This is most evident in the lack of accommodation and support packages for those with moderate to high support needs.

Case management appears to have been almost entirely abandoned in favour of clinical management (often interpreted as and being merely medication management in the community). Where case management does exist, there is inconsistency across the mental health regions as to who receives services and the quality of them.

It is rare nowadays to find clients with comprehensive holistic management plans developed and coordinated by mental health workers. Whilst this may be in line with the reform agenda of mainstreaming non-clinical responses, by and large, the non clinical responses are not put in place (sometimes not even thought of) making relapse prevention mere rhetoric.

Some clients have non-clinical service coordinators who look at social, recreational and support needs. It is our experience that many of the people employed to provide the non-clinical responses lack the training and support to confidently undertake their roles with the most complex of clients. This is reflected in their comments about a sense of abandonment by clinical mental health systems.

It is our belief that state mental health systems do have a responsibility to provide ongoing holistic case coordination/management for clients with the most multiple and complex needs. In addition, these providers must be available to assist with responsive consultancy and direct intervention to backup non-mental health providers in playing their part in appropriate service responses. Whilst we acknowledge that resourcing of mental health remains a critical issue in delivering such services, the appropriate training of mental health personnel to work effectively, collaboratively and in a holistic way is critical.

My office tends to see the "more difficult situations" in mental health. None-the- less, I am disturbed by the amount of time and effort that this office is required to commit to ensuring that services talk to each other, coordinate their work and demonstrate proactive planning. This problem is not unique to the state's mental health system. However, the culture and morale of many mental health workers in South Australia reflects a siege mentality and a long history of operating within a silo.

South Australia is criticised at the national level for its lack of progress against the reform agenda. Our observations would support this. However, I express my sympathy for the leaders and staff in this state who I am sure currently feel under enormous pressure. Reform cannot be achieved without difficulty; it certainly cannot be achieved without financial and philosophical commitment by the government of the day. The building blocks for reform have been under funded, poorly cemented together and significantly affected by inconsistent leadership.

Workers are exhausted and have become cynical by lack of resources, constantly changing reform agendas to satisfy immediate political demands and a lack of commitment by and a failure of successive governments to match their rhetoric with financial support.

4. Deinstitutionalisation, Funding and the Impact of Contractual Processes

The SA Department of Health plan to further deinstitutionalise people with mental health disorders currently resident in Glenside Hospital which is our only residential/treatment facility devoted exclusively to adults with mental health disorders. While Hillcrest Hospital still maintains care for the aged with mental health disorders, the adult mental health residential treatment service closed in the 1990's.

This latest plan for deinstitutionalisation is both welcomed and bemoaned by many in the field.

The following factors are generally seen as contributing to the policy rationale for deinstitutionalisation :

- *concern to extend the legal and civil rights of people with mental illness*
- *the effectiveness of the newer pharmacological agents in controlling the more severe manifestations and behavioural disturbance of mental illness*
- *real and perceived abuses existing in the institutions, including custodial approach to treatment, social under stimulation and loss of independence*
- *a growing awareness of the values of personal autonomy and equality*
- *a community mental health philosophy that it is better to treat people in the community in which they live; and*
- *the increasing financial burden on a health system of maintaining large institutions.*
- *(Source: Mechanic and Aiken (1987))*

OPA believes that the concept of deinstitutionalisation should refer primarily to changing the way in which we engage and work with people. The downsizing of the bricks and mortar that we call "institutions" will not automatically lead to deinstitutionalised thinking. What will

be achieved (given the paucity of alternative community responses) is a lack of appropriate safe places or asylums in which people with mental illness, their families and the community can be afforded some safety and dignity at times of maximum disturbance.

The following factors particularly concern us in the South Australian situation:

- *The significant reduction in beds in psychiatric hospitals has not been accompanied by an increase in the numbers of beds in the community. This has led to inappropriate increased admissions of mental health clients to already overloaded emergency wards in acute hospitals.*

  The solution most often mooted is that funding for the community services be redirected from the psychiatric institutions or psychiatric wards in acute hospitals. However, this does not recognise the need for a successful transition phase. A well funded transition period, will increase the overall costs for a significant period of time. OPA endorses ongoing concerns about the lack of appropriate funding strategies in South Australia to enable sound community based alternatives to develop before stand alone inpatient focussed programs are reformed. Much is made of the disproportionate expenditure on inpatient facilities in this state in comparison with other states in Australia. We are also concerned that this discussion has not taken into account the increasing demand for services, including inpatient services, to which mental health is required to respond.

- *We believe that "hump" funding is necessary to prevent the creation of additional or new problems that, in the long term, will cost the state more financially. We already see this in the criminal justice system and public housing for example.*
- *At present there is a chronic lack of appropriately trained government and non-government workers and accommodation in the community.*
- *A side effect of deinstitutionalisation and mainstreaming appears to be a threat to funding stability. Psychiatric institutions have had a significant power base within the mental health system which has ensured the protection of funding to their facilities. We accept that such power bases intent on retaining funding do not necessarily lead to a "quality of service". With decentralised community services providing generic treatment in smaller accommodations within the community, the power base is likely to be lessened, and the funding is therefore more dependent on the goodwill of the government of the day and of the commitment of the regional host organisations. If mental health services do not feature highly, then small programs are likely to lose funding, particularly where it is linked to temporary contractual arrangements (eg non-government sector programs are particularly vulnerable to political whim).*
- *Service providers in the non-government organisation (NGO) sector are often contracted to work in the community for people with a mental illness on an "as needs" basis. Agreements between government agencies and the NGO's do not take into account the conditions of the workers in those*

agencies. They particularly do not consider well the tenure of workers, their wage structure, or their training needs in order to equip them for the job type. Recruitment and retention is difficult. Workers with insecure positions are unable to make long term plans and are therefore more likely to be less satisfied in their jobs and less in control of their own lives. This leads to a much less stable work force impacting negatively on the client group receiving their services. OPA has examples of NGO service providers, unable to retain staff due to the prevalence of casual and short term contracted work, which has clearly impacted negatively on some of our client group.

- *It appears to us that tendering for services in the community contributes to an ad hoc way of working with needy client groups, and involves a competitive environment that is at odds with the collaborative models that are touted as the successful way forward in the health and welfare fields.*
- *Contracts that run from month to month are common and again contribute to a lack of accountability of contracted service providers. If we are to provide successful community care for people with mental illnesses, tendering of service provision should not be the only process for contracting services. Agreements between government and NGO's should promote program continuity (staffing stability in particular), create collaborative working environments and ensure adequate continuous funding.*

5. Culture and Acceptance

<u>Community Culture:</u>

It would appear that education strategies and media focus have raised community sensitivity to mental health issues. However, in a community culture which is increasingly concerned about personal safety and conformity, this sensitivity centres around issues of the dangerousness of people with mental illness and ambivalence about the increasing expectation of communities embracing the mentally ill.

This culture is reflected in current government/community priorities of law and order, harsher penalties for offenders and so on. The current government mindset and response to a perceived community pressure for personal safety is well illustrated by the introduction of barbed wire adorning the external courtyard fences in the state's intensive care unit for mentally ill people.

Whilst the media have played a significant role in informing the public on mental health issues, it is unfortunate that some of their strategies serve to reinforce community fears. Public policy is also confusing. On the one hand, the state through its children's education system, promotes respect and concern for the wellbeing of disadvantaged people. In contrast, society appears to be promoting intolerance, for example, of refugees, of offenders, of the disabled of the unemployed and so on.

It seems to this office that community attitudes and expectations and the drivers for mental health reform are still significantly in conflict. In South Australia, the inability of the mental health system to reassure the public

that help is available to the mentally ill (and lack of funded community support alternatives) serves to reinforce the very fears which the reform process seeks to overcome.

Systems culture

I find the current culture surrounding mental health confusing:

- *Many non-mental health personnel still appear to be reluctant participants in service responses for the mentally ill and their families.*
- *The occupational health and safety issues and responses to protect staff seem to drive considerations of service responses (at times appropriately) which may serve to further traumatise and alienate already severely disturbed people (eg the use of security guards to guard detained patients in general hospitals).*
- *There are conflicting beliefs from site to site about the nature, scope and service responsibilities and ethos that mental health services should be providing.*

6. Human rights and the Mentally Ill

Whilst mental health reform has sought to enhance the human rights of the mentally ill, there are a number of problems which appear to have been exacerbated during the reform period.

Examples include:

- *physical restraint/shackling strategies used to manage an acutely mentally ill patient in a public hospital environment eg in emergency departments and as overflow patients in medical wards;*
- *detained patients waiting for days under guard in emergency departments waiting for access to an appropriate bed;*
- *acutely/chronically ill people remaining in their community whilst their behaviour significantly jeopardises their own wellbeing and their future relationships with landlords, neighbours and family members-we lack safe havens to preserve not only their safety but also their dignity and relationships; and*
- *increased disputes around public safety and public housing, identifying the mentally ill as a "problem" group which increases the stigma associated with it.*

7. Service Access and Focus

Narrowed focus of mental health to acute emergency and clinical services

There is and apparent narrowing focus of state mental health providers towards acute short term intervention for people with treatable psychiatric disorders. People with chronic mental health problems are the most vulnerable because of their inability to make their wishes known and to make their own day to day decisions. They, however, seem to be the most neglected and disadvantaged of all.

South Australia has not matched their reform process of the mental health system with sufficient complementary programs to support those with chronic mental illness and their carers.

OPA recently participated in an advocacy project pertaining to residents with mental disabilities of privately managed supported residential facilities under threat of closure. The lack of externally provided advocacy and support and clinical management for these

residents from mental health services was of concern.

Dual and multiple disabilities

People with dual and multiple disabilities still remain the subject of dispute between mental health and other service providers eg a problem may be defined as "behavioural" by mental health and "psychiatric" by disability providers. Complimentary and collaborative programs are rare and we find ourselves repeatedly involved in negotiating/advocating for such strategies around individuals.

People with "personality disorders" or "conduct disorders" appear to receive very patchy services and eligibility rules for provision of services seem to fluctuate often in accordance with the degree of difficulty that the client presents to the system. In the adult arena at least, one can form the view that those with the most challenging of behaviours are less likely to receive a service despite the fact that they are more likely to be rejected/ exported to the criminal justice system for management which essentially means containment. It would appear that we are getting more people with multiple and complex disabilities, particularly those with drug induced problems.

Service integration and collaboration

There are some excellent examples of good work where services have joined forces to deliver a program. However in the main programs still appear to operate in isolation.

In particular, the isolation of drug and alcohol services from mental health services continues to present a major problem given the numbers of psychiatric presentations that are based on drug or alcohol induced psychoses.

Whilst we recognise that services must be clustered according to some rationale, the move towards mainstreaming mental health has not substantially assisted in areas such as:

- *inter region mental health management of itinerant clients and acceptance of other regions' assessments for like programs;*
- *seamless transition from youth to adult to aged services;*
- *inter sectoral client management within family systems with a view to family preservation (eg collaboration between education, youth services, mental health and guardianship; and*
- *integration between diagnostically streamed services …*

9. Things That Are Working

The Office of the Public Advocate provides guardianship for adults across a broad range of sectors, and also divisions within services.

For example, OPA is guardian for approximately 12 individuals deemed to have "exceptional needs". Typically, these are people living with co-morbid illnesses who fall between eligibility criteria for services and have a level of need that no one service can meet alone.

South Australia is one of a small number of states that offers a holistic resource stream to clients deemed to live with exceptional needs. It provides a model of service delivery that is genuinely holistic, dedicating resources to the individual person, targeted to the key domains of their

lives. Commonly, this combines issues of housing, daily support, case management and therapy. The success of this program is that it is well resourced, allows resources to follow needs rather than diagnostic or multiple eligibility criteria and it's commitment to clients is strong. This stands in stark contrast to the more typical picture, where housing, health and welfare services are discrete entities that create a degree of inertia that can mitigate against positive outcomes for clients.

The Exceptional Needs Program offers a model of successful multi-sectoral intervention in mental health. The Office of the Public Advocate strongly recommends that further opportunities for multi-sectorial intervention be sought in mental health service delivery, particularly in terms of forging a direct link between housing and community supports.

We also commend the efforts of the South Australian Government for its Social Inclusion initiatives. A Thinker-in-Residence program has recently promoted debate on the issue of how services can follow client need as they move through accommodation and support programs as their needs change.

We are also seeing an increased recognition of mental health and related issues in the legal system through the establishment of court diversion programs. Here, mentally ill clients are being linked with service providers in an attempt to achieve optimal mental health. In addition there are a range of advocacy services that assist mentally ill people and their families with their legal rights.

Collaborative clinical and support programs do exist in some areas. For example Collaborative Action is a partnership between state mental health services, district nursing services and a non government direct care provider to managing older people with complex mental health issues.

10. Mental Health of Detainees

I have been heavily involved in trying to redress the injury and injustice experienced by individuals whose mental health has been severely affected by their life experiences and their detention firstly in Woomera Detention Centre and now in Baxter Detention Centre in South Australia.

A recent High Court decision highlights the negligence of the government with respect to the mental health care of 2 detainees who have been unable to access appropriate responses to ameliorate their distress. This is not an isolated problem.

OPA has adopted the role of guardian for a small number of detainees who have subsequently been released into the community. I have no right of access to detainees within Baxter and therefore cannot afford them any individual support or advocacy to have their needs mental health needs met.

It is well validated that refugees are likely to have mental health issues arising from situational trauma which cause them to flee their countries of origin. Extended periods of incarceration when there is no certainty about the future can only serve to exacerbate or create mental health problems potentially resulting in longer term or permanent disability.

We urge this Senate enquiry to advise the government to provide more humane responses to detainees,

particularly those exhibiting mental health problems. In the short term this should include improved access to local/state mental health programs and community based accommodation that sustains family and cultural ties.

11. Information and Privacy

Privacy, confidentiality and sharing information with carers and family members remains a confusing area. Some time ago, I participated in a mental health working party whose objective it was to produce a balanced set of guidelines on this issue. We are still awaiting the release of the documentation. In the meantime, carers still express frustration about the difficulties that they experience in engaging help, being kept in the communication loop and being expected to act as primary carer without due consideration of their needs in the discharge planning and case management processes.

12. Miscellaneous Issues

Recognition of state laws by commonwealth entities:
All states and territories have experienced difficulties with Centrelink accepting the authority of an administrator appointed under state law. Private administrators in particular have experienced unnecessary delays and flat refusal to accept their authority. Such action or inaction on the part of the Centrelink places mentally incapacitated persons, whose inability to manage their affairs has been determined through a legal process, at financial risk.

Cost of administration
In South Australia, the Public Trustee is the default administrator of the financial affairs of protected people. This organisation receives no government funding for undertaking this role and charges all but the poorest for its services. In so doing people with more than $2,000 to their name receive less income than any other citizen just because of their incapacity. (This is sometimes called a tax on lunacy).

Community Visitors Schemes
In all other states, residents of long term hospitals or institutions, disability housing and privately run supported accommodation are visited by volunteers or community visitors to establish their wellbeing and needs. South Australia has no such scheme to supplement and complement the work of mental health and disability workers.

Mental Incapacity and Justice Processes

People with mental illness or other forms of mental incapacity find themselves as parties to some form of legal process either as perpetrator, defendant, victim, witness or interested party. The Courts system has gone some way towards recognising alternative ways of dealing with defendants through diversion programs (Mental Impairment Diversion Program).

OPA and the state Public Trustee become involved in a small number of civil litigation non criminal matters where an individual lacks the competence to instruct legal counsel. This work is essential for the protection of the rights of those individuals and to enable the courts to respond appropriately to their circumstances. This work is poorly resourced at present and warrants expansion to assist in addressing human rights issues.

In some states of Australia programs have been established to ensure that mentally incapacitated people involved in police and court processes are supported by third parties to ensure their understanding of the process. South Australia has developed a proposal but this has not been funded.

<u>Rural and Remote issues</u>

South Australia is a large state but most of the population is centred around Adelaide.

- *Rural and remote areas lack the centres of population to develop the full range of mental health services.*
- *There are now no resident rurally based practising psychiatrists and no approved treatment centres for the purposes of treating detained patients within their local community.*
- *Country mental health providers still struggle with engaging primary health care practitioners in a commitment to mental health service.*
- *Recruitment and retention of workers in this area remains a problem."*

John Harley
PUBLIC ADVOCATE

Role, structure, legislation

Functions and objectives
The Public Advocate was established under the *Guardianship and Administration Act 1993*.

The key legislative functions are:

- to act as guardian of last resort when appointed by the Guardianship Board;
- to investigate matters where a person who has a mental incapacity is at risk of abuse, exploitation or neglect (including self neglect);
- to provide advice and information about the *Guardianship and Administration Act 1993,* the *Mental Health Act 1993* and the *Consent to Medical Treatment and Palliative Care Act 1995* in a variety of formats;
- to take an interest in the programs being offered to meet the needs of people with mental incapacity;
- to undertake systemic advocacy to identify and act on areas of unmet or inappropriately met needs of people with mental incapacity;
- to provide some individual advocacy services through our education, investigation and guardianship work, to speak for and negotiate on behalf of mentally incapacitated persons;
- to support and promote the interests of carers of people with mental incapacity;
- to make recommendations to the Minister for legislative and operational change.

Legislative authority
The Office of the Public Advocate (OPA) takes its legislative authority from the *Guardianship and Administration Act 1993* and the *Mental Health Act 1993*.

OPA is also bound to comply with legislation that relates to the management and accountability requirements of Government, including:

- *Equal Opportunity Act 1984*;
- *Occupational Health, Safety and Welfare Act 1986*;
- *Public Sector Management Act 1995*;
- *Sex Discrimination Act 1984;*
- *Workers Rehabilitation and Compensation Act 1986*.

Organisation of the agency
The Public Advocate is an independent statutory official accountable to the South Australian Parliament. The Public Advocate is not subject to the control or direction of the Minister.

Relationship to other agencies
The Office of the Public Advocate was funded by the Attorney General's Department 2004-2005.

The funded staff positions of the Office of the Public Advocate as at 30 June 2005 are reflected in the organisational chart in the Employment and Human Resources section.

Mission and values

Our clients
The Office of the Public Advocate has three main client groups:

- People with a mental incapacity;
- Family, carers and friends of people with a mental incapacity;
- Individuals and organisations with an interest in issues arising from mental incapacity.

Mental incapacity
The *Guardianship and Administration Act 1993* defines mental incapacity as:

"*..the inability of a person to look after his or her own health, safety or welfare or to manage his or her own affairs, as a result of –*

(a) any damage to, or any illness, disorder, imperfect or delayed development, impairment or deterioration, of the brain or mind; or

(b) any physical illness or condition that renders the person unable to communicate his or her intentions or wishes in any manner whatsoever."

Mission statement
To fulfil our statutory responsibility to promote and protect the rights and interests of people with a mental incapacity through the provision of adult guardianship, information, individual and systemic advocacy, and investigation services.

Legislative principles
In all aspects of its work with clients, the Office of the Public Advocate is bound and guided by the principles contained in Section 5 of the *Guardianship and Administration Act 1993*. This section states:

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

- *Consideration (and this will be the paramount consideration) must be given to what would, in the opinion of the decision maker, be the wishes of the person in the matter if he or she were not mentally incapacitated, but only so far as there is reasonably ascertainable evidence on which to base such an opinion.*

  This is often called the substituted judgment principle, which is in contrast to promoting decision making for people in their best interests.

- *The present wishes of the person should, unless it is not possible or reasonably practicable to do so, be sought in respect of the matter and consideration must be given to those wishes.*

  This principle ensures that the views of people with mental incapacity are taken into account in any decisions made about their lives.

- *Consideration must, in the case of the making or affirming of a guardianship or administration order, be given to the adequacy of existing informal arrangements for the care of the person or the management of his or her financial affairs and the desirability of not disturbing those arrangements.*

This principle allows and encourages families, friends and/or community networks to take responsibility for the health and welfare of people with mental incapacity without unnecessary government intervention.

- *The decision or order made must be the one that is the least restrictive of the person's rights and personal autonomy as is consistent with his or her proper care and protection."*

This principle ensures that, out of all the alternatives available, the one to be chosen is the one that places the fewest limits on the person's autonomy.

Vision

To enhance the quality of life whilst safeguarding the health and well being of those people in our community who are vulnerable to self neglect, abuse or exploitation because of their mental incapacity. We will achieve this by:

- Working to increase the quality of adult guardianship services across South Australia.
- Fostering strong partnerships with service providers and the community to enhance the lives and potential of OPA's clients.
- Identifying key areas of unmet, or inappropriately met needs of mentally incapacitated persons and taking action for improvement.

Values

The staff of the Office of the Public Advocate is committed to the following values:

- The people with whom we are involved deserve to be treated with courtesy, dignity and respect.
- We work in partnership with others, to achieve the best possible outcomes for our clients.
- We encourage and support creative, innovative thinking and ideas, including measured risk taking within an environment that values learning and dynamic problem solving.
- We will act with integrity and professionalism in all our dealings.
- We are accountable for our decisions and actions, and give particular attention to ethical and human rights principles, in accord with United Nations declarations and Australian Governments' standards.
- We see our role as a privilege, and recognise the importance of a skilled and cohesive team in making a meaningful contribution to the welfare of those vulnerable people with mental incapacity.

Some 2004-05 highlights

- Being part of the Attorney General's portfolio.

- Development of new premises for OPA.

- Funding provided by the Department of Families and Communities for a temporary senior position to advocate for residents affected by the closures of supported residential facilities (SRFs);

- Completion of a manual for private guardians called "Now you are a guardian" funded by the Law Foundation.

- Circulation of "Now you are a guardian" to 100 private guardians between January and June 2005.

- Celebration of the 10th birthday of the Office of the Public Advocate and the Guardianship Board in April 2005.

- Contributing to the improvement of the wellbeing of detainees through our advocacy and guardianship work.

- Managing 511 active cases during the year, including guardianships under the Guardianship and Administration Act, individual advocacy matters, investigations and court related guardianship.

- Providing education to 50 people, including 2314 in metropolitan and country South Australia.

- Responding to 5000 enquiries from members of the public and service providers.

- Conducting 176 screenings and minor investigations relating to matters before the Guardianship Board where the Public Advocate is the potential guardian.

- A new Staff Orientation Manual was developed and provides links with AGD orientation materials.

- There were on average 140 visits to the OPA website each day.

Detainees, human rights and the role of the Public Advocate

The Public Advocate is currently guardian appointed by the Guardianship Board of South Australia for 6 refugees, 5 who are residing in the community on temporary visas and one person recently granted a permanent visa now residing in the community. The Public Advocate is also guardian for a further five detainees, appointed by either the Supreme Court or the Magistrate's Court of South Australia, of whom three are residing in Glenside Hospital due to their severe mental illnesses. The Public Advocate's role is predominantly to make decisions about the refugees' accommodation and health care, to ensure they are not placed in environments that further exacerbate their mental illnesses and to ensure their health needs are being met appropriately.

In the early 1990's the then Australian Federal Government legislated for mandatory detention of asylum seekers reaching Australian shores without passing through the legally acceptable refugee process. Increasing numbers of asylum seekers predominantly from Afghanistan and Iran during the years 2000 and 2001 as well as others in lesser numbers from various other war torn, or, dictatorship led countries, led the current Federal Government to set up additional detention centres in Australia and on Nauru and Christmas Island. There are now eight detention centres across the country. In South Australia they built the Woomera Detention Centre in an extremely remote part of the state, followed by its replacement, Baxter Detention Centre near Port Augusta, many miles from Adelaide and conveniently distant from the scrutiny of independent and relevant bodies.

The Public Advocate along with lawyers and other advocates have, since the inception of the Woomera Detention Centre in SA been refused entry into these centres unless granted entry by the invitation of particular detainees. Detainees therefore need to have the capacity to seek such advocacy. Detainees who suffer with mental incapacity due to psychiatric illnesses developed whilst in detention, or due to existing psychiatric illnesses exacerbated by detention, are generally mentally incapable of inviting their lawyers or the Public Advocate to visit with them. Whilst more refugees have been released from Baxter since changes to the Department of Immigration and Multicultural and Indigenous Affairs (DIMEA) began earlier in 2005, a Catch 22 situation continues to exist with mentally incapacitated detainees needing the strongest advocacy for appropriate, humane mental health treatment denied the right to such advocacy, and whilst in detention denied the right to independent psychiatric assessment.

The Public Advocate made a submission to the Palmer Inquiry in May 2005 providing evidence encompassing information gathered from the files of four people who were, and in one instance continue to be, under the guardianship of the Public Advocate. Such guardianship orders only came about through the dogged persistence of asylum seeker support volunteers and mental health professionals within the South Australian public sector recognising the severe mental illnesses suffered by these people due to their experiences in detention. In each case OPA illustrated DIMEA's:

- disregard for the impact of detention and the processes of detention leading to these individuals suffering life threatening psychiatric conditions;

- lack of appropriate communication and, at times deliberate obstructionism, with relevant State agencies;

- prolonged disregard of the risks to these four people by keeping them in detention and in one case returning the individual to detention; and

- late action to consider the health of these people, action that only took place as a response to extreme measures taken by advocates to highlight each individual's plight.

OPA contended that the Minister and DIMEA, and their agents ACM and GSL, ignored the suffering of people with mental illness whilst in detention, only acting appropriately when there was enormous pressure brought to bear upon them by persistent advocacy. OPA suggested that the culture of disregard and deliberate obstructionism resulted in an Australian citizen being detained illegally in Baxter for many months without identification, without treatment and without consideration for that person's humanity. OPA's conclusion was that the process of detention is inappropriate and ignores many aspects of human rights according to various UN Charters, and OPA recommended the following:

- that DIMIA institute ongoing medical and psychiatric services for refugees independent of DIMIA and their agents;

- that DIMIA and its agents allow advocates and legal representatives to enter the detention centres to visit detainees without restricting such access (similar to the state prison system);

- that DIMIA and its agents respond appropriately, professionally and respectfully to the advice of state agency professionals, when they have been involved in assessing the mental health of detainees; and

- that the Minister for DIMIA detain refugees who have arrived on our shores illegally, for a very limited period of time ranging from 48 hours to three months, in order to determine whether or not their release into the community would breach national security. That following this process they are provided with community accommodation arrangements to await the outcome of their applications for permanent resident status. This would be in keeping with the systems in place in Canada and many countries in Europe.

Since the changes to DIMEA, which began taking place early in 2005 in the lead up to the Palmer Inquiry and the release of the Palmer Report in July 2005, many more detainees have been released into the community on various visas. Over 100 detainees however, continue to remain in Baxter Detention Centre and asylum seekers released on Bridging Visa class E are disallowed access to Centrelink payments, Medicare support or the right to seek work or study, and are often still wholly dependent on community groups and private individuals funding their living expenses. In recent times detainees released on these visas are considered for care

plans devised by approved and contracted local advocacy and support services. These care plans provide them with some monies to assist them with living expenses and in some instances payment for medication. However, some requests for care plans are denied and many granted are not instituted upon the detainee's release into the community placing further burden on private individuals and community groups to support them in the interim.

OPA remains committed to advocating for all people in South Australia suffering with mental incapacity including detainees. OPA applauds DIMEA for making long needed changes to the system imposed by mandatory detention and the treatment of asylum seekers. However, OPA feels that the changes have not yet gone far enough and continue to stand by the recommendations made in the OPA submission to the Palmer Inquiry as listed above.

OPA is also concerned about the long-term ramifications of detention on the mental health of many of those people now residing in the community on both temporary and permanent visas. This concern is two fold. First there is the concern that the detention process over the last six years will have resulted in permanent damage to many of those already suffering from trauma experienced in their countries of birth thus having a permanent impact on the landscape of Australian society. Secondly, that the financial cost to the state and the community to provide necessary ongoing mental health treatment is a burden that our state has little capacity to bear. It should be the ongoing responsibility of DIMIA to continue to provide for the community support services which are needed to ameliorate the damage done to the mental health of the detainees.

Key outcomes

The Office of the Public Advocate has four key service areas. During 2004-05, funding and reporting is according to these four key areas:

- **Advocacy**
- **Guardianship**
- **Investigation**
- **Community education**

The following pages detail the objectives, resources and outcomes in each of these areas. The **Enquiry Service** is reported on separately, but is integral to all of OPA's work in the above outcome areas.

Advocacy

Responding to requests for assistance and support for persons with a mental incapacity and their carers at both individual and systems levels.

Objectives

- To investigate community complaints or concerns that a person with a mental incapacity may be at risk of abuse, neglect or exploitation.
- To identify and promote the interests of people with a mental incapacity to government and in forums and enquiries concerned with the development and implementation of public policy.
- To speak for and negotiate on behalf of mentally incapacitated persons.
- To support and promote the interests of carers of people with a mental incapacity.
- To make recommendations to the Minister for legislative and operational change.

Resources

This year, whilst the Public Advocate personally undertook most systems advocacy work, all staff actively participated in identifying key issues of concern for people with mental incapacity. The Office is now recording and prioritising these key issues with a view to developing a more strategic approach to our advocacy work.

Outcomes

Individual advocacy cases

The office was involved in 77 individual client advocacy matters during 2004-05, 48 of which were new cases this year. This compares with a total of 62 active cases in 2003-04 and 53 in the 2002-03 period.

Examples of Advocacy:

- The Public Advocate has represented several mentally incapacitated individuals in court matters where there was no other mechanism available to assist the individuals and the Courts resolve the issues at hand
- Families of a number of mentally ill people have sought this office's assistance in linking their kin with help which did not appear to be forthcoming
- Several young women who have been temporarily unable to instruct solicitors have been assisted through the Youth Court processes with OPA advocating for the best possible access arrangements to enable contact between mother and child to continue where ever possible
- OPA supported a small group of young people displaced by an SRF closure and now living in substandard accommodation to arrange more appropriate accommodation and support programs.

Negotiations between the Public Advocate and the Senior Judge of the Youth Court led to a changed interpretation of the role of the Public Advocate in this jurisdiction. Our participation in Youth Court matters is now in an advocacy rather than guardianship ad litem capacity. This in part explains an increase in advocacy cases and a decrease in guardianship cases during this year.

The Guardianship Board has also encouraged the Office to take on a small number of advocacy matters either to support private guardians in their role or in an attempt to obviate the necessity of making an order.

Advocacy for those attending Guardianship Board hearings

OPA unfortunately has not been able to provide individual advocacy for those people with mental incapacity who appear before the Guardianship Board. Other advocacy services provide some assistance but the vast majority of people appear without support. It is hoped that, with the legislative review process currently in progress, provision will be made for greater access to representation at hearings.

Systemic Advocacy

Supported Residential Facilities

Again the SRF project resulted in a number of displaced residents receiving individual assistance prior to the project closure. OPA concluded, in its final report to the Department of Families and Communities, that there is a need for ongoing advocacy for residents of this sector. Further, it was recommended that a Community Visitors Scheme be established within South Australia and that its mandate

extend to visiting Supported Residential Facilities.

Staff members were active within the following external committees during 2004-05:

- Australian Guardianship and Administration Committee;
- Interagency working party comprising the Public Trustee, the Guardianship Board and OPA;
- Chair, Interdepartmental Committee on Monitoring in Prisons;
- Alliance for the Prevention of Elder Abuse;
- Department of Human Services Ethics and Privacy Committee;
- Intellectual Disability Services Council Ethics Committee;
- Intellectual Disability Services Council Legal Committee;
- Magistrates Court Diversionary Program Steering Committee;
- Advance Directives Review Steering Committee;
- Interdepartmental Coordinating Committee for Closures of SRFs;
- Steering Committee for Aldridge Court;
- Respecting Patient Choices steering group;
- Respecting Patient Choices Ethico-legal Committee;
- State Council, Australian Institute of Administrative Law;
- Member, Committee for the Review of Mental Health Legislation;
- Member, Calvary Hospital Ethics Committee;
- Chair, Human Rights Coalition;
- Deputy Member, Ministerial Advisory Committee on Supported Residential Facilities;
- Member, Street to Home Steering Committee;
- Member, Adelaide Aged Care Assessment Consent Committee;

and

- Member, Advocacy Services Forum.

Human Rights and Detainees

This year the Public Advocate and his staff committed significant time and energy to highlighting the plight of detainees. This work is featured earlier in the report. In addition to our guardianship role for 8 detainees, since the concerns about the care of refugees in detention centres became public, the Supreme Court and the Magistrate's Court have released a further 5 detainees into the care of the Public Advocate.

Deinstitutionalisation and Asylum Care

Individuals under guardianship often present with the most challenging behaviour. They may engage in risky behaviour, so as to gain re-entry to an institution. These same clients tell us that the reason why they do this is to escape the judgement of the community. To them, institutions frequently represent security, safety, structure and consistent behavioural management.

OPA believes that the experience of devolution in SA from the demise of Hillcrest indicate that these values do not get translated into community living.

We now face the proposed devolution of inpatient/resident facilities of Strathmont, Glenside and Julia Farr Services. OPA is concerned that this not occur without the creation of alternative safe places or asylums where those living with mental incapacity, their families and the community can be afforded some safety and dignity at times of maximum disturbance.

Services Coordination

People under guardianship succeed best where services that support them are closely coordinated, and offer an holistic response to their needs.

Conversely, the absence of a holistic response to need is directly connected to the failure of independent living for people under guardianship.

Some groups are particularly poorly served. For example, those people who experience homelessness, brain injury, alcohol related dementia and premature ageing generally fall between the gaps of service eligibility. Such people may well finish up not receiving support from any state funded service.

Frequently guardians find they have to encourage services to collaborate, so that they might deliver outcomes that are greater than the sum of the parts. For example, asking mental health services to participate in in-patient assessment for an individual suffering from both brain injury and mental illness.

Too often if an individual under guardianship succeeds in an accommodation and support option, they have to leave it. That support does not continue and the individual goes backwards.

Good Practice

SA is one of a small number of states that offers a holistic resource stream to clients deemed to live with exceptional needs. It provides a model of service delivery that is genuinely holistic, dedicating resources to the individual person, targeted to the key domains of their lives. Commonly, this combines issues of housing, daily support, case management and therapy.

The success of this sort of approach is that it is appropriately resourced and allows resources to follow needs rather that diagnostic or eligibility criteria.

This stands in start contrast to the more typical picture, where housing, health and welfare services are discrete entities, commonly referred to as service silos. As a result, service delivery becomes a reductive exercise.

The Co-location of Housing and Support Services

OPA also commends the efforts of the SA Government for its social inclusion initiatives. Roseanne Hegarty, a recent Thinker in Residence, challenged all of us to think of positive ways of supporting those in greatest need. Three themes resonate in particular:

- As an individual succeeds in their housing, it is the service that is withdrawn, rather than the client leaving the accommodation.
- A greater proportion of budget allocation needs to go into community rather than inpatient support.
- Current resource levels mitigate against innovative holistic intervention models.

Guardianship

The provision of guardianship services when appointment of a guardian is considered necessary, and there is no one else suitable or available to take on that role.

Objectives

- To provide a quality adult guardianship service across South Australia.
- To ensure that, wherever possible, substitute decisions made by a guardian preserve the personal autonomy of that person.
- To ensure that orders made by the Guardianship Board are the least restrictive of the protected person's welfare and are relevant and necessary to the development and maintenance of their health and safety.

What is guardianship?

A guardian is someone who has been appointed by the Guardianship Board (under Section 29 of the *Guardianship and Administration Act* 1993) to make decisions on behalf of some other person, who, because of a mental incapacity, is unable to do this for him or herself. The Public Advocate is appointed as guardian of last resort where no other suitable private guardian exists.

Guardianship is the authority that may be exercised and the protection that may be afforded by a guardian in relation to personal life decisions for the protected person. Personal life decisions are all matters, except financial affairs and legal affairs, which can affect a person's health, welfare or lifestyle.

Resources

OPA has converted its education and information positions to guardianship, advocacy and investigative activities in recognition of the steady increase in client workloads. The Public Advocate and Assistant Public Advocate also carried a guardianship caseload throughout the year.

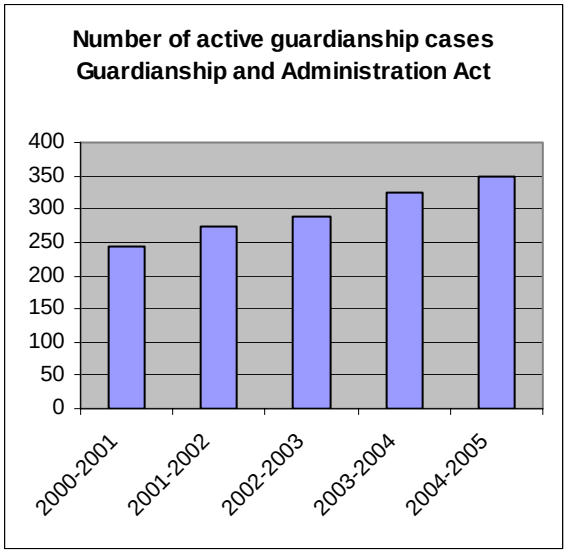
At the end of the financial year, there were 5 FTE PSO permanently funded positions primarily devoted to guardianship work.

Guardianship cases are divided into intensive/continuity cases managed by the senior guardians and monitoring (stable) cases managed by a monitoring worker. Approximately 0.6 FTE PSO1 time is now devoted to this latter client group and is used mainly for reviews required by the Guardianship Board. Numbers in monitoring fluctuate but have been as high as 80 cases and as low as 40.

Outcomes

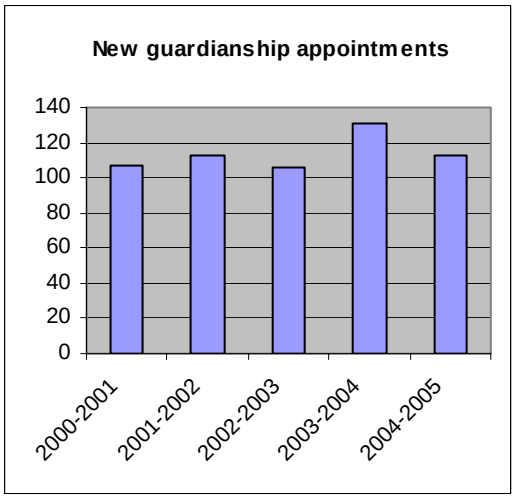
Guardian of last resort

During 2004-05, OPA provided guardianship services under the *Guardianship and Administration Act* on behalf of 349 people (324 in 03/04). The number of active cases managed by the office in each year has continued to rise, as can be seen on the following graph.



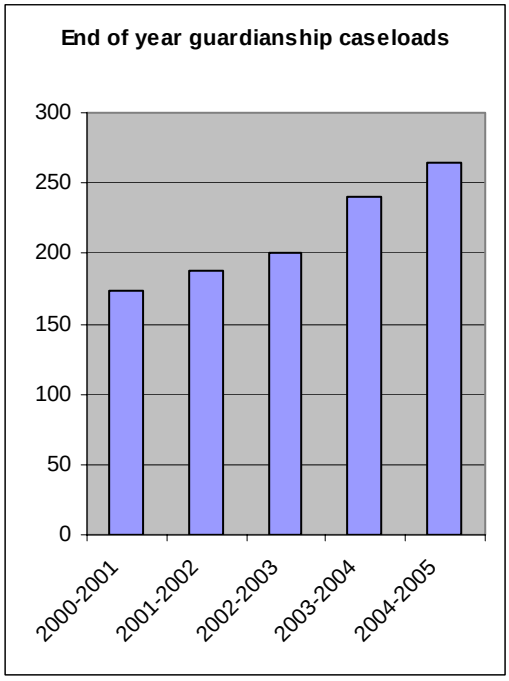
New guardianship appointments

This year there were 113 new guardianship appointments under the Guardianship and Administration Act, a decrease on last year's figures (131) for the first time in several years (see graph below).



End of year caseloads

Case closures again fell well below new appointments thus continuing the upward trend in end of year active caseloads. As at 30 June 2005, there were 264 active cases under guardianship (G&A Act).

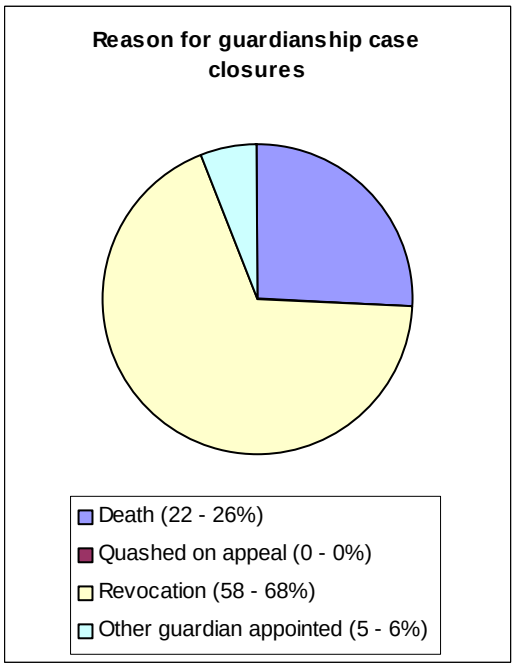


Disability profile of guardianships

Dementia (40%), mental illness (33%), intellectual impairment (22%) and brain damage (18%) remain the primary diagnostic groupings of the clients under guardianship. This is a similar profile to the previous two years. Many clients have more than one recognised disability.

Guardianship case closures

Eighty five cases were closed this year: 22 due to death, 58 due to revocation and 5 because other guardians were appointed. This is illustrated in the chart adjacent.



Guardianship and Court Matters

OPA has continued to provide a service in cases where people are involved in legal proceedings during a period where they are suffering a mental incapacity. This is consistent with the mandate of OPA to promote and protect the rights and interests of people with a mental incapacity. If a person with a mental incapacity is unable to instruct a solicitor, the Public Advocate can be appointed by the court in order to provide instructions to a solicitor. This enables the person with the mental incapacity meaningful participation in the proceedings.

In Youth Court matters, due to a reinterpretation of our role this year, OPA will accept only an advocacy role on behalf of an adult who is unable to instruct due to mental incapacity. This change in policy and practice affects interpretation of trends in court activities undertaken by OPA.

During 2004-05 OPA was involved in 10 matters where courts requested assistance. (Some of these may have been Youth Court matters carried over from the previous year.) Four of the 10 were opened this year.

Issues Faced in Guardianship

Again guardians were faced with a range of challenging issues.

Several elderly people who opposed placements agreed prior to or in the early stages of guardianship orders, have been assisted to return to independent living.

A small number of 18 year olds have been referred by Child Youth and Family Services for the appointment of adult guardians due to mental incapacity and complex needs. Again the transition between child and adult services has proved difficult, particularly for those with long histories of abandonment.

OPA has also worked with a number of clients who have mild intellectual disabilities and social dysfunction linked with family environments. Some have responded well to the support and structure of guardianship which has enabled them to "break free" of controls that have not allowed appropriate social development. The importance of family and informal networks, even though these ties may be painful, comes forward in many client circumstances, including for those young people who have been removed from their parents' care some years before coming under adult guardianship.

Whilst guardianship is essentially about substitute decision making, guardians frequently find themselves in the role of intermediary, trying to preserve and enhance relationships between service providers and individual family members. This also occurs in joint guardianship appointments where private guardians share decision making responsibilities with OPA and require significant assistance in negotiating conflict and systems issues affecting the protected person.

OPA works with a number of clients with high and complex needs in collaboration with the Exceptional Needs Unit. It has been rewarding to see several of these clients progress to the point of not requiring the status of "exceptional needs". One young man whose forensic status resulted in him being assessed as a high risk to the public has shown his capacity to live independently with lowering levels of support and increasing insight into his own circumstances.

Increasing workloads have led to the introduction of a waiting list for allocation of clients. Each case is now considered on its merits and a priority rating assigned. All staff are now operating at well over the recommended benchmark of 35 intensive/ continuity cases per full time equivalent and 75 monitoring cases per FTE.

Investigation

To investigate the circumstances of people referred to the Office of the Public Advocate by other services, the Guardianship Board and by members of the public and to initiate action as appropriate.

Objectives

- To investigate and identify the circumstances and needs of people with a mental incapacity who are the subject of an application to the Guardianship Board and to ensure that their interests are represented at hearings before the Board.
- To ensure that the appointment of a guardian or administrator is made only when there is no alternative solution to the presenting problem.
- To investigate matters where a person with a mental incapacity is at risk of abuse, exploitation or neglect (including self neglect).

Resources

Whilst OPA has maintained the objective of having one staff member specialise in investigation work, this is not always possible because of staff movements and fluctuating workloads. For the majority of the year, approximately 0.6FTE of staff time was committed to investigation work, the majority of which was used in investigations requested by the Guardianship Board. Screening of new applications which nominate OPA as potential guardian accounts for approximately 0.3FTE staff time. The screening role was shared amongst staff.

Outcomes

A total of 233 investigations were opened in the 2004-05 financial year. There is a wide variation in the amount of time involved in conducting an investigation. Some are very complex matters, involving days of work, whilst others are relatively straightforward. In 2004-05, 57 of the 233 investigations (approximately 25%) warranted individual client files being opened. A further 22 were carried forward from the previous year.

A small number of clients are double counted as investigation of a simple matter sometimes leads to more complex work and transfers to client file status. (For example 21 screenings led to the opening of a client file).

The following are the types of investigations undertaken by OPA:

Pre-hearing screenings and investigations

There were 176 undertaken prior to a Guardianship Board hearing.

Wherever practical, a representative of OPA attends Board hearings to make comment on the applications which nominate a role for this Office. OPA is now seldom appointed without this service having an opportunity to comment on the appropriateness of our involvement.

Section 28 investigations.

There were 30 new investigations requested under Section 28 during this financial year.
The Guardianship Board requests these investigations under this section of the *Guardianship and Administration Act 1993*. A comprehensive report is prepared at the direction of the Guardianship Board to assist them in their decision making. Board requests were less this year (30 compared with 32 in 03-04).

Section 21 investigations

There were 2 significant client investigations commenced under Section 21.
These are investigations that are undertaken as a result of an external request to OPA. They can include matters that relate to the *Guardianship and Administration Act 1993* or the *Mental Health Act 1993,* but clients are not necessarily the subject of an application to the Guardianship Board.

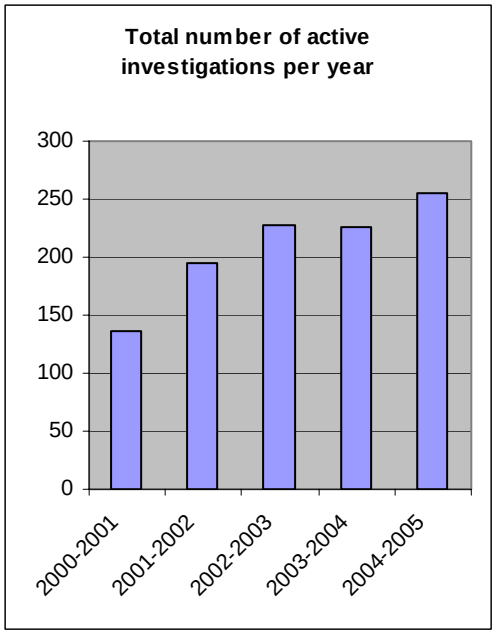
Sterilisation investigations

There was one new sterilisation investigations commenced this year.

Other investigations

There were three other matters dealt with this year.

The graph on the next page compares the number of investigations open in each of the past 5 years.



Issues in Investigation

OPA has no legislated powers of investigation under the Guardianship and Administration Act and is therefore reliant on the skills of workers to engage parties in a collaborative manner. In general, most parties are willing to cooperate with OPA during this process. However, several matters were referred back to the Guardianship Board because of difficulties in proceeding due to problems with cooperation of interested parties.

During this year the Board requested assistance in:

- determining the suitability of family members as guardians;
- advising on family conflict and its impact on potential protected people;
- locating client and private administrator where the Board had not received information for several years;
- arranging assessments to provide additional jurisdictional information;
- investigating the financial circumstances and financial management of attorneys operating Enduring Powers of Attorney and where allegations of mismanagement have been made;
- determining the best ways to assist a person who was the subject of domestic violence;
- mediating or advocating for a potential protected person in attempt to resolve matters without the Board making orders.

Community education

Empowering individuals, service providers and the community through the promotion of advance directives and the principles and practicalities of the legislation.

Objectives

- To facilitate and conduct education sessions and forums in both metropolitan and country locations on a diverse range of issues relating to mental incapacity and the law.
- To provide written responses to external agencies and individuals, where requests for OPA's input on issues relating to mental incapacity are made.
- To actively participate in interagency forums and committees where the terms of reference meet OPA's strategic directions.
- To provide regular updated online information on OPA as well as written resources.
- To make selected pamphlets available in other languages.

Resources

Responsibilities for education and information activities have again been shared across staff this year. The 1.5FTE originally committed to these activities when OPA was established are now permanently committed to client activities. The agency was again largely reliant on the Public Advocate for delivering education sessions.

Despite the resourcing difficulties, OPA maintains a commitment to responding to education requests where possible.

Outcomes

Manual for Private Guardians

A Law Foundation Grant for the development of a private guardians' manual was obtained in the previous financial year. The manual titled "Now you are a Guardian" was developed by staff member, Suzanne Bull. It was published in late 2004 and launched by the Attorney General in April 2005 at the OPA/Guardianship Board tenth anniversary celebration at Parliament House. The Manual is provided to all new private guardians free of charge with approximately 100 being distributed from January to June 2005. The manual can also be purchased through all Services SA outlets (phone 13 23 24) and personally at OPA office.

Education sessions

OPA has continued to respond to requests from organisations and individuals and participates in a range of activities. OPA was unable to respond to 23 of 73 education requests due to short notice, lack of resources at the time requested, recent activities in the same area, or inappropriateness of the request. Where possible, alternative speakers were suggested or written material provided. Several were advised to resubmit their requests at a later date and positive responses were given at that time.

In total, 2314 individuals received advice and information through 50 education sessions conducted by OPA during 2004-05. The number of sessions provided has decreased in comparison with the previous two financial years but the number of participants was similar to 2003-04 .

OPA uses three main audience categories for classification of its education sessions, but acknowledges that this only provides a guide as to the primary audience, as many sessions are given to mixed groups of carers, consumers and service providers.

Metropolitan service providers

A total of 1373 service providers attended 32 education sessions provided in the metropolitan area. 10 requests were rejected.

Comparative data for education sessions to metropolitan service providers

Year	Sessions	Audience
1997-98	44	828
1998-99	52	1552
1999-2000	33	1440
2000-01	42	613
2001-02	36	741
2002-03	28	1116
2003-04	33	1257
2004-05	32	1373

Metropolitan carers and consumers

These talks focus on the promotion of advance directives and general guardianship and administration issues.

This year, 14 education sessions were given to carers and consumers, reaching 846 participants. OPA rejected 11 requests to speak to consumers and carers during this reporting period but numbers reached increased.

Comparative data for education sessions to metropolitan carers and consumers

Year	Sessions	Audience
1997-98	39	934
1998-99	14	615
1999-2000	10	337
2000-01	19	596
2001-02	9	295
2002-03	23	973
2003-04	13	457
2004-05	11	846

Country talks

In 2004-05, OPA gave only 2 talks in country areas, reaching a total of 45 people. This represents the lowest commitment to country participants in recent years. Only 1 request was rejected.

Comparative data for education sessions given in country areas

Year	Sessions	Audience
1997-98	14	246
1998-99	5	173
1999-00	3	75
2000-01	14	372
2001-02	6	263
2002-03	9	450
2003-04	15	607
2004-05	2	45

Future Directions in Education

Proactive education planning.

OPA's proposal to undertake a strategic planning exercise with other key stakeholders with a view to some rationalisation of effort and priority setting did not occur during this reporting period. It remains an objective of OPA to reinvigorate a proactive approach to education.

Website

OPA continues to develop the role of its website in the provision of information and education for members of the public. The site receives approximately 140 visits per day and about half of those visitors download information. Anecdotal feedback indicates its value to students, service providers and members of the public.

Work is well advanced on a new website which will allow search by subject matter, provision of customer feedback, housing of a broader range of materials and linkages and self tutorials particularly for service providers. OPA is committed to establishing a regular training program which will be advertised via the website.

Workshops and seminars

OPA's new office accommodation will include a small training room. This will allow on site workshops for up to 30 people. In addition, upgrading of Guardianship Board video conferencing facilities will allow both organisations to enhance communication with off site locations in metropolitan and country areas.

2003-04 Annual Report

During the 2004-05 period, the 2003-04 Annual Report was produced and made available on the website.

Education activities

Education activities have been varied this year, including:

- submission to Rau Enquiry;
- submission to Senate Standing Committee on Mental Health;
- submission to the review of the Mental Health Act 1993;
- submission to the Attorney General's review of the Power of Attorney and Agency Act.

End of life decision making: improving our approach

The Public Advocate and his staff are frequently involved in advising others on the legislation as it relates to people and the final stages of life. For most families, this is a time of great stress and for some, a time of heightened conflict.

When service providers find themselves in the midst of family conflict, it may be easier to avoid being involved and it may feel time consuming. However, time spent in focussing distressed parties' thoughts on what their loved one might have wanted can result in effective problem solving. The end result can be most rewarding for all involved.

End of life decision making is helped when families have given attention to how each other would like to be treated should this situation arise. The use of advanced directives is in its embryonic stage but should be encouraged where people have definite ideas about their own life and death.

The national "Respecting Patient Choices" project is encouraging providers of health and disability services to learn about and develop skills in engaging customers in their own health care decision making. It is also encouraging improved documentation of choices made by patients about their future health care.

The Public Advocate has participated in several projects aimed towards improving the practices of health and disability facilities. OPA will also be examining its own client documentation processes to improve its decision making for clients under guardianship.

Enquiry Service

To provide advice and information to service providers and the general community about the state guardianship and mental health legislation and related matters.

Objectives

- To inform the general public and service providers about advance directives, informal arrangements, and appropriate use of the *Guardianship and Administration Act 1993*, the *Mental Health Act 1993* and the *Consent to Medical Treatment and Palliative Care Act 1995*.
- To disseminate information on the role and functions of OPA.
- To promote the least restrictive alternatives in the resolution of issues relating to people with a mental incapacity.
- To promote awareness of how to prepare comprehensive and carefully considered applications for the Guardianship Board.
- To provide appropriate referrals to other agencies as required.

Resources

In 2004-05, OPA continued to provide an Enquiry Service during office hours with the objective of providing a 24 hour response time to calls, including provision for urgent responses. OPA allocated on average 1.0 FTE PSO1 and 2 resources sharing calls across a number of staff during the year. 0.6FTE PSO1 time was removed from the enquiry team during the year to devote to monitoring of stable guardianships. In order to meet the 24 hour return response, enquiries were regularly passed on to other staff to assist in meeting the demand. We continue to estimate that enquiries requires 1.5 FTE to meet current community expectations. OPA is contemplating giving priority to members of the public over service provider calls in the future in the belief that service providers can access resources on the OPA website to answer most of their basic enquiries.

In addition to the Enquiry Service, OPA also offers an emergency contact that is available 24 hours, seven days per week. A representative of OPA carries a pager to respond to urgent matters on behalf of OPA and the Guardianship Board. This is an emergency service only, and provides urgent information and advice about guardianship issues, urgent decisions in relation to people under guardianship, and the negotiation of emergency interim Board orders with the Guardianship Board President.

Outcomes

During the financial year, OPA received 4955 enquiry calls. The vast majority of contact with OPA occurs via the telephone, but 48 requests were received by email, 42 by letter, and there were 145 walk-in enquiries.

The enquiry activity has continued its upward trend with an 8% increase from 2003/04 and 62% increase on 1999/00 year activity.

OPA is now dealing with an average of 20 enquiry episodes per day, some of which require more than one contact.

Details on enquiries for the past 6 years are compared in the following table.

Comparison of total numbers of enquiry calls

Year	Total enquiries
1999-2000	3063
2000-01	3229
2001-02	3642
2002-03	3611
2003-04	4594
2004-05	4955

Enquiry Types

Some enquiries include more than one issue and up to 3 issues can be recorded by the Enquiry Officer.

The ‘other’ category was broken down this year to identify calls where connection between OPA and the enquirer did not eventuate despite attempts or the caller had resolved the matter without OPA assistance. We also sought to identify the number of calls which were primarily complaints or concerning risk management/duty of care issues. It can be seen that that 9% of enquiries did not have an advisory outcome but a record is kept of the time and the attempts to link with the enquirer.

Data regarding enquiry issues for the past four years is recorded on the next page.

Time spent on each enquiry is now systematically recorded. Average time spent on each episode varies from 6 minutes (no action/withdrawn) to 12 minutes (education/information) to 25 minutes (potential guardianship issues) to 27 minutes (complaints/risk management/duty of care).

Future directions of service

A feature of enquires is the use of the service by professional providers for case consultation and support. Whilst OPA recognises the difficulties faced by other organisations in working with clients who have a mental incapacity, this office is finding it increasingly difficult to adequately respond to these needs.

OPA is considering the development of regular training strategies including "train the trainer" options with a view to enhancing the knowledge of the jurisdiction and therefore the internal support available within key organisations. In addition, OPA website is being enhanced to allow subject searches and by providing self guided training materials.

Data management remains cumbersome and it is hoped that a new client management system will improve efficiency in enquiries management.

Comparison of number and enquiry types for past four years

Enquiry category	2001-2002	2002-2003	2003-2004	2004-2005
1. Potential Administration	1118	910	1038	1096
2. Potential Guardianship	755	688	920	806
3. Advance directives	554	540	739	894
4. Guardianship Board process /appeals	116	260	184	290
5. Information/ Education	210	302	548	943
6. Mental health	411	239	282	277
7. Consent to treatment	129	154	213	147
8. Other calls	860	978	1072	539
9. No action/ withdrawn				439
10. Complaint				46
11. Risk mgt/ Duty of Care				82

Consolidated Data 2004-2005

The following is a summary of the client related data provided in other sections of the Annual Report.

1. Comparison of 03-04 and 04-05 activity related to registered clients

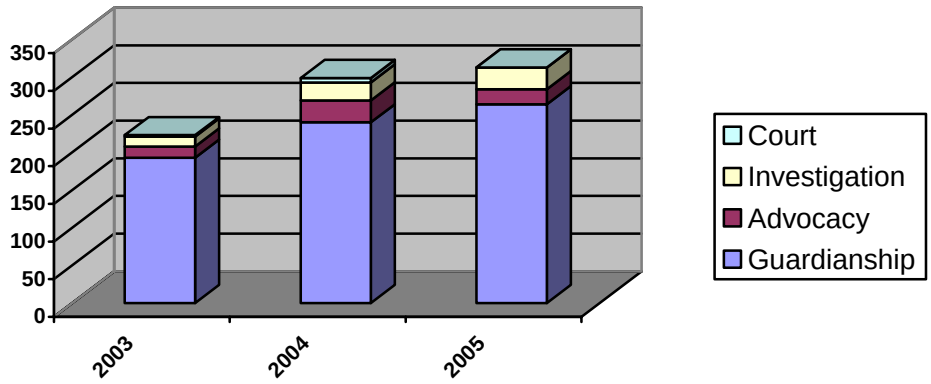
1.1 Summary of episodes of service by episode type

Episode type	Year	Open at begin-ing of year	Opened in year	Open at yr end	Closed in year	Revoc-ation	Death	Other guardian	Total Active
Guardianship	03/04	193	131	240	84	52	26	6	324
	04/05	**236**	**113**	**264**	**85**	**58**	**22**	**5**	**349**
Advocacy	03/04	15	47	29	33				62
	04/05	**29**	**48**	**20**	**57**				**77**
Investigation	03/04	13	69	24	58				82
	04/05	**22**	**53**	**29**	**46**				**75**
Court work	03/04	2	10	6	6				12
	04/05	**6**	**4**	**0**	**10**				**10**
Total Active Cases	03/04	223	257	299**	181				480
	04/05	**293****	**218**	**313**	**198**	**58**	**22**	**5**	**511**

** difference in figures relates to timing delays where closures are backdated to previous financial year after data analysis has occurred.

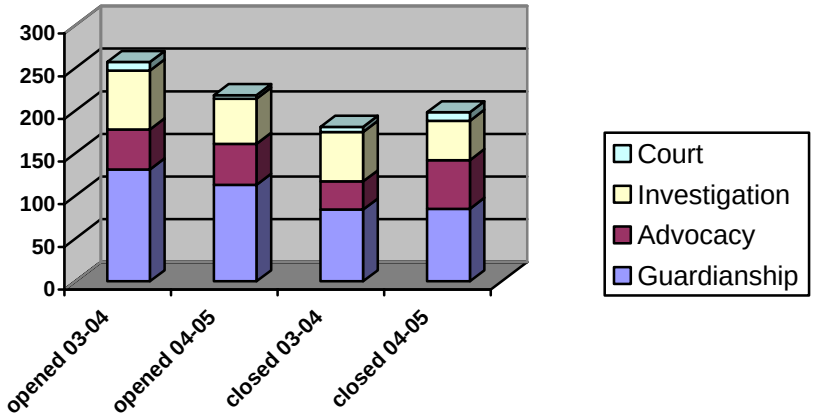
1.2 End of Financial year active caseload comparisons

This graph illustrates the end of year active cases for the past 3 financial years in all categories of cases. Note that guardianship accounts for the increase in active caseload.



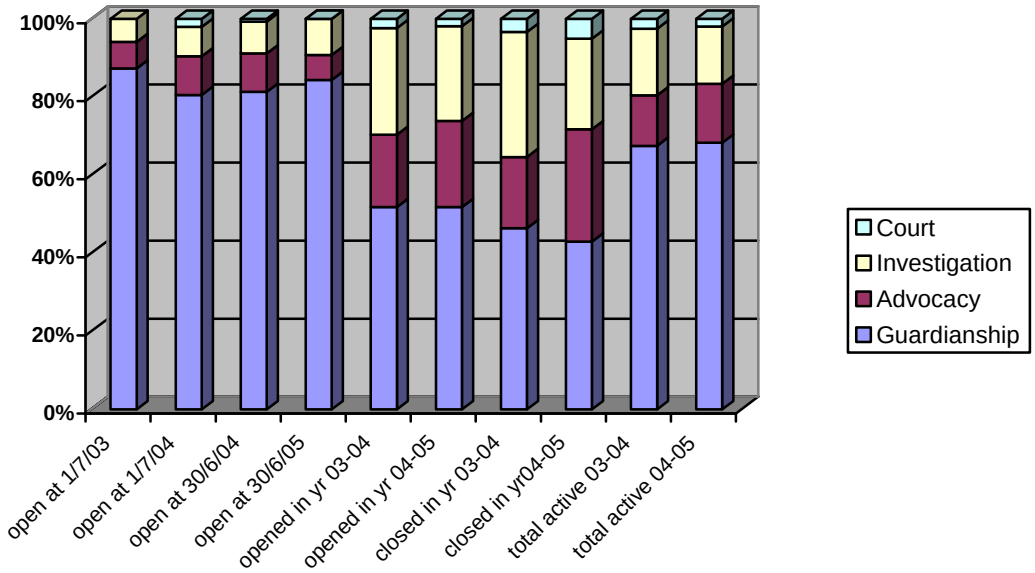
1.3 Comparison of case opening and closures 2003/04 and 2004/2005

The graph below illustrates the rate of opening cases with closures. Note that the number of closures is less than cases opened in each year.



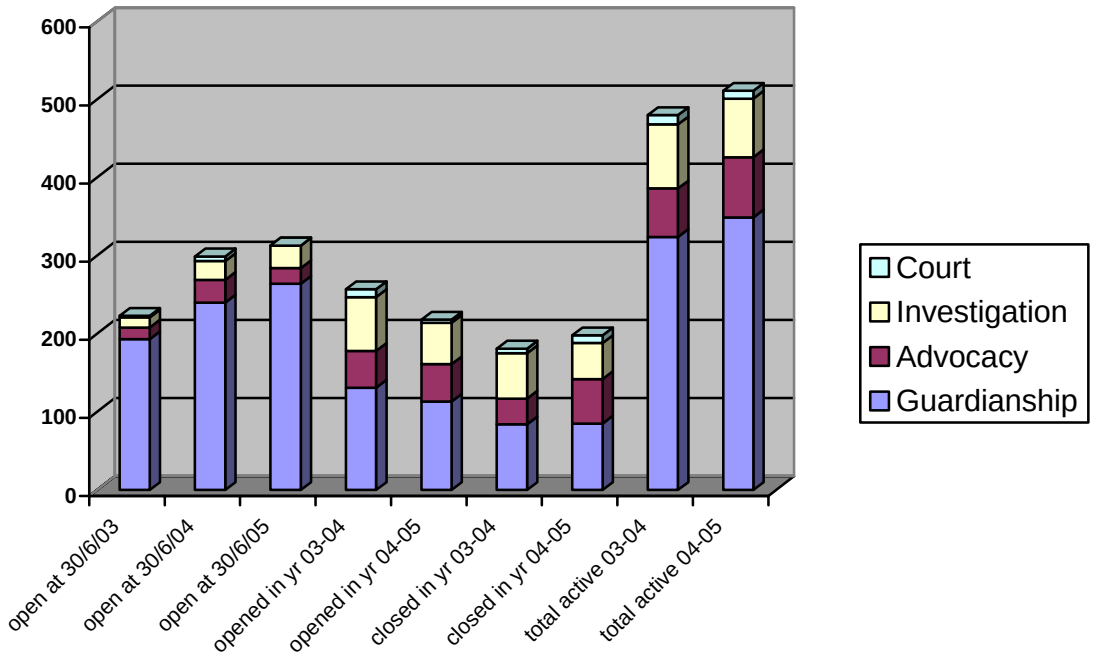
1.4 Case type as a proportion of total case activity 2004-2005

The graph below shows each case type as a proportion of all case types.



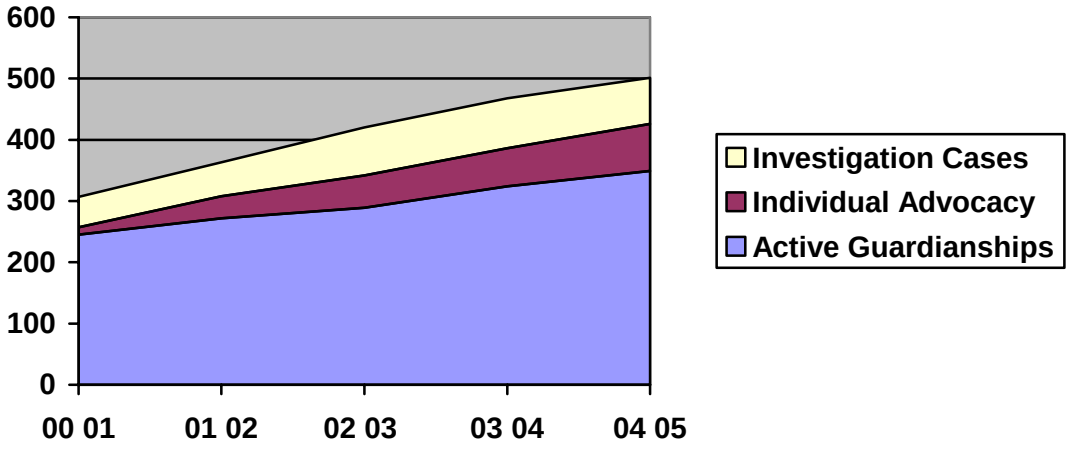
1.5 Comparison of case numbers and types 2004-2005 financial year

The graph below compares the case types as shown in table 1.1 above.



1.6 Case activity over recent years

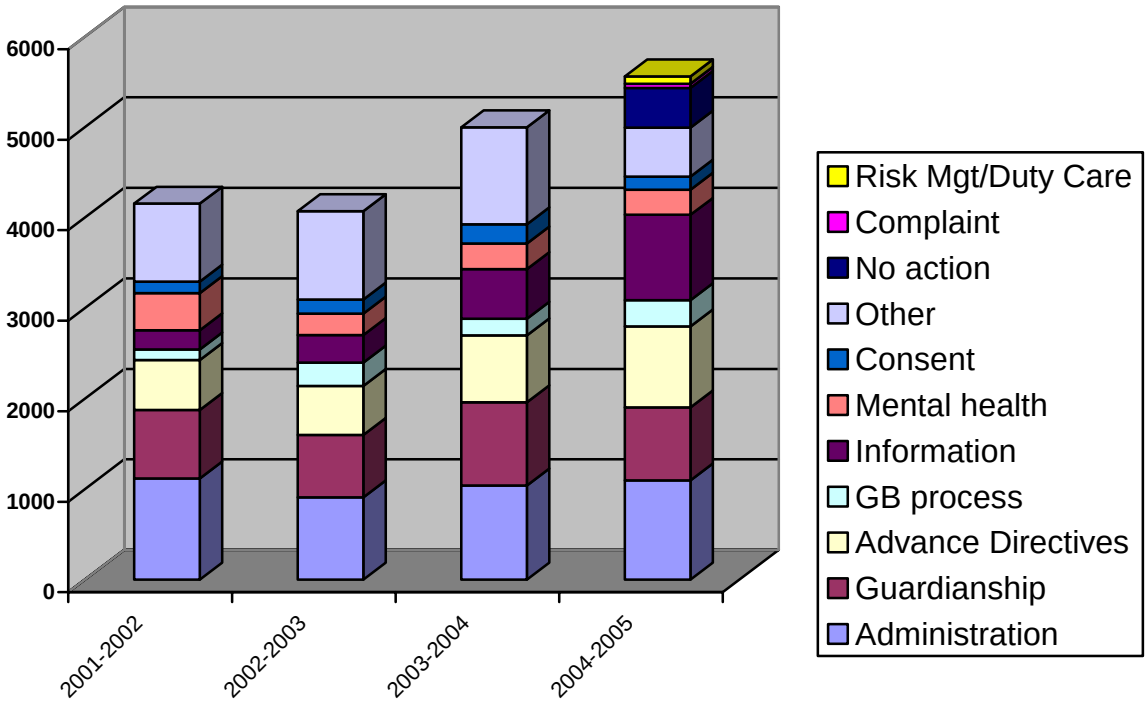
The graph below illustrates the number of active cases over the past 5 financial years and demonstrates the upward trend in numbers.



2. Non client activities

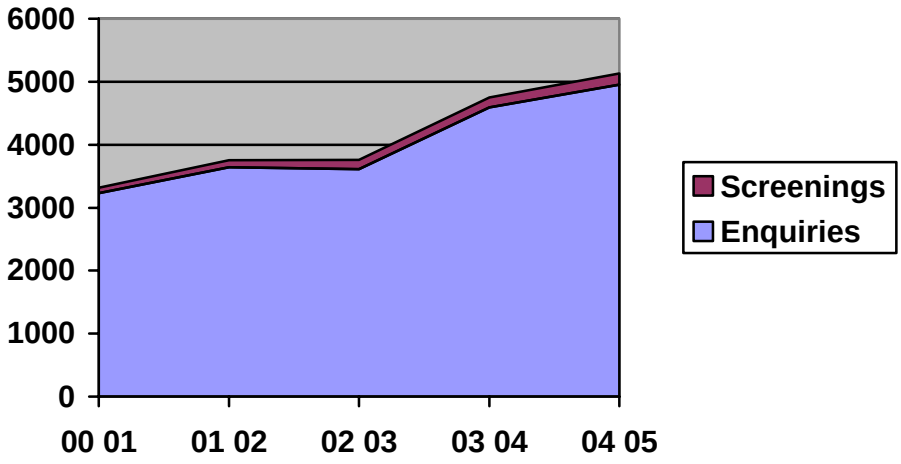
2.1 Enquiry Data

The graph below compares enquiries in each recorded category over the past 4 years. Note that the "other" category was broken down this year to include "no action", complaint" and "risk management" as separate categories.



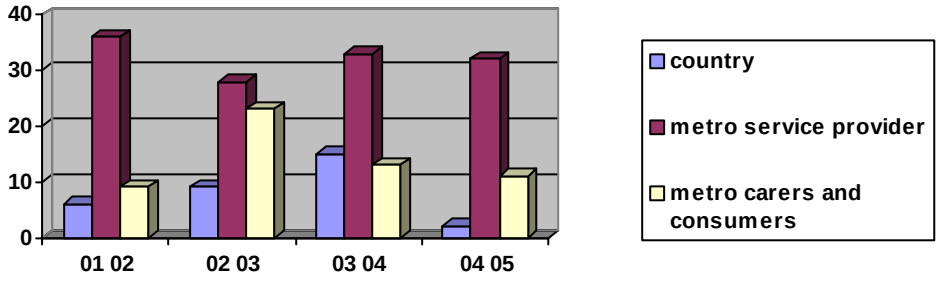
2.2 Enquiry and Guardianship Board case screening activities

The graph below indicates the trend in screening and enquiries activities over the past 5 financial years. This demonstrates the growth in activity.

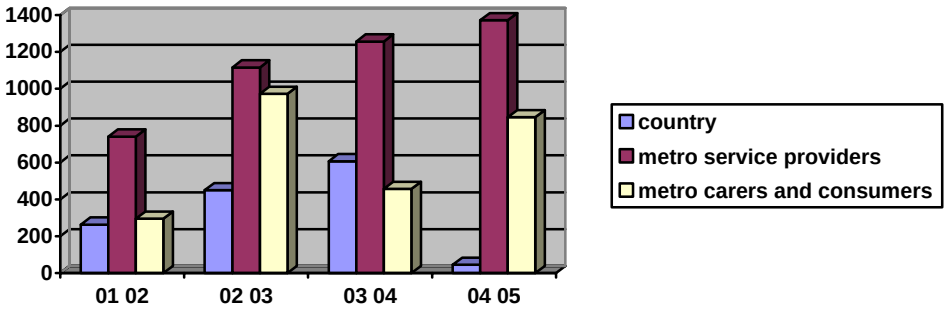


2.3 Education Sessions

The graph below indicates the numbers of education sessions given by audience type over the past 4 years.



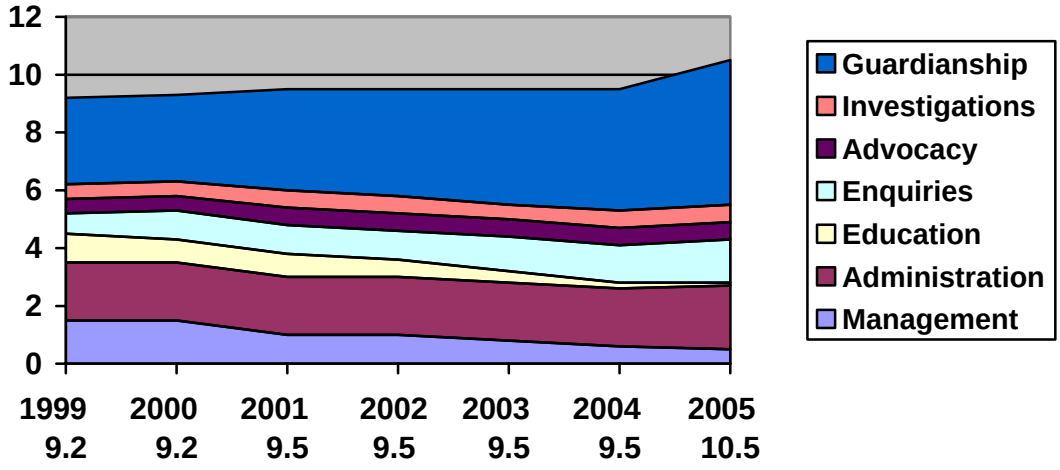
This graph indicates the audience numbers by type of audience over the past 4 financial years.



3. Utilisation of staff time

The graph below maps estimated time spent on various office roles over the history of OPA. Note the increasing proportion of resources devoted to guardianship.

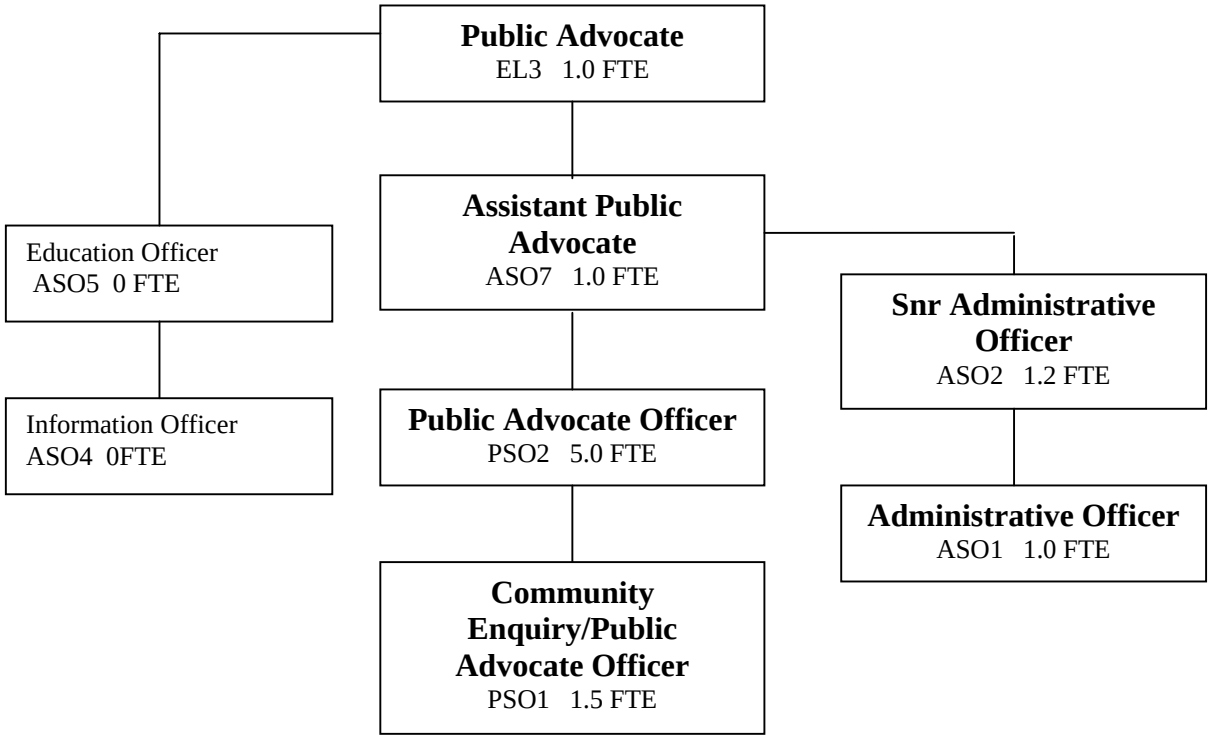
Staffing levels and allocation of resources



Employment and human resources

Organisational chart – Funded positions

As at 30 June 2005



- Staff changes throughout the year are described on page 53.
- Public Sector Management Act employees by stream, level, appointment type and gender as at 30 June 2004 are listed in Table 1 on page 54.
- Sick leave, family carers leave and special leave with pay for individual needs and responsibilities is listed in Table 2 on page 55.
- Workforce diversity is described in Table 3 on page 55.
- Cultural and linguistic diversity is described in Table 4 on page 55.
- Age profile is listed in Table 5 on page 56.
- Voluntary Flexible Working Arrangements are listed in Table 6 on page 56.

Actual resource utilisation throughout 2004-05 varied considerably due to staff movements, organisational priorities and additional temporary funding.

Human resources development

OPA encourages staff to pursue development opportunities. A number of activities were undertaken during the year.

2 staff undertook introductory mediation training ín work time and at OPAs expense. Feedback on the course was very positive and it is hoped that additional staff will be offered this opportunity in the future.

One staff member undertook training in project work to coincide with her work on the Supported Residential Facilities Project.

Administrative staff undertook several courses to enhance public sector knowledge.

Conference attendance has been a minor source of development this year.

Leadership and management development

OPA employs one Executive EL3 and one Assistant Public Advocate ASO7 who have responsibilities for staff management and strategic directions. Staff representation at Executive meetings is also included in the organisation management. The Public Advocate participates in executive fora on a regular basis.

Occupational health, safety and injury management

OPA was guided by the policies and best practice principles of the Attorney General's Department in relation to occupational health and safety and injury management. Practical assistance was provided by the AGD on request, and OPA used the Department's Workplace Health and Safety Division when required. OPA participate in the AGD policy reviews and audits.

OPA has an elected, trained OHS representative. OHS matters are routinely discussed in OPA staff meetings.

2 staff suffered minor injuries as a result of falls/collapses whilst at work. Both required time away from work and assistance with medical expenses.

OPA continues to focus on improving the working environment for staff. It is anticipated that the new office facilities will be an improvement for all.

Loss of work time through sick leave was extensive during the reporting period with upwards of 0.5FTE (hours) resources on leave at any given time. This is in part explained by chronic and ongoing health problems for several staff members. However, management remains concerned about the impact of high workloads and the nature of the work on staff wellbeing.

OPA management encourages the use of time off, working from home and use of leave to ensure that workers maintain health and wellbeing. Client waiting lists and work prioritisation are other strategies in regular use.

Staff Orientation

During the reporting period, Jenni Wright developed a new staff orientation manual which is now in use. OPA also utilises the AGD staff orientation process and provides links to the AGD intranet.

Administrative matters

Account payment

OPA's policy is for all accounts to be paid within one week of receiving them. Accounts were processed by Attorney-General's Department.

Consultants

There were no consultants engaged during the 2004-05 financial year.

Contractual arrangements

During this financial year, OPA was not involved in any reportable contractual arrangements.

Disability Action Plans

A report on our progress against the five outcome areas outlined in Promoting Independence – Disability Action Plans for South Australia is as follows.

Ensure accessibility to services to people with a disability.

OPA is a statutory body specifically set up to further the interests of people with mental incapacity. Its target population is people with mental incapacity and their carers.

Ensure information about services and programs is inclusive of people with disabilities.

OPA's education program is directed towards informing the public and people with a disability about matters pertaining to the Guardianship and Administration Act 1993, the Mental Health Act 1993 and the Consent to Medical Treatment and Palliative Care Act 1995. During this reporting period, a manual for private guardians was released. This will assist people who are close to a person with a disability to more effectively fulfil their guardianship responsibilities.

Deliver advice or services to people with disabilities with awareness and understanding of issues affecting people with disabilities.

OPA delivers a range of advice and services specifically to further the interests of people with mental incapacity. In particular, individual and systemic advocacy is a feature of our work. This year OPA took a particular interest in the plight of detainees whose mental health was being seriously affected by their circumstances.

Provide opportunities for consultation with people with disabilities in decision making processes regarding service delivery and in the implementation of complaints and grievance mechanisms.

OPA has in place resource material developed in consultation with people with disabilities and their family members. There were no activities during the reporting period however the private guardian's manual was produced with "consumer" input.

Ensure that the office has met the requirements of the Disability Discrimination Act 1992 and the Equal Opportunities Act 1984.

OPA is bound to comply with legislation that relates to the management and accountability requirements of Government, including the *Disability Discrimination Act 1992* and the *Equal Opportunity Act 1984*.

Equal opportunity programs

OPA promotes a workplace environment in which the *Equal Opportunity Act 1984* and the *Sex Discrimination Act 1984* are fully supported. OPA adheres to the relevant policies and procedures of the SA Department of Human Services.

In particular, OPA is committed to providing a flexible work environment that takes into account family commitments. This includes providing opportunities for part time employment, job sharing and opportunities to work from home on specific duties. Over half of OPA employees are employed on a part time basis and most administrative and professional positions are advertised as full time/ part time/ job share opportunities when they become vacant.

Fraud

There were no instances of fraud during the 2004-05 financial year.

Computing

OPA received an upgrade of its hardware and software in July 2004 ensuring compliance with government standards. A service level agreement is in place for the support of OPA's client database for the next 2 years. Preliminary work has been undertaken to scope the needs of OPA for its new case management system.

Energy Efficiency Action Plan Reports

OPA is a tenant of the ABC and is in part governed by landlord practices.

Overseas travel

There was no overseas travel by staff of OPA during 2004-05.

Accommodation

During this financial year, level 7 of the ABC Building has been redeveloped to accommodate OPA. The area will be occupied in August 2005. This will provide an improved environment for visitors and staff. Included in the development is a conference/training room which should allow more efficient use of staff time in training and an expansion of our training activities.

Staffing

Restructuring of the establishment has allowed for a 10.7FTE staff base to be permanently available for the 05/06 financial year.

Temporary funding for special projects created additional activity within the office until January 2005. Sessional hours were also purchased to help with the development of a business case for purchase of and new case management system. During the reporting period several staff have taken or returned from leave of absence. Whilst this can be destabilising it does allow for the recruitment of new blood and new ideas .

Freedom of information

The following information is published as a requirement of Section 9 of the *Freedom of Information Act 1991*.

Structure and functions of the agency – (s9 (2)(a))
A description of the structure and functions of the Office of the Public Advocate as required under s9 (2)(a) is set out elsewhere in this Annual Report.

Effect of agency's function on members of the public - (s9 (2)(b))
The nature of OPA's work leads to:

- involvement in family/care provider dynamics;
- consultation with government and non-government service providers;
- advice to the public about the provisions of the legislation;
- increased networks for people who have reduced mental capacity and their carers.

Arrangements for public participation in policy formulation - (s9 (2)(c))
The public can participate in agency policy development through the Enquiry Service and through the provision of feedback and comment at public forums facilitated by OPA and mentioned elsewhere in this report. OPA also consults target groups on specific matters.

Descriptions of the kinds of documents held by the agency – (s9 (2)(d))

- OPA Annual Reports.
- Files relating to investigation and the care of protected persons.
- Administrative files relating to the business operations of OPA.
- A series of printed resources, including OPA fact sheets, which provide information about the state guardianship and mental health legislation. A list of OPA's publications is on page 49.

Access arrangements, procedures, and points of contact - (s9 (2)(e) & (f))
OPA provides information on the FOI application process when contacted.

While FOI aims to provide access to the maximum amount of information possible, a number of exemptions are necessary to ensure that other people's privacy is not unduly invaded, for example, documents that would lead to an unreasonable disclosure of another person's affairs.

Amending personal records
Under FOI, an individual may apply to have documents corrected if they are incomplete, incorrect, misleading or out of date.

FOI requests 2004-05
OPA received 7 requests under FOI this year. Resignation of the accredited officer led to a delay in processing some applications pending training of a new officer.

All FOI applications can be directed to the Accredited FOI Officer at:

Office of the Public Advocate
Level 7, ABC Building
85 North East Road
Collinswood SA 5081

Financial summary

The Office of the Public Advocate operated as part of the Attorney General's department for the full reporting period. The financial operations of OPA are consolidated into reported and audited with the financial statements of the Attorney General's Department. For this reason, full general purpose financial reports are not provided as part of this Annual Report.

The chart below provides an expenditure summary for OPA for the 2004-05 year.

Office of the Public Advocate Financial Result 2004-05			
	Budget $'000	**Outcome $'000**	**Variance (unfavourable) $'000**
Operating Revenue	**927**	**1,027**	**100**
Operating Expenses	**892**	**989**	**(97)**
Assets	**6**	**6**	**0**
Surplus/deficit	**29**	**32**	**3**

During the reporting period, OPA received one off funding from several sources for projects being undertaken:

- Law Foundation Grant was used for the printing of the manual for private guardians
- 7 months of PSO2 salary and on costs was recharged to the Department of Families and Communities for the Supported Residential Facilities Advocacy Project which finished in January 2005.
- As part of the transfer between the Department of Human Services and the Attorney-General's Department, funding was provided towards information technology hardware and database development.

During this year, Cabinet agreed to expenditure on office refurbishment for the Office of the Public Advocate and the Guardianship Board. This project is well under way.

Appendix 1: Staff changes 2004-05

Public Advocate

- Mr John Harley commenced his second year in his second term as Public Advocate in 2004-05.

Assistant Public Advocate

- Ms Margaret Farr continued full time for the year.

Public Advocate and Community Enquiry Officers

- Ms Anita Micallef, Ms Yvette Gray, Ms Mary Allstrom, Ms Bianca Fecycz, Ms Annelise van Deth and Ms Suzanne Bull are the 6 permanently employed Public Advocate Officers and Community Enquiry Officers.
- Ms Gray undertook a special project for part of the year.
- Ms Suzanne Bull enjoyed 12 months leave of absence for the financial year, returning in late June 2005.
- Mr David Cripps continued on contract for the full 12 months.
- Ms Annie Phillips terminated her contract in June 2005.
- Ms Bianca Fecycz took 12 months leave of absence in February 2005.
- Ms Elly Kirk accepted a 12 month contract in Febuary 2005.
- Ms Tarnia White commenced contract in April 2005.
- Ms Sophia Lemke and Ms Josephine Magarey completed short term contracts during the reporting period.

Administrative staff

- Mrs Jenni Wright returned to full time employment after the resignation of Ms Stephanie Evans.
- Ms Sarah Barry was recruited in November 2004 to the Administrative Officer position.
- Agency staff have also been employed during various periods to assist in the administrative area. We are grateful in particular for the assistance of Ms Liliane Fox.

Student placements

OPA was fortunate to have the assistance of Ms Alison Tanzer.

Appendix 2: Staff profile tables

Table 1: OPA Public Sector Management Act employees by stream, level, appointment type and gender as at 30 June 2005

Public Sector Management Act employees by stream, level, appointment type and gender as at 30 June 2005									
Stream	**Ongoing**			**Contract**			**Total**		
	M	**F**	**Total**	**M**	**F**	**Total**	**M**	**F**	**Total**
Administrative	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
ASO1	**0**	**1**	**1**	**0**	**0**	**0**	**0**	**0**	**0**
ASO2	**0**	**1**	**1**	**0**	**0**	**0**	**0**	**2**	**2**
ASO3	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
ASO4	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
ASO5	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
ASO6	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
ASO7	**0**	**1**	**1**	**0**	**0**	**0**	**0**	**1**	**1**
Total	**1**	**3**	**3**	**0**	**0**	**0**	**0**	**3**	**3**
Professional	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
PSO1	**0**	**0.5**	**0.5**	**0**	**0.9**	**0.9**	**0**	**1.4**	**1.4**
PSO2	**0**	**3.4**	**3.4**	**1**	**1.1**	**2.1**	**1**	**4.5**	**5.5**
Total	**0**	**3.9**	**3.9**	**1**	**2**	**3**	**1**	**5.9**	**6.9**
Executive	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
EL3	**0**	**0**	**0**	**1**	**0**	**1**	**1**	**0**	**1**
Total	**0**	**0**	**0**	**1**	**0**	**1**	**1**	**0**	**1**
Total all streams	**1**	**6.9**	**6.9**	**2**	**2**	**4**	**2**	**8.9**	**10.9**

Table 2: OPA sick leave, family carers leave and special leave with pay for individual needs and responsibilities as at 30 June 2005

OPA sick leave, family carers leave and special leave with pay for individual needs and responsibilities as at 30 June 2005			
	Average number of sick leave days taken per FTE	Average number of family carer days taken per FTE	Average number of special leave with pay days for individual needs and responsibilities taken per FTE
2004-05	10	0	0
2003-04	4.82	.035	0
2002–03	6.82	0	0

Table 3: OPA workforce diversity as at 30 June 2005

OPA workforce diversity as at 30 June 2005					
	Total number of employees	Female	%	Indigenous employees	Employees with a permanent disability
Executives	1	0	0	0	0
Senior Managers	1	1	100	0	0
Middle Managers	0	0	0	0	0
First Line Supervisors	0	0	0	0	0
Other Administrative	2	2	100	1	0
Other Professional	9	8	89	0	0

Table 4: OPA cultural and linguistic diversity as at 30 June 2005

OPA cultural and linguistic diversity as at 30 June 2005			
Cultural diversity as at 30 June 2004	Country of birth Australia	Other country of birth	English is main language spoken at home
Executives	1	0	1
Senior Managers	1	0	1
Middle Managers	0	0	0
First Line Supervisors	0	0	0
Other Administrative	1	1	2
Other Professional	6	3	9

Table 5: OPA age profile as at 30 June 2005

OPA age profile as at 30 June 2005					
Age groups (years)	**Number of employees (persons)**			**% of all agency employees**	**% of South Australian workforce**
	Male	**Female**	**Total**		
15-19	**0**	**0**	**0**	**0**	
20-24	**0**	**1**	**1**	**8.3**	
25-29	**0**	**0**	**0**	**0**	
30-34	**0**	**2**	**2**	**16.7**	
35-39	**1**	**0**	**1**	**8.3**	
40-44	**0**	**1**	**1**	**8.3**	
45-49	**0**	**2**	**2**	**16.7**	
50-54	**0**	**3**	**3**	**25**	
55-59	**0**	**0**	**0**	**0**	
60-64	**1**	**1**	**2**	**16.7**	
65+	**0**	**0**	**0**	**0**	

Table 6: Voluntary Flexible Working Arrangements as at 30 June 2005

OPA Voluntary Flexible Working Arrangements as at 30 June 2005					
Type of arrangement	**Total employees**	**Number of employees using a Voluntary Flexible Working Arrangement**			
		Executive		**Non-executive**	
		Male	**Female**	**Male**	**Female**
Purchased leave	**0**	**0**	**0**	**0**	**0**
Flexitime	**12**	**0**	**0**	**2**	**10**
Compressed Weeks	**0**	**0**	**0**	**0**	**0**
Part time and job share	**6**	**0**	**0**	**0**	**6**
Working from Home	**0**	**0**	**0**	**0**	**0**

List of OPA publications

FACT SHEETS

1. An introduction to the *Guardianship and Administration Act 1993*
2. An introduction to the *Mental Health Act 1993*
3. What is the Guardianship Board?
4. Guardianship Orders *(Guardianship and Administration Act 1993)*
5. Administration Orders *(Guardianship and Administration Act 1993)*
6. What to expect at a Guardianship Board hearing *(Guardianship and Administration Act 1993)*
7. Advice to applicants *(Guardianship and Administration Act 1993)*
8. Advance directives in SA
9. Consent to medical and dental treatment for people with mental incapacity
10. Prescribed medical treatment *(Guardianship and Administration Act 1993)*
11. Section 32 powers *(Guardianship and Administration Act 1993)*
12. Detention and Continuing Detention Orders *(Mental Health Act 1993)*
13. Community Treatment Orders *(Mental Health Act 1993)*
14. What to expect at a Guardianship Board hearing *(Mental Health Act 1993)*
15. Advice to applicants *(Mental Health Act 1993)*
16. Prescribed psychiatric treatment *(Mental Health Act 1993)*
17. Section 12 appeals *(Mental Health Act 1993)*
18. Appeals to the District Court *(Guardianship and Administration Act 1993)*
19. What is the Office of the Public Advocate?
20. Office of the Public Advocate complaints policy
21. Information, advocacy and complaints services for people with mental incapacity
22. Mental capacity and advance directives
23. Informal arrangements for people with mental incapacity
24. What is a liaison person? *(Guardianship and Administration Act 1993)*

APPEALS FLOWCHARTS

A. Section 12 appeals for detained patients
B. Appeals against Guardianship Orders
C. Appeals against Administration Orders
D. Appeals against Continuing Detention Orders
E. Appeals against Community Treatment Orders

TRANSLATED MATERIALS
The following table provides a list of OPA's translated materials:

Language	Basic Fact Sheet	Guide to Guardianship and Administration	Statement of Legal Rights for detained patients (form 7)
Arabic	✓	✓	✓
Chinese	✓	✓	✓
Croation		✓	✓
English	✓	✓	✓
German	✓		
Greek	✓	✓	✓
Italian	✓	✓	✓
Khmer		✓	✓
Macedonian		✓	✓
Persian	✓		
Polish	✓	✓	✓
Russian	✓		
Serbian	✓		
Spanish		✓	✓
Tagalog	✓		
Turkish		✓	✓
Ukrainian	✓		
Vietnamese	✓	✓	✓

POSITION PAPERS
- Sterilisation position paper
- Restraint position paper
- Guardian ad litem position paper

MANUALS

"Now you are a Guardian: a manual for private guardians in South Australia" can be purchased from Service SA at a cost of $8.80 (phone 13 23 24 or from their website at **www.service.sa.gov.au**) or by coming in to the Office of the Public Advocate on the 7th floor of the ABC Building, 85 North East Road, Collinswood.

All pamphlets are obtainable on the OPA website www.opa.sa.gov.au or for Medical Power of Attorney and Anticipatory Directions and the guide to their use, see http://www.health.sa.gov.au/consent