

South Australian Office of the Public Advocate

ANNUAL REPORT 2010



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South Australian Office of the Public Advocate Annual Report 2010

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Front Cover: *"The Journey" by Krystyl*

The first of a series of two sketches has been used as the cover illustration. Both sketches are reproduced on page 10 in the body of this report.

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Office of the Public Advocate
ABC Building
Level 7, 85 North East Road
Collinswood SA 5082

Phone: 08 8342 8200
Fax: 08 8342 8250
Email: opasa@opa.sa.gov.au

ABN No: 21 587 257 523

30 September 2010

The Hon John Rau MP

Attorney-General

45 Pirie Street

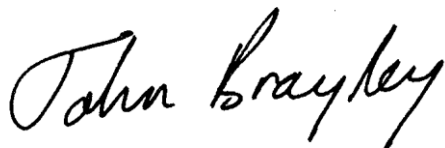
ADELAIDE SA 5000

Dear Mr Attorney

I have the honour to present to you the sixteenth 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 2009 to 30 June 2010. Part A is an overview of major matters arising during the year, and includes a review of programs, consideration of unmet need, and advocacy positions taken by the Office. Part B provides statistical data on direct client services provided by our office.

Yours Sincerely

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

John Brayley

PUBLIC ADVOCATE

Office of the Public Advocate Annual Report

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Introduction

The 2009-2010 Annual Report of the Office of the Public Advocate is divided into two parts.

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

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

Part A: General functions of the Public Advocate

This year's report follows up matters identified in the 2008-2009 report and charts further progress. A particular focus has been the development of a trial of Supported Decision Making, in keeping with the expectations of the United Nations Convention on the Rights of Persons with Disabilities that options of decision support be available. We wish to where possible ensure that people have the support to make their own decisions rather than have others make decisions for them.

In addition, there is a more detailed analysis of two issues that were introduced in the previous report. These are the application of Restrictive Practices in Disability Settings and the operation of the Supported Residential Facility (SRF) sector which provides accommodation and support for vulnerable adults.

Across all these areas, the analyses in this year's report conclude that law reform of three acts could be pivotal in improving the lives of vulnerable people. The *Disability Services Act 1993*, the *Supported Residential Facilities Act 1992* as well as the *Guardianship and Administration Act 1993* need to be brought up to date with recent advancements in rights, social policy and service delivery.

The overall summary from this office's observations this year is that vulnerable people in South Australia are still suffering significant gaps in services, and for many needs are only partly met or not met at all. This means that some people live in inadequate housing, are not receiving sufficient support services and are not getting adequate health care.

The consequence of this is lost opportunity for individuals to contribute and participate in their community. A person deprived of such opportunity is likely to lose more of their ability than they would in a system that can support independence and skill development. Our society overall is worse off.

Part B: Direct Services

Each year the number of people brought under guardianship in South Australia continues to surge. This year a guardianship service was provided to 705 people compared to 661 last year and 603 the year before that. There has been a corresponding increase in resources provided

by our funder, the Attorney General's Department, to employ more staff to respond to this increasing statutory workload.

In keeping with our review in Section A on Restrictive Practices, in Section B we have reviewed in more detail our own use of enforcement powers (under Section 32 of the *Guardianship and Administration Act 1993*). These powers are used in 21% of active guardianship cases with a median length of the orders of 294 days. This highlights the paradox of our work – on one hand promoting rights, but on the other overseeing powers that can direct where a person lives, and can be used to authorise detention and the use of force. As suggested last year we consider it is appropriate that an agency such as ours that is focussed on rights, also be the agency that oversees the use of such measures with careful consideration.

In other work the office also responded to over 4,000 enquiry matters, and reviewed 280 new applications for guardianship where the Public Advocate was nominated for appointment as guardian. Thirty four investigations were completed for the Board. Our office also undertook an internal review of our investigation processes. The office has acted as litigation guardian for 9 clients with respect to matters in the Youth Court, Federal Magistrates Court, Family Court and Supreme Court. The work of litigation guardianship has been poorly defined so this year the office developed detailed policy and guidelines for acting as litigation guardian.

Strategic Projects

Throughout this report a number of strategic projects are described. The office has actively sought community and government partners and grant funding to advance rights based initiatives in keeping with the role of the office. They include:

Mental Health Law Project (Australian Rotary Health Research Fund): This has examined variation in decision making about involuntary mental health care, and factors that influence its use.

Supported Decision Making (in partnership with the Julia Farr Association MS McLeod Benevolent Fund): This will fund a trial to examine the use of supported decision making which we hope will inform future law reform. Extensive planning has occurred this year with recruitment of clients due in 2010-2011.

Private Guardians Survey (Law Foundation of South Australia): A project to better determine the needs of private guardians in undertaking their role.

Adult Protection for Older South Australians (In partnership with Office for the Ageing, Department of Families and Communities). Our aim is to look at how linkages between health, community and legal services can respond together, so that persons can be kept safe and retain their rights by avoiding guardianship if possible and refocus legal intervention on perpetrators (modelled on approaches to adult protection in the UK, and approaches used in Australia for domestic violence). Our office has made a submission to the Office on the Ageing on this topic and if this is supported it is likely that we will undertake further policy and consultative work in this area during the coming year.

The development of a Community Visitors Scheme for Mental Health Services (in conjunction with the Mental Health Unit, Department of Health). Further planning has occurred on how the

scheme might operate in response to the requirements of the new Mental Health Act. The Principal Community Visitor is an independent statutory appointment. It is likely that this position and the scheme will be hosted at the Office of the Public Advocate.

Acknowledgement

The office by the nature of its mandate looks for gaps and systems problems. We also wish to acknowledge the good work that is done by so many committed people across the sectors that we work with.

Much of this report is an amalgam of the views expressed to us by service users, carers, advocates, service providers, academics, policy makers and funders combined with our own direct observations and reviews of best practice. Creating this report is only possible because of the generosity of committed people in this state and elsewhere who have spent time with us talking through how they see our systems could change – the need for new laws, more services and different services that could then improve the lives of so many people.



“The Journey” by Krystyl (2010).

The first of these two sketches has been reproduced on the front cover of the Annual Report

Together, the sketches illustrate a journey towards recovery.



Part A:

General Functions of the Public Advocate

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

Reviewing Programs and Identifying Unmet Need

Overview

Guardianship and Administration Act 1993

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

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

This section overviews Disability Services, Mental Health Services, the Supported Residential Facilities and updates last year's Annual Report discussion about Adult Protection.

There are a number of commonalities across these areas. They include:

- The current state of service provision is underdeveloped with significant unmet need, and concerns about service quality, in part because of demand pressures.
- A requirement for additional resources to respond to community needs.
- A need for transformational change in the delivery of services – it is not simply a matter of providing more of the same.
- A requirement that change is embedded with legislative reform. The legislation that oversees Disability Services and Supported Residential Facility services needs updating to reflect advances in rights and service delivery in the last 20 years. Mental health law reform has already occurred.
- The involvement of the Social Inclusion Board. The Board's 2007 mental health report has made it possible to chart progress against an agreed plan in mental health and the same will apply with the Board's development of a Disability Blueprint for the state.

There is also a need to tackle a view in these sectors and in the community generally that problems in these services are inevitable and that the status quo is acceptable. Examples of best practice, in this state and elsewhere demonstrate that this is false, and we can reasonably expect much more to be delivered with improved systems and adequate resourcing.

Reviewing Programs and Identifying Unmet Need

Disability Services

Introduction

2009-2010 has been a year of promise for people living with disability and during this period momentum has developed at both a federal and state level for substantial change. Two key initiatives are:

- The Productivity Commission's Inquiry into a National Disability Long-term Care and Support Scheme which commenced in April 2010, and will report by 31 July 2011 (Productivity Commission, 2010).
- The Social Inclusion Board Disability Reference. The Board has been commissioned to develop a blue-print for long term reform across all government agencies in South Australia. It has released a discussion paper *Activating Citizenship* (Social Inclusion Board, 2010) which canvasses three key areas of inquiry: (1) strengthening dignity, independence, participation and rights of people with disability, (2) accelerating the development of integrated and joined up services where the focus is on the personal and long term needs of people with disability, and (3) ensuring the role of carers and families is more effectively recognised and supported.

These longer term initiatives have the potential to fundamentally redesign the delivery of disability services in this state and in the country. A new SA blueprint will not only set a new direction for our services, but provide benchmarks for reviewing programs and assessing unmet need.

Sadly, while there is hope and promise on the horizon, the situation on the ground has remained very difficult for many people living with disabilities and for their families. This is despite new government funding that has assisted some people who without it would otherwise be waiting for services.

Update on service use and unmet need.

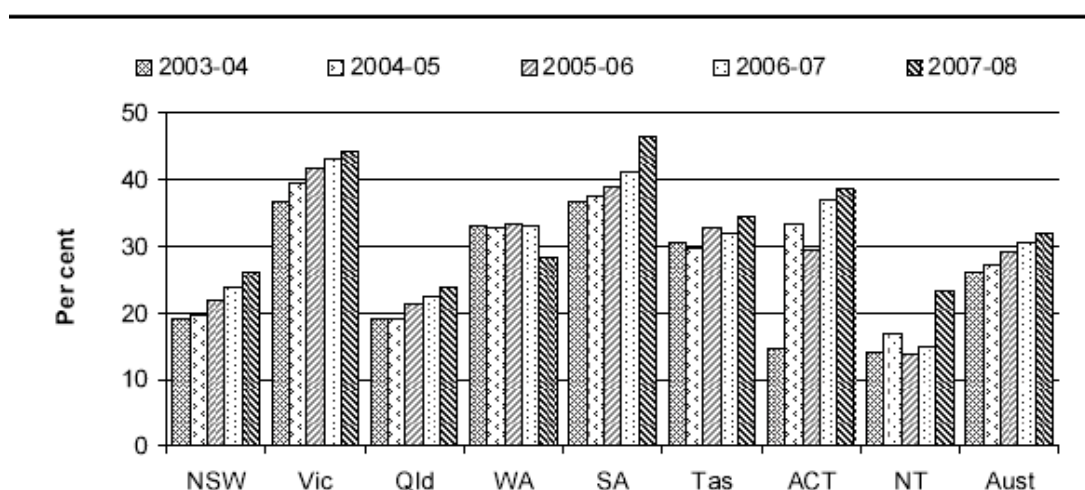
In last year's Annual Report we reviewed publicly available data describing Disability Service provision in SA to determine access to service for people with intellectual disability, brain injury and neurological disease. These are the people for whom the Office of the Public Advocate has a specific role. While much of the data used from Productivity Commission and other reports describes all people with disabilities, it is still indicative of access for these the specific groups served by our office. Our overview last year was as follows (Office of the Public Advocate, 2009):

- Based on data published in 2009, overall SA had been reaching more people who have a disability than any other state except Victoria, and providing supported accommodation services to more people with a disability than any other state.

- In order to achieve this result, each person was receiving less funding than individuals in other states, suggesting that a significant component of the unmet need in SA relates to people who are recognised as requiring a service and are registered with a provider, but are not receiving an optimal level of service.
- It was also noted that more work needed to be done to consider access to service for people who have specific needs related to their disabilities. With respect to people who have an intellectual disability, it would seem that many but not all people are receiving a service. For people who have experienced a brain injury more work is needed to consider timely access to services in the critical post-injury period. The response to people who have an autism spectrum disorder needs to be better organised to meet the needs of increasing numbers of people presenting with these conditions.

A similar pattern exists in data published in 2010. The data used in this year's Report of Government Services Report is from 2007-08.

This data confirms that South Australia is reaching a higher percentage of potential users – now the highest of all states including Victoria.

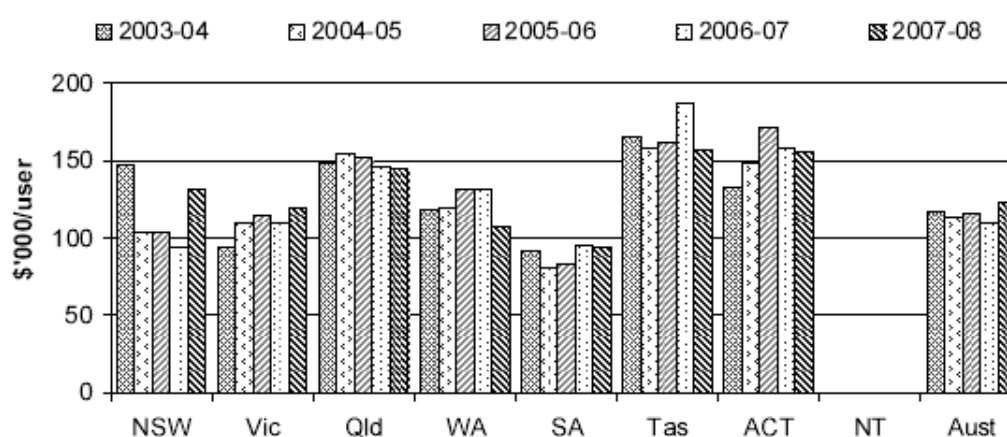


^a Data need to be interpreted with care due to a number of factors affecting data quality. Section 14.6 contains further information on these quality issues. ^b For the ACT, improved data capture for therapy services resulted in an increased service user count between 2003-04 and 2004-05. The decreased service user rate for 2005-06 was due to incomplete data collection for therapy services.

Source: AIHW (unpublished) CSTDA NMDS; AIHW (2009 and previous years) *Disability Support Services 2007-08, 2006-07, 2005-06, 2004-05, 2003-04: National Data on Services Provided under the CSTDA*, Cat. no. DIS (56 and previous publications); table 14A.12.

Figure 1: Users of CSTDA funded services as a proportion of the estimated potential population (Reproduction of Figure 14.5, Productivity Commission, 2010)

The result for the corollary statistic, how much is spent per user, is similar to the result last year
 - South Australia spends less per user than any other state.



^a See table 14A.52 for detailed notes relating to these data. ^b Service user data used to derive this indicator have quality issues, so estimates of jurisdictional efficiency need to be interpreted with care. Section 14.6 contains further information on these quality issues. ^c In NSW, the change in expenditure per user between 2006-07 and 2007-08 is largely caused by a correction in the NMDS service user data. Some users of non-government provided services were coded as government users in the reports of previous years and this has been rectified for 2007-08. ^d WA service user data for 2007-08 were provided directly by the WA Government and have not been validated by the AIHW. The revisions correct for a coding error related to users allocation to government or non-government services. ^e In the ACT, the increase in expenditure between 2004-05 to 2005-06 is the result of a combination of factors including service user information being excluded as a result of data cleansing analyses of the NMDS forms or being reclassified to 'other community settings'. ^f There were no government providers of accommodation support services in group homes in the NT.

Source: AIHW (unpublished) CSTDA NMDS; State and Territory governments (unpublished); table 14A.52.

Figure 2. Estimated annual government expenditure per user of CSTDA State and Territory Administered Services (2007-08dollars) (Reproduction of Figure 14.27 of the Productivity Commission (2010))

The most recent published data from the Commonwealth State Disability Agreement is for 2007-2008 (AIHW, 2010). In South Australia 19,350 people received 37,361 services funded under this agreement.

More recent data on Unmet Need is now released 6 monthly by the Department of Families and Communities and published on the web. We noted last year that this was in response to requests from key community advocates including David Holst. It is now possible to chart progress on unmet need.

The Disability SA unmet needs process categorises unmet need according to the type of service required and the urgency of the need.

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

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

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

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

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

The types of services are listed as follows (based on information obtained from Disability SA):

Supported Accommodation – this comprises clients who are referred to the Accommodation Placement Panel;

Personal Support – which describes clients requiring up to 50 hours per week maximum in home support. If the number of hours is greater than this the need is considered to be one of supported accommodation;

Respite;

Community Access - which includes day options (daytime activity), learning and life skills development, recreation and community access; and

Community Support- which includes a range of therapies.

Figure 3 charts unmet need over time for all four categories of service. There has been a significant increase in unmet need over this time.

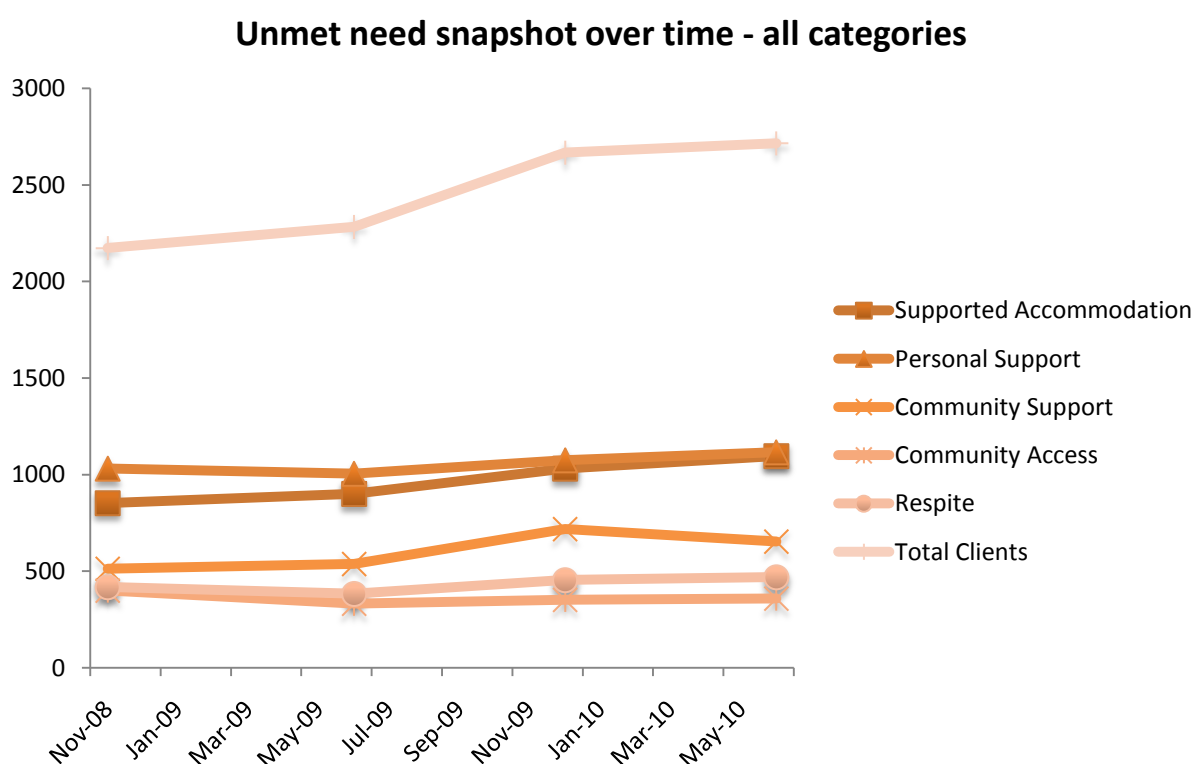


Figure 3. Increase in unmet need list November 2008 to June 2008. For clients in all categories.

Figure 4 demonstrates a similar increase in category 1 unmet need – those people who are in critical need because of homelessness or at immediate and high risk of harm to self or others. The unmet need for supported accommodation, personal support and respite are all increasing.

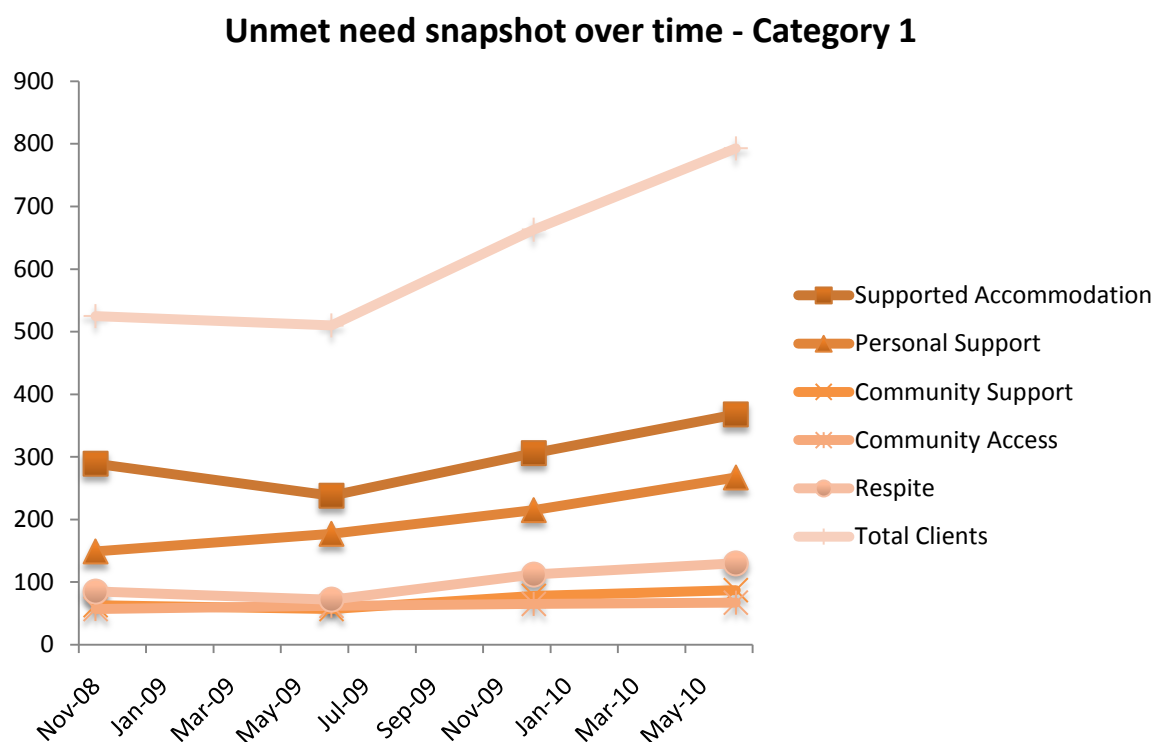


Figure 4. Increase in unmet need list November 2008 to June 2008. For clients in Category 1.

It would seem that it has not been possible for providers to effectively address the general unmet need list or the critical list. This is in spite of the release of new funding from the Department. This funding has included an allocation of \$31M over 4 years to families needing respite and in-home support (made in December 2009), and further commitments in March 2010 for equipment and home modifications, specific funding for families with children with autism, and funding for alternative accommodation for people living with disabilities who are in hospital and ready to be discharged (Department of Families and Communities, 2010). These are the latest in a number of increases in disability funding over recent years (Department of Families and Communities, 2010).

Given that unmet need has still increased, without this new investment the situation on the ground would be even worse.

Disability reform and new legislation

Our Annual Report last year promoted the idea that access to services could be enhanced through new legislation and a move from a welfare based to rights based system. We received a number of comments about the analysis and the solutions of new legislation and service redesign which we promoted. One observation concerned the very nature of unmet need analysis and its focus on those who are not being served or are underserved. While this is the reality of a stretched system, it was said to us that, despite this, the system can also get it right – there are many people who are satisfied with services provided either from the government directly or through non-government organisations. This is an important reminder of the amount

of good work currently undertaken but it also highlights inequity. It demonstrates that when adequate resources are allocated for a person's needs, the system can deliver in its present form and expectations of people who are receiving inadequate services can then be met.

There was also debate about what the solution should be. Last year's report made the statement that considering unmet need as a funding issue alone will be insufficient, and argued that new legislation and service reform through individualised funding is needed to achieve quality service outcomes. In response, concern was expressed that these reforms should not be seen as a substitute for providing the necessary investment in services. There is a fear that new service plans and system designs may be offered as a substitute for investment. In fact all of these elements are likely to be required.

Traditionally services overwhelmed by demand can end up spending more on each client because of the time spent determining what services are provided or not provided, internal advocacy for funds, and then finding services. In addition, if predictable service needs are not provided for up front, it can be more expensive to use crisis management solutions at the last minute to meet people's needs than having a more ordered response. This is our current observation of what occurs at Disability SA. While our advocate/guardian staff appreciate the dedicated effort of disability staff in obtaining services for clients, ideally this time could be redirected into actual service provision.

Therefore, while acknowledging the concerns that redesign might be put forward as an alternative to new investment, we believe that the full benefits of any new investment will be lost without significant change in existing services as well.

Legislation

Traditionally in Australia the day to day operation of human service systems has been determined by policies established at a departmental or service level. Legislation has set broad objectives only. This is how the current *Disability Services Act 1993* operates, with important details such as eligibility for service, how vulnerable clients are protected from harm, and the use of restrictive practices contained in departmental policies.

There are an increasing number of examples of more detailed legislation where key elements of service provision are described in some detail – such as who receives services, the objectives of those services, the requirement to have a support plan and a direction to provide the necessary professional and support services. If there is a support plan in place there is an obligation to deliver what it requires. An international example is legislation that determines disability services in California – the *Lanterman Developmental Disabilities Services Act and Related Laws 2009* (California Department of Developmental Services , 2009).

Legislation in Australia in the human service area is following this trend by making good professional and service practice a legal requirement, and not one that is just defined professional standards or service planning documents. This is because departments and services will obey the wishes of parliament. It seems that relying on traditional policies, plans and agreements generally does not get a result. An unfortunate observation can be made that in difficult social policy areas across Australia, it has become the norm for plans to say the right things, but fail to deliver. Generally progress against such policies is reported as actions or

processes (ie what we did). In contrast, legislation mostly describes what the individual citizen can expect and therefore in key areas requires absolute outcomes.

The opposite view to this is that parliament should only define the broad directions and then leave it to the executive to determine details. However many of these details are fundamental to good practices, and are the key issues that confront community members. We hasten to add that, in making the suggestion to create binding legislative provisions, the intent is to bind the government itself to service provision, not to bind the person with a disability. The emphasis is on ensuring that clients are offered an intervention rather than making them accept it. This approach is about legislating for people's positive rights.

Legislation can address the provision of service at a population level and at an individual level. At a population level it can define eligibility criteria for intake to services. For example the Victorian *Disability Act 2006* is very explicit in describing eligibility to services, and provides an appeal mechanism to the state administrative tribunal if a person is not satisfied with a service decision. At an individual level legislation can require that a support plan be developed. A support plan is more than an administrative nicety. It forces a provider to write down what is being provided, and to involve the service user and carers in developing it. The plan can then be measured against known best practice. Support plans can ensure that a service's interventions are focussed on the client's own goals, have involved the client in decision making and address all key aspects of a client's life. Without effective support plans services might just do what is obvious and immediately necessary and not provide a breadth of services based on the client's wishes.

Figure 5 illustrates the inter connection between legislation, support plans and service obligations.

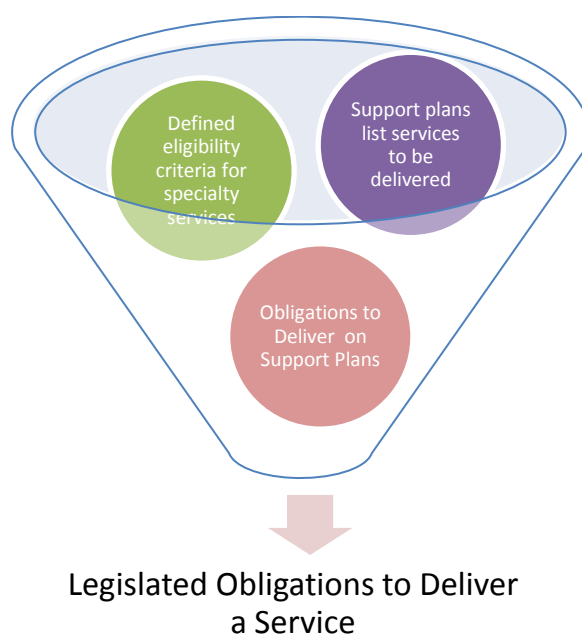


Figure 5. Eligibility criteria and support plans.

There are examples of legislated support plans in other areas of legislation that deal with service provision to vulnerable people. Examples include recent legislation in mental health (such as SA's *Mental Health Act 2009*), and in supported residential care (Victoria's *Supported Residential Services (Private Proprietors) Act 2010*).

Some people may be concerned with a legislative approach as it is only possible to legislate for what is achievable, and it would be a risk for government to create laws requiring something that cannot be achieved. However, there are shining examples of achievement by individual programs and organisations here in South Australia, and internationally there are rights based disability systems that deliver at a consistent level across entire jurisdictions. A population based approach to disability need can be achieved, and therefore it is possible for these expectations to be defined in law.

Legislation can also act as a catalyst for rapid change. Changes to existing policies and plans are usually implemented over a number of years and people continue to experience the older services in the interim. While implementation is occurring it is usually expected that consumers will continue to personally bear the burden of ongoing rationing of services with the knowledge that change is underway and life will improve down the track. In contrast, legislation has an implementation date for delivery. If providers are not ready for the start date, and it costs more for the legislated services to be delivered from this time, then it is the providers and the government as funder that bear this burden. This is where the burden should rest - not with vulnerable individuals. (Such a cost burden is also a transparent driver for improving outdated systems.)

The Social Inclusion Board's Disability Reference has now placed the topic of a new Disability Act firmly on the agenda. The view of our office is that the new Act should be one that is detailed and specific, and upholds positive rights of people in a tangible way. This can be achieved by defining within the Act the objectives of government in meeting the needs of people with disabilities, the role of government generally and that of specialist disability services either provided or funded by government. These general statements could be updated to be consistent with the UN Convention on the Rights of Persons with Disabilities.

The following are some potential features that could be included in a new Disability Act.

- *A restatement of rights.* The rights embodied in the UN Convention can be restated and affirmed as they apply to people living with disabilities in South Australia.
- *Access.* A statement of what expectations community members can have to access state government provided and funded services for people who have a disability. Preparing this statement would allow a transparent community debate on who should be eligible for services and who should not be.
- *Assessment.* A requirement that necessary assessments are available so that a person's eligibility for service can be determined, and information is available to assist service users and their providers develop a support plan.
- *Client and Carer Participation.* While participation would be encouraged for all aspects of care, the requirement that services seek to involve clients, and carers in the formulation of support plans could be stipulated.

- *Support plans.* The completion of a comprehensive support plan within a designated time that lists professional and support services that a person needs from specialist disability services and from other government services.
- *Obligations to deliver services listed in a support plan.* This would require specialist disability services to deliver the services agreed to in a support plan for that individual and describe what is to happen if they are not delivered.
- *Safety and quality obligations of service providers.* Including reporting on client outcomes, and critical incidents, which would supplement the existing financial reporting. Related to this are requirements for reporting restrictive practices which are described in a later section of this report.
- *Expectations on all government services with respect to support plans.* This would require other government providers generally to provide services to people with disabilities in accordance with support plans. Such a requirement would go beyond existing anti-discrimination provisions. There is little point in only making it a requirement for specialist disability services to be provided, if the same expectation is not made on other services. given that people living with disability may need services from many agencies across government.
- *Appeal processes.* Appeal mechanisms for clients and carers should there be a disagreement on matters of eligibility, the inclusion of specific services in a support plan, or a failure to provide a service specified.
- *A legislated framework for self managed funding.* This would define the rights and responsibilities of service users managing their own funds, and facilitate its more widespread use.

Service redesign

The need for service redesign has been raised earlier in this section.

In June 2010 the Department of Families and Communities released a consultation paper for Ageing and Disability Service Improvement (Department of Families and Communities, 2010). This foreshadows the merging of a number of departmental and service functions for aged people and people with a disability. Key elements of this plan are summarised below.

The overarching objective of this change to funding and delivery is to “enhance the quality of life of frail older people and people with a disability, and their carers.” The paper notes that “new models of service delivery, improved funds management, and integrated intake and assessment are at the heart of these changes”.

The paper outlines changes to Departmental structures including a single entry point and common assessment for ageing and disability services. The D-START (Disability Support Training and Resource Tool) assessment tool is identified as the assessment tool for people under 65. The intake and assessment point will either make a referral direct to a service provider that has a vacancy or the person will be placed on a waiting list (there will be a Capacity Monitoring Database).

Funds management will occur from a single funds management directorate, and policy, planning and research will merge the existing offices in the Department for Ageing and Disability.

Disability SA and Domiciliary Care SA will be combined to form one structure at the point of service delivery. The consultation paper outlines a simple client pathway. Working parties have been formed and will develop options for the structure and function of each of the streams and these are due to report in October 2010.

The Office of the Public Advocate was briefed about the proposed redesign. Whilst OPA has a legitimate role in identifying unmet need, and putting forward suggestions for new and improved programs, it is not our role to provide commentary on departmental structures. Ultimately the Chief Executive of the relevant department has this authority, and also the responsibility for delivering the services from their structure.

However a concern of our office was that specific expertise in disability may be lost through the merging of the disability and aged care organisations. Knowledge related to underlying causes of disability, skills in assessment and rehabilitation, and a developmental approach to assist people with their lives in the long term are prerequisites of working effectively with people who have a disability. This work is more than the generic provision of care and support.

Our office was reassured by officials that only the intake systems would be merged, and that existing Disability SA and Domiciliary care teams will continue to function as they currently operate. Specialist disability teams will not be merged with aged care teams. A diagrammatic representation of the model is in Figure 6. Our understanding is that the only merged client function will be the initial response only (such as the initial needs identification and the provision of brief information and referral.)

A Simple Client Pathway

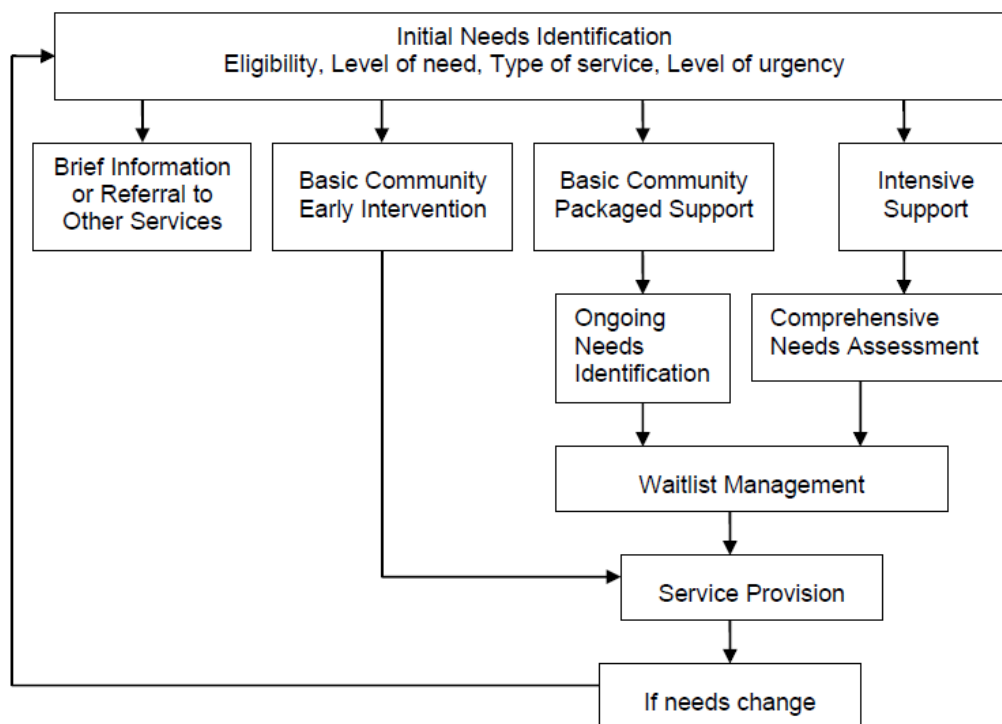


Figure 6. Simple client pathway for a merged Ageing and Disability sector copied from the Disability SA paper describing the reform (Families and Communities, 2010).

Another consideration is that under the Council of Australian Government Agreement, aged care resources will be transferred back to the Commonwealth so that the Commonwealth government can operate a nationally consistent aged care system delivering both in home care and residential care (Council of Australian Governments, 2010). Therefore the apparent merger of aged care and disability functions may not be as significant as it might first seem. The increasing demand for aged care services in the home will be one for the Commonwealth to respond to, rather than an ultimate responsibility of a merged aged care-disability system operated by the state. The state may remain a provider of Commonwealth funded community aged care programs and this new structure may still need to respond to a significant aged care need if this is the case. Funding lines will be separate even if the commissioning of services at a state level is merged.

The new model has a focus on capacity monitoring and unmet need, as if some level of waiting will be inevitable. In line with service system reform agendas outlined previously in this section, an alternative conceptual approach is for the service to aim to meet the anticipated needs of the people it will serve, so that resources do not need to be invested into operating a significant waiting list.

The planned use of the D-START tool will also need further public debate. This office has some understanding of how this tool operates but has not seen a copy of the full tool. This tool has been developed by the University of Adelaide with the support of the Department of Families and Communities. It is expected to be comprehensive. A component of it has already been used as a pilot screening tool for a program for youth. The full tool will have a wider application and trials of it are underway.

At this point we raise a word of caution about computer based assessment tools. Such tools can have a fundamental effect on people's lives because they may become the primary determinant of eligibility for service, and then influence how services are planned for an individual (and therefore which services are delivered). The settings within computerised tools should be driven by legislation or policy rather than the reverse and a high level of vigilance is required to ensure that the scoring systems in computer tools do not end up creating defacto policy settings. By way of explanation, this is because such tools usually contain algorithms that score information about a person's disability, and level of available unpaid carer support in order to then determine the level of paid services to be provided.

Our office considers that these systems should be transparent and open to scrutiny. We all need to know what is 'under the bonnet' of software that converts an assessment of need to access to services. Until we know more about the proposed new system, our office has more confidence in simple systems that ask straightforward questions about people's needs, have immediate face validity to both professionals and lay people, and can be readily audited to ensure equity of decisions. We will monitor the implementation and impact of this tool in practice, in particular the potential impact of D-START assessment on the provision of services.

2009-2010 also saw the commencement of a trial of Self Managed funding within Disability SA. The Public Advocate is a member of the Disability SA reference committee for this trial. Information from this program will no doubt inform further reforms. It will be subject to an independent evaluation.

Self managed funding will be discussed further in next year's Annual Report. Early impressions however are that, despite the limited scope of the trial (for example, it does not include case coordination and government provided services), so far participants have found benefit in being able to manage their own funding.

A related topic is the relationship between Supported Decision Making (as described elsewhere in this report) and self managed funding. Developing effective systems of Supported Decision Making will allow as many people as possible to make choices about services. This link was explored in detail in a 2010 submission our office made to the Productivity Commission Inquiry into a possible disability insurance scheme. The submission can be downloaded from the OPA website. (www.opa.sa.gov.au). For this reason it will be also important to develop Supported Decision Making services to go alongside the reforms currently occurring in the disability sector.

Summary

During 2009-2010 significant planning for a new rights based disability system began at both a state level (the Social Inclusion Board disability blueprint) and at a national level (the

Productivity Commission review into long term care and support for people living with disabilities), while unmet need continued to increase.

In South Australia the prospect of new legislation is now on the agenda. New legislation can define the objectives of government in meeting the needs of people consistent with the UN Convention on the Rights of Persons with Disabilities. We need to define;

- access to services,
- the provision of assessment,
- the development of support plans (and a requirement for client and carer participation),
- obligations on government to deliver the services required in the support plan, and
- expectations across government for non-disability service providers to respond to service needs in these plans.
- appeal processes, and
- a framework for self managed funding.

These provisions are a starting point, and the content is likely to become richer and more detailed with more community discussion.

New legislation can be a catalyst for change, as reasonable expectations that services will be provided apply from the start date of new legislation. The burden would then be on government to meet these expectations, as opposed to the present situation where the burden is on service users and their carers through unmet need and gaps in services.

Reviewing Programs and Identifying Unmet Need

Mental Health Services

Introduction

In the 2008-2009 Annual Report progress in mental health reform was compared to the policy and service directions set by the Social Inclusion Board in the Stepping Up report (Social Inclusion Board 2007). This report sets the priorities and goals for mental health reform in this State, and provides a benchmark to use when reviewing programs.



Figure 7. Stepped Model of 24 Hour Care and Community Support (< 24 hours) (Department of Health, 2007)

For this reason it is worth quickly reviewing the 2007 Social Inclusion Board report which is determining the direction of reform now.

This report made 41 recommendations, and proposed a stepped model of care, with community mental health at the centre. There was a focus on interventions across the spectrum of need. For people early in the course of their illness the report prioritised prevention and early intervention services. For people with complex needs the report identified the need to have coordinated care that linked across government and set expectations of consumer and carer participation, and prioritised Aboriginal mental health.

The Social Inclusion Board recommendations are cohesive and interlinked. The report's analysis of the numbers of consumers in the early intervention group and the chronic and complex need group indicated that progress should be achievable in these areas.

Catering properly for each group will have flow on impacts. Reducing current multiple hospital readmissions of consumers with

complex needs who fall through gaps will free beds for others.

The Social Inclusion Board report has not only made community mental health pivotal to the operation of the stepped system, but also to the financial management of the reform process. Community mental health services should hold and manage funds that are linked to reform, and

critically “Transition funding and the reinvestment of funds that can be freed up through the implementation of the Plan must be enveloped and managed carefully” (part of Recommendation 11, Social Inclusion Board, 2007).

This enveloping should include control of the recurrent funds freed up from the closure of existing long term beds at Glenside. These should be reinvested in funding the operation of the 60 community recovery centre beds and the additional seventy three 24 hour supported accommodation places (Department of Health, 2007). The 2007-2008 state Budget, also included additional funds to support people in the community who may require less than 24 hour care. Note that these funds are in addition to the 24 hour care funding as illustrated in Department of Health literature reproduced in figure 1. This was shown as a new bottom step in the stepped model in the 2007 illustration.

Ultimately the outcome of this transition will be determined by whether or not the stepped model is delivered, and by the effective reinvestment of the “enveloped” recurrent funds required for operating each of these steps.

Should it turn out that these funds are insufficient to run all of the places in the steps, the Office of the Public Advocate would argue that additional funding should be sought. The Stepped Model numbers are reasonable, and there has been no suggestion that this state could operate with less than the stated numbers. If on the other hand any of the steps cost less than expected to operate, then there is an argument that the enveloped funds should be re-allocated to provide more places than those promised as there is already significant demand for some of the steps. (That is, it should be invested to provide more places for clients given the current demand for some of these new services.)

Update on matters raised in 2009 report

Last year we acknowledged positive changes following the implementation of the reform plan as well as describing areas of concern.

The *positive changes observed* last year included:

- The new capital program which has seen the construction of new adult and psychogeriatric inpatient units.
- The work of the three community recovery centres (CRCs) that admit people for 3-6 months of residential rehabilitation.
- A greater access to non-government support services due to increased funding.

This year we received further positive reports about the operation of the CRCs. We are aware of cases where all three centres have been prepared to accept people with very high needs, some not strictly meeting their formal criteria.

We hear positive stories of people being assisted by these programs, sometimes after long periods of illness and disability. While some of this success has been due to a combination of the centre’s rehabilitation program and the prescription of modern medications, other people have improved when the only change has been the rehabilitation program itself without the

new medications. As in any program there are also times where people have not been helped, but we have observed that the centres have left the way open for people to return for a second time.

Our observations are only one perspective. We are also aware that some service providers have found the entry criteria restrictive, and have only referred small numbers of people to the program for this reason. They consider that a greater range of people might be assisted by this type of program. Our office will await the more formal evaluations of the operation of the CRCs (including qualitative work underway at the University of South Australia (2010)).

However it seems that the CRCs have generated a level of demand that they find difficult to meet in a timely way. The main problem our office observes is consumers having to wait for a place to become available either on a ward, at home or in a supported residential facility.

At the time of preparing this report it had been announced in the 2010-2011 State Budget that CRCs would be transferred to the non-government sector resulting in “a more cost effective service” for a saving of just over \$2M per year (Department of Treasury and Finance, 2010; Vol 6 page 105). A critical question will be whether this savings target is reasonable, and in particular if services can continue to be delivered effectively at such a dramatically reduced cost irrespective of whether the operator is perceived to be cost-effective or not. Arguably any savings from such a measure should be reinvested in mental health clinical or support services.

With the respect of non government community support, consumers are continuing to access a greater range of community support services than in the past because of additional funded NGO services. This has enabled people with significant disabilities to pursue rehabilitation goals. There are frequent examples of clinical and support services working closely together. An example is where a person at home needs twice daily visits and this responsibility is shared by government Mobile Assertive Care Service clinicians, and NGO support workers.

The *matters of concern* in our report last year were:

- Aboriginal and Torres Strait Islander mental health.
- Early intervention
- Services for people with chronic and complex needs.

Each of these topics is discussed in the following sections.

It is also important to note the significant capital works program in mental health that has been underway for some years and continued at an active pace in 2009-2010. While this review focuses on programs and services, the building of new facilities should form a base for better service delivery in the future.

Aboriginal and Torres Strait Islander Mental Health

Last year we observed that there were many instances of innovation and development in Aboriginal mental health services, that has mostly been developed directly by front line services rather than as a result of system wide planning. This has led to some areas of excellence, but also significant gaps. Local innovations such as this need to be complemented with central planning to ensure services are generally available for Aboriginal people.

The Social Inclusion Board (2007) noted the major concern of Aboriginal advocates that Aboriginal people may not benefit from broad change in mental health reform. The Board considered that there needed to be a specific and concerted effort to make reform benefits flow on to Aboriginal people. Implementation would require strong leadership from the top (Social Inclusion Board, 2007). It was expected that a leadership group would undertake strategic audits of progress against key measures and report to the Chief Executive on progress and options for improvement for Aboriginal people (Social Inclusion Board, 2007). There is still a lack of tangible outcomes in this area, both in the development of new initiatives and in the production of strategic audits to objectively measure progress.

We are concerned that a key report telling the stories of Aboriginal mental health consumers, their families and communities is yet to be released although data collection that occurred in December 2008. It is now expected to be released soon. Action plans will need to be developed in response to the issues raised in the report. We look forward to the results of these deliberations and hope that they incorporate the high level leadership and outcomes measurement envisaged in the Social Inclusion Board plan.

As we are entering the last years of the Social Inclusion Board 5 year plan, progress in the area of Aboriginal mental health can only be described as painstakingly slow. At the same time, in the community the immediate and pressing needs remain. While dedicated mental health workers (including those in Aboriginal health services) and GPs respond as best they can, the amount of unmet need in all age groups is significant.

Young people (particularly teenagers) mostly do not seem to have easy access to culturally appropriate youth services. Generic youth services and hospital emergency departments try to cope. The lucky ones do link into culturally appropriate services, but the workers in those services can be overwhelmed by demand. School counsellors cope as best they can if consulted. The Social Inclusion Board report, as a general recommendation (not only related to Aboriginal and Torres Strait Islander communities), said that South Australia should be working towards professional school based counsellors who themselves practice in partnership with specialist child and adolescent services. Such services could be particularly beneficial to many Aboriginal children who do not access clinic based services outside of school providing that these professional counselling services were to be delivered in a culturally appropriate manner. Dealing with grief, loss or trauma early may then prevent the later development of illness.

Older people also fall through the gaps created by artificial institutional divisions between mental health, disability and drug and alcohol services. Once again hospital emergency departments, the housing sector and aged care attempt to fill the gaps as does the legal system. On so many occasions the basic care that can be obtained by the population generally is elusive when sought for Aboriginal people and care, when it comes, can be too late. The eligibility of

younger Aboriginal people for residential care (50 years old and above), while positive, can be abused by services. Sometimes Aboriginal people in their fifties with co-morbid mental illness and brain injury and who are in need of high level supported accommodation, have been placed in nursing home , through lack of any other alternatives. This is not satisfactory for the person themselves or the other residents. It would be possible to provide supported accommodation for adults in this age group either clustered in units, or in small group settings, without needing to rely on the good will of local aged care providers.

The Social Inclusion Board had recommended the creation of a dedicated plan for improving training, recruitment and retention of Aboriginal people in clinical positions. We have not assessed progress in this area, but it is still evident that a lack of such a workforce in mental health services remains a significant factor in preventing further gains. Another related recommendation of the Board called for a dedicated research program for Aboriginal Mental Health care to be based at a Glenside specialist service for Aboriginal people.

Consideration of future plans

We await with interest the new actions that will be undertaken by the Department of Health. The OPA will look for features such as those listed below in any strategy that is released.

- The congruence of any planned actions with the wishes of Aboriginal and Torres Strait Islander communities in South Australia. The plan should be completed using a participation approach with Aboriginal individuals, communities and service providers, rather than as a stakeholder management exercise.
- A basis in Cultural Respect. The Cultural Respect framework (AHMAC, 2004) defines this as the

Recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander Peoples.

- An approach that extends beyond specialist mental health care, and uses a primary health care construct to deliver an holistic approach. The approach needs to consider nations, communities, and families as well as services to individuals. For example Hunter's (2004) table below gives examples of coordinated approaches to address Social and Emotional Wellbeing.

Level	Activity
Society	Social justice, reconciliation
Community	Community development empowerment
Family/clan	Family wellbeing and parenting programs
Individual	Indigenous therapies Adapted/appropriated therapies (e.g. narrative therapy) Culturally appropriate conventional therapies

For this reason a strategy cannot just be developed from within mental health.

- The strategy addresses the key issue of *access*, and the lack of it. A common problem reported to our office by consumers, families, communities and providers is lack of access to service, lack of coordination and lack of follow-up. The problems we hear are greater than those experienced by the rest of the community. They can be addressed through the provision of additional services designed to meet the common service standards as they apply to services to children, young people, adults and older people.
- Given the requirement for strategic audits –a system that identifies and monitors Aboriginal clients as they travel through the care system. This could indentify gaps and changes over time in areas such as early intervention and follow-up care and support.
- An approach that links the plan with workforce training, research in clinical care, the operation of a specialist centre, that measures progress through regular strategic audits.

Early intervention

The Social Inclusion Board considered that the development of specialist service for first episode and early psychosis clients should be fast tracked. In this context, the response to establish this service was modest and slow, notwithstanding the energy and drive of the staff on the new team.

In 2009 a specialist early psychosis service began – the Early Psychosis Intervention Service (EPIS) based at Parkside. This is a small team funded on a budget of \$400,000 a year for four years (Department of Health, 2007) with a little further supplementation to cover the salaries.

In discussions with Department and the Minister our office has acknowledged that the EPIS is a positive development, but advocated that more teams are required because of the demand for services and the difficulty for a few people in one team to change a whole service. The EPIS model is a hub and spoke model –the functions of the hub and spoke are illustrated diagrammatically below.

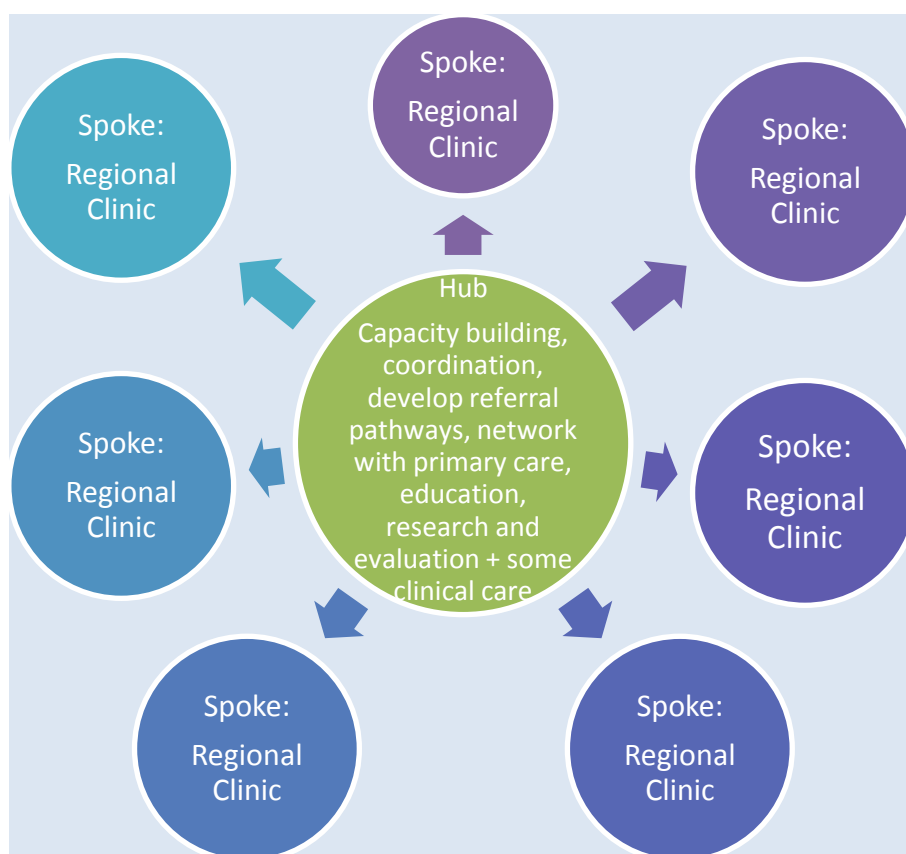


Figure 8; Functions in A Hub and Spoke Model. The hub is the EPIS team based at Unley. The spokes are mental health regional teams based around the state. This diagram has been prepared by the OPA based on information in briefings from the Department of Health.

Spoke functions include:

- Clinical service provision
- Case management
- In reach to hospital and intermediate care
- Refer to a range of services coordinated by a hub

In April 2010 the Council of Australian Governments (COAG) announced national funding of \$24.8M over 4 years to expand the Early Psychosis and Intervention Centre (EPPIC) model based on its success in Victoria (COAG, 2010). This will focus on the needs of 16 to 25 year olds. This corresponds to an increased investment of \$2.8M over 4 years for South Australia (Minister for Mental Health, 2010), or \$700,000 per year. It is not yet clear how these additional funds will be allocated in South Australia.

At the same time through COAG the Commonwealth has agreed to provide \$78.3M over 4 years to deliver up to 30 new headspace centres around the country. This will translate into approximately three in South Australia. Headspace centres bring together a range of youth services, and importantly seem prepared to tackle both mental health problems and drug and alcohol problems. They would be an asset at a range of metropolitan and rural locations. We have been particularly struck by the need for such a centre to assist Aboriginal youth in Port Augusta and the Far North, and by the examples in other states where such clinics have been successfully hosted by Aboriginal community controlled health organisations.

Early psychosis service guidelines

It is worth reflecting on the expectations of early psychosis services and the standards that they need to meet.

Critical to an effective service is a prompt response. Internationally the traditional approach in mental health services has been to expect patients to cross a high threshold of disturbance and risk and to have significant disability to “earn” continuing care (International Early Psychosis Association Writing Group (IEPAWG, 2007).

This leads to delays in treatment, and unnecessary prolongation of the duration of untreated psychosis (DUP). In many studies, a long duration of untreated psychosis has been shown to lead to poor longer term outcome (Singh et al, 2007) and also to lead to toxic structural changes to the brain which can be measured both in the short and long term (Penttila et al, 2010). Although there is no formal definition of what a long duration of untreated psychosis is, it would be reasonable to conclude from the research evidence (as described by Singh et al, 2007) that clinical services should seek to reduce the duration of untreated psychosis to under 3 months, and at least under 6 months.

Best practice standards for services have been well described in the International Guidelines (IEPAWG, 2007) and Australian modifications such as the EPPIC 16 clinical guidelines (<http://www.eppic.org.au/eppic-clinical-guidelines>). The international guidelines recommend intervention in pre-psychotic at risk individuals before they become ill, as well as close follow up of the first episode. Psycho education, counselling and family support all play a role. For people who are in the prodromal phase of their illness this may involve providing services to young people who are withdrawn, performing worse at school or work for a sustained period or are distressed or agitated for no particular reason, or have low level sub-threshold symptoms (IEPAWG, 2007). Many of these individuals are also using illicit drugs which may affect their mental state.

This year Catts et al (2010) published the results of a census of Australian public mental health services assessing their implementation of early psychosis best practices. The survey described

disturbingly high variability in the implementation of these practices across the country, and identified particular concerns for consumers of rural and remote mental health services.

To reduce the duration of untreated psychosis, early psychosis services need to be promoted in the community, and people encouraged to come forward. (This can be before a person becomes so unwell that they may no longer wish to seek help). Catts et al (2010) noted that low levels of service promotion “are consistent with the view that under-resourced mental health services managed demand by limiting access, or at least not encouraging early referral.”

The statistical analysis also examined service characteristics that might predict a better response. Only one was significant – the value of identifiable resources allocated to early psychosis services, suggesting that for effective early psychosis intervention resources must be quarantined to prevent these resources filling other gaps (Catts et al, 2010).

It is difficult to get a precise view of South Australia’s position from this published census. South Australia had the lowest response rate of any state – only 4 services out of 12 responded to the authors, which compared to a 60% national response rate. Results for the smaller states were grouped together, and were poorer than those in New South Wales and Victoria (Catts et al, 2010)

Instances of untreated early deterioration

Each year, the Office of the Public Advocate sees a number of instances of carers and family members desperately seeking help to obtain treatment for people in their early 20s. Typically this is for a young man who becomes irritable and withdrawn, but who has fluctuating symptoms that may be relatively non-specific – vagueness, fearfulness and unpredictable decision making. In some cases increasing apathy is also a problem. There can be multiple assessments from mental health services, sometimes drug and alcohol services, and involvement of the police. Because the person is not accepted for a case management service, they are seen by many different clinicians who then make cross sectional assessments, but are not in a position to pick up subtle longitudinal patterns of deterioration.

In the absence of psychotic symptoms unusual behaviours are put down to drug use, and violent behaviours are considered suggestive of antisocial personality and requiring police involvement. There can be disputes between clinicians about diagnosis, and not uncommonly, conflict between mental health services and carers. Carers who push for more services for a young adult child can be portrayed as over worried, intrusive, and to be part of the problem. Only with time when a more typical symptom pattern has developed are carer concerns finally accepted and referrals for ongoing services made.

A systematic response to young people would ensure that services would engage earlier in such situations, addressing both mental health and drug and alcohol problems.

Future plans

As noted the current EPIS model is described as a “hub and spoke” model. The small hub of less than a handful of people is expected to change and influence the practices of hundreds of practitioners across the state.

Given the size of the team this approach is all that can be done, as it would be unrealistic to expect that young people across the state receive services from one small community based group. It does require practitioners to balance the expectations of early psychosis service delivery with other demands. The evidence though would suggest that there should be designated early psychosis services instead.

Our SA system retains the traditional transition point between Child and Adolescent Mental Health Services and Adult Mental Health Services; people under 18 receiving services from the former and over 18 from the latter. Young people invariably need the developmental and family skills that have been the expertise of CAMHS services on the one hand, with skills in psychosocial rehabilitation, pharmacotherapy and community case management that are familiar to adult services on the other.

The alternative to the age 18 to transition between CAMHS and adult services is the creation of dedicated young persons' services to meet the needs of teenagers and young adults. Age ranges can be either 16 to 25, or in some cases 12-25. In South Australia there has been a reluctance to do this, and perhaps at one level there is a good reason not to look for simple structural solutions. However, such programs can make it very clear whether resources are allocated to early psychosis or not and ensure that time and resources for early intervention are quarantined for that purpose.

It is hoped that there will be greater expenditure from the Commonwealth to further support designated early psychosis services. However, South Australia is coming from a low funding base, and the additional Commonwealth funds should not absolve the state from making further investments so that youth wherever they live can have access to mental health workers with early intervention expertise.

In conclusion

- The existing early psychosis strategy is positive, but would seem to be overly optimistic in its desire to use a hub and spoke model to transform a system.
- Recent Australian evidence suggests that the quality of the response to early psychosis is directly related to the dedicated resources provided in this area.
- The strategy of offering dedicated young people's services for youth and young adults up to 25 needs further consideration. Given the success of such models in other states, the time may have come to look at this problem differently in our state. Whereas the question in the past was whether or to make the change, the question now has increasingly become how it can be justified not making the change to a model of providing dedicated services for young people that has delivered results elsewhere.
- Best practice is now reasonably well defined. The care of all people in the mental health system in this age group can be reported against the early psychosis standards – currently defined internationally and by EPPIC, but with new Australian standards also expected. In reviewing programs in the future it will be possible to map service performance for young people against these standards.

Services for people with complex needs

Our report last year described significant waiting times for people with chronic and complex needs to receive services. This situation continued in 2009-2010.

In addition to waits for supported accommodation, many consumers with significant needs also have difficulty accessing community case management, personal support services, and a range of non-drug therapies.

Waiting for high level supported accommodation

Our office has made repeated advocacy approaches to the Department and to the Ministers for Mental Health during this period seeking services and support for individuals. The responses we have received from managers, clinicians and ministerial officers have been energetic and helpful. While this is very positive and most appreciated by clients and advocates, when system reform is complete, such services should be routinely available without the need for such intervention.

The group who are most obviously waiting are those who have become “stuck” in an acute ward. Living in an acute ward for months – or for some people up to two years - can be a demoralising experience. For a person whose acute illness has stabilised and who seeks a calm place to live, the acute ward environment is continually unsettling as new acutely unwell people are admitted. This can lead to personal disappointment because these people respond to care and leave the ward quickly, while the “stuck” consumer is the one left behind in the place that they do not wish to be in. These consumers see literally hundreds of people arrive and leave. Inevitably this in itself leads to demoralisation, depression and agitation.

It can still take months for a solution to be found for some individuals who need supported accommodation and are waiting in hospital wards. People in this group mostly have a combination of conditions –for example a primary psychiatric illness that has been associated with substance use leading to brain injury, and general medical illnesses. While our office deals with a small number of cases of people who have stayed for extreme lengths of time, when we visit wards there are often others who have stayed on wards for extended time for similar reasons. While their stay may be a few days or weeks longer than required, rather than months, it is still unhelpful for them to be there, as well as to others who may be waiting for that bed.

The other group of people that we hear about are those who are waiting for a place at a community recovery centre. As noted earlier our office is aware of the positive regard which has developed for these centres and shares the frustration about long delays in admission.

In last year’s report we tabulated the progress in rolling out beds under the stepped model. This table has been updated below for 2010. Once again it demonstrates that we have been at a critical point of low bed numbers during the transition. This will eventually be relieved as 24 hour supported accommodation and the new secure rehabilitation ward come on line as part of the Glenside redevelopment.

In the meantime, flow-on problems remain for acute wards. A number of acute ward beds are due to be closed in coming months so that recurrent funding for these beds can be reallocated to the new Intermediate Care Centres. In last year’s report we stressed that the transition process

should make allowance for the numbers of acute beds currently being occupied by patients who have long term needs – people who should be in a long term community placement or a hospital bed if one were available. Acute bed numbers are modelled on a presumption that beds are being used for acute purposes. Therefore, beds currently occupied by people who would otherwise be in a longer term placement are already effectively ‘closed’ for acute purposes.

Medium to Long Term Mental Health Beds	Pre-existing prior to reform	Mid-2009	30 June 2010	Completion of reform
Traditional “extended care” beds	129	60	40	0
New Secure Extended Care	0	0	0	40
Community Recovery Centre	0	60	60	60
New 24-hour supported accommodation	0	0	20 (“The Glen” ward is currently used for this purpose)	73
TOTAL	129 beds	120 beds	120 beds	173 beds
Additional intensive community support. (Not 24-hour support) “Returning home”	0	50	52 (20 consumers in transition)	Transition funding to be ongoing added to the pool of NGO funds.

Figure 9: Transition in long term bed numbers (figures for the eventual final number of beds obtained from Stepping Up brochures, Government of South Australia, Feb 2007, June 2007, August 2007 and updated brochure April 2008) 2010 estimates have been made by the Office of the Public Advocate based on information obtained in discussion with officials and clinicians

In addition, during 2009-2010 our office requested further information about the transition of long term aged care places. A table has been prepared illustrating this transition based on the information provided to us (see figure 10 below). In keeping with models interstate the care of people who have long term care needs due to behavioural and psychological symptoms of dementia will occur in the aged care system rather than the specialist mental health system. Resources will be relocated to providing more community psycho-geriatric care, including in reach into nursing homes, as well as specific transitional and intensive care behaviour support units for people with high level needs that cannot be met in existing nursing home closed units for people who have dementia.

We will review this further in the coming year. The involvement of the aged care sector would seem to be a positive. Critical in the implementation of this reform will be the redirection of all existing clinical resources into the clinical delivery of care in the new model, and the commissioning of the transitional and intensive care behavioural units which will play a significant role. Without these units there is a risk that the aged care stepped model could become unbalanced and acute psychogeriatric wards may end up using their bed capacity to provide long term care

–Figure 10. FUTURE OLDER PERSONS MENTAL HEALTH SERVICES (OPMHS)

Proposed future non acute bed numbers and Community team positions

State funded long term care for older people	Pre-existing prior to reform	Mid-2009	30 June 2010	Completion of reform
Traditional “aged extended care” beds	72 (In addition there were 55 Commonwealth funded nursing home beds = total 127 beds. Note that only 40 of the 55 licensed beds have been used at Makk and McLeay Nursing Home for some time and hence the usage was 112 beds. The 15 licenses are still held by OPMHS)	48 Closure of 24 beds in Acacia Ward	40 Closure of additional 8 of the 24 beds in Jacaranda Ward	0
Transitional Care Units (TCU's) (owned and managed by the NGO sector with in-reach support by Older Persons Mental Health Services) Step-up and step down	0	0	0	24 Three groups of 8 beds.
Intensive Care Behavioural Units (ICBU's) (owned and managed by the NGO sector with in-reach support by Older Persons Mental Health Services)	0	0	0	40 Five groups of 8 (Note – 15 Commonwealth licenses above the 40 beds available for future expansion beyond 2016 or contingencies through Older Persons Mental Health Services)
TOTAL	72 beds	48 beds	40 beds	64 beds
Additional Older Persons Mental Health Community Staff	57FTE's pre-existing metropolitan staff	0 additional	7.0 FTE staff for Country Health SA (funded by COAG sub acute funds)	40 FTE staff (funded by former inpatient funds) Plus 10FTE in-reach staff from community teams to support ICBU's and TCU's (funded by former inpatient funds) TOTAL 50 FTE additional within community teams (funded by former inpatient funds) making a total FTE community team numbers of 107FTE + 7.0 FTE COAG

Notes for Figure10:

The above beds are for people with a mental illness or severe behavioural and psychological symptoms of dementia (BPSD). Number have been calculated by the Office of the Public Advocate based on information obtained in discussion with officials and clinicians.

We are informed that as of September 2010 the above community FTE staff (including in-reach) are indicative only to be confirmed when a formal Business Case is completed by June 2011. Similarly ICBU bed numbers are contingent on negotiations with the Australian Government (which we understand will determine how patients are referred and discharged from these units).

Access to case coordination and intensive support

This year the Department of Health released a document describing a new community model of care for metropolitan services (SA Health, 2010). This was in response to the Stepping Up report, as well as 22 recommendations from a more detailed review of Community Mental Health Services in South Australia conducted by the Department in 2007 and reported in early 2008 (SA Health, 2008).

Our observations of mental health service delivery in 2009-2010 need to be seen in the context of these plans. The new model of care has yet to be implemented and so we would not be expecting significant changes yet. The experiences of our clients have been more in line with what was described in the 2008 review. It is worthwhile recapping some of that review's observations and recommendations.

The Community Mental Health Review (SA Health 2008) described inconsistency of access to the service for consumers. The review noted

It was very clear that the potential for consumers to "fall through the cracks" is very significant and that transfers of care do not seem to carry any level of accountability (page 13).

It went on to say

In conclusion it was apparent that there was no consistent or agreed pathway for consumers to access service in the public mental health services (page 13)

With respect to the continuum of service delivery that report noted

There was no sense of an overall continuum of care. In some places it seemed that a consumer could stay with a team for a period of time and then had to move on regardless of need. The review team heard someone described as not fitting in with the system. The concept of putting the consumer's needs first was not a strong theme (page 14).

The report made a number of detailed recommendations.

For community mental health teams it recommended providing every consumer with an individual needs assessment, a key worker, the delivery of local services, emergency care in the community, and seamless transitions (SA Health 2008, page 23).

The 2010 Model of Care responds to these problems positively. It is a detailed document that describes each aspect of the consumer's journey. Some outcomes have been taken from the document and illustrated in figure 11. These features have been selected by us from the SA Health document because we consider them to be significant in addressing the problems of accessing services experienced by both our advocacy and guardianship clients.

Figure 12 is included to provide further context. The diagram is extracted from the SA Health document and lists the features of the model more comprehensively.

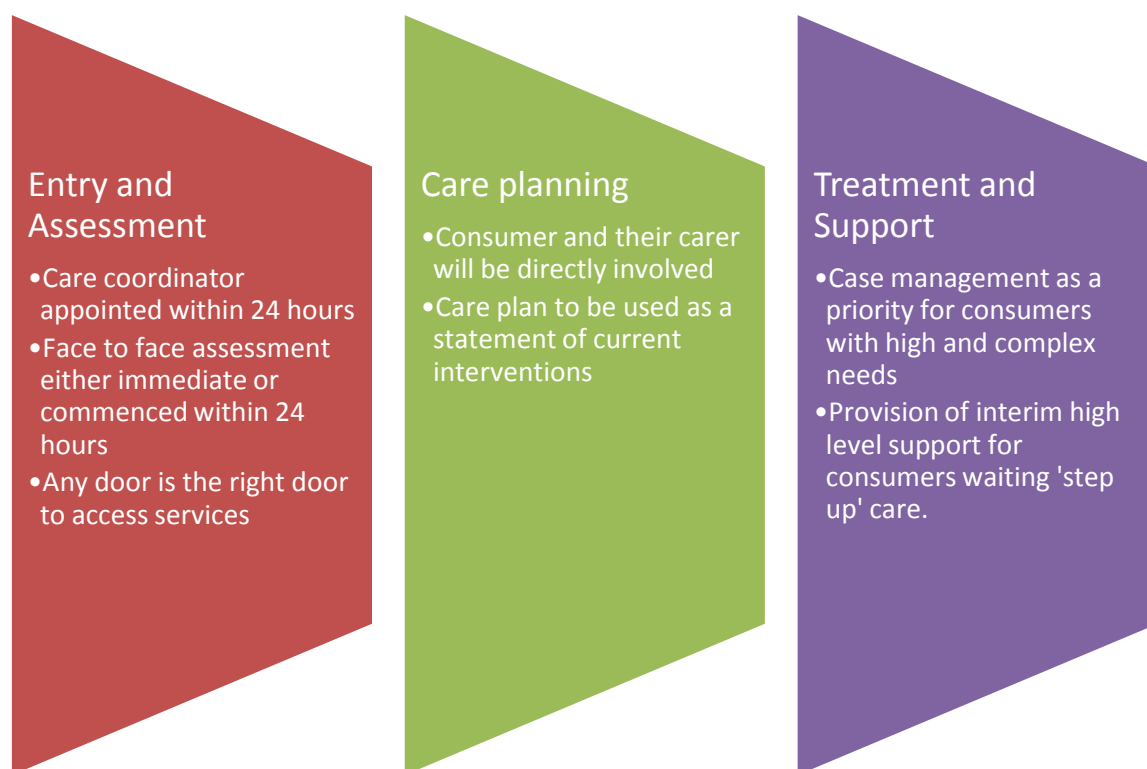


Figure 11. Some key outcomes for consumers from the new Model of Care (details extracted from the Model of Care document (SA Health, 2010)).

The provision of care coordination and case management may seem like obvious requirements, but our office has been surprised by the extent to which these services are not provided at the present time. Because of the current variation in the system it is not possible to extrapolate across the metropolitan area, however the gaps that exist in some clinics and regions are significant, probably affecting hundreds of people.

In 2010 clients are not routinely allocated a care coordinator in some clinics but instead receive a more limited service.

Need for care coordination

In those clinics, people with significant disability from psychotic illness have regular medical reviews and visits with a nurse for the administration of depot antipsychotic medication. This replicates a model of care common in outpatient departments of psychiatric hospitals 20- 30 years ago. The medical staff have significant patient numbers, and the time that they have available for case coordination tasks is limited. More often than not diagnosis and mental state is reviewed, medication is adjusted, letters written to GPs and advice given about housing and support services. However this is not the more comprehensive “broker or navigator function” given to the care coordinator who has a role to “coordinate, broker and oversee provision of multidisciplinary (MDT) care plan to consumer and carer. (SA Health, 2010).

Diagram : Consumer Pathway

Pathway	Principle	Processes
ACCESS	<i>Any door is the right door Consumers will always receive Good Service</i>	<ul style="list-style-type: none"> Consumer & carer are provided with contact name & number Recognition of consumers and carers as our central concern
ENTRY	<i>No barriers to entry</i>	<ul style="list-style-type: none"> Triage processes are in place All Triage Services are aware of & implement new MoC principles, pathways & processes Consumer Data is entered on IT system immediately
ASSESSMENT	<i>Core skill for all MH workers</i>	<ul style="list-style-type: none"> Consumer & carer are provided with contact name & number Use SA Standard MH Assessment & Risk Assessment document ("standard Assessment document") which includes Physical Health assessment Data is entered on IT system immediately All Treatment/care needs are established Standard Care Plan is developed in consultation with consumer & carer Care Co-ordinator / Case Manager is appointed as per consumer & carer needs & degree of complexity (ie: multiple agencies involved) Contact details for CC/CM are entered on IT system immediately
CONTINUITY OF CARE	<i>Always act in consultation with consumer & carer</i> <i>Always be responsive to consumer & carer requests for variation in level of care</i>	<ul style="list-style-type: none"> Regular/scheduled review of Care Plan with Consumer & Carer Regular/scheduled re-assessment is conducted with Consumer & Carer Data is entered on IT system immediately Overview by Care Co-ordinator / Case Manager – advised of any changes
INTERNAL MHS TRANSFER OUT OF CMHC (eg INTO BED-BASED CARE, OR TO NGO)	<i>Transfers to bed-based care or NGO provider do NOT constitute discharge from CMHC</i> <i>Electronic Records follow consumer (No retelling history)</i> <i>Always be responsive to consumer & carer requests for variation in level of care</i> <i>Always act in consultation with consumer & carer</i> <i>No barriers to re-entry and No direction to re-enter via Triage</i>	<p>Example: Step-up care episode requires transfer to bed-based services, or most services are provided by an NGO</p> <ul style="list-style-type: none"> Decision to transfer care made is in consultation with consumer & carer Care Co-ordination remains in place at all points of pathway Data is entered on IT system immediately Update Care Plan Provide consumer & carer with contact name and number at new care location Advise Care Co-ordinator/Case Manager of any change in level of care When episode settled, consumer returns to CMHC and enters at "Continuity of Care" point in pathway (NOT via Triage) Advise Care Co-ordinator/Case Manager of any change in level of care Full and proper handover occurs, with both parties named & signed; data entered into electronic record within 24 hours
DISCHARGE - EXIT TRANSFER TO AN EXTERNAL CARE PROVIDER eg: GP, NGO	<i>Electronic Records follow consumer (No retelling history)</i> <i>Always act in consultation with consumer & carer</i> <i>No discharge into homelessness</i>	<ul style="list-style-type: none"> Decision is made in consultation with consumer & carer Standard Discharge Plan is completed (to be developed) with copy to consumer/carers and to new provider Utilise Standard Referral form (to be developed) Data is entered on IT system immediately Consumer & carer are provided with contact name & number Consumer records demonstrate/indicate housing/accommodation arrangements and duration in place at time of external transfer
RE-ENTRY TRANSFER IN TO CMHC - ENTER AT CONTINUITY OF CARE	<i>NO barriers to re-entry and No direction to re-enter via Triage</i> <i>Electronic Records follow consumer (No retelling history)</i> <i>Always be responsive to consumer & carer requests for variation in level of care</i>	<p>Examples: after an absence of several months, recurrence of symptoms, early warning signs or return from bed-based care</p> <ul style="list-style-type: none"> Assessment conducted Use standard Assessment document Data is entered on IT system immediately Revised Treatment/care needs are established Revised Standard Care Plan is developed in consultation with consumer & carer Care Co-ordinator / Case Manager is advised of re-entry

Figure12. Consumer Pathway diagram from the new Model of Care April 2010 document (SA Health 2010)

While in many clinics the nurse providing the depot service will now spend more time with their clients than was the case in the past, and take a greater role, this is generally not equivalent to the role of a care coordinator.

This scenario creates a minimal involvement that can sometimes suit the needs of those consumers who do not want to be engaged with the service. It can also suit the service's need when it does not have the resources to engage fully with all the consumers under their care. For a consumer, a community treatment order may be in place. Apart from turning up for injections and the occasional doctor's appointment, little more may be required. For the busy clinic with too many clients, it can be possible to manage many clients this way.

The result though can be significant under-treatment, and a failure to deliver best practice. Non-drug therapy, skills rehabilitation (eg through referrals to non-government services) and trials of new oral medication are all options that might be delivered but are not through a lack of staff resource. The more passive model is one from the past, when improvement was not considered possible and people with illness were discouraged from making life goals. This is in contrast to our knowledge today about the benefits of active engagement with clients, the provision of skills based rehabilitation services, and the need to make this relevant by working towards personal goals.

Our office hears about problems of under treatment principally from concerned family seeking more active treatment for an unwell family member. It seems to them that their family member has been left to live with their psychiatric disability without all options being tried. This is not to say that such interventions will always be taken up, or be successful. There is a strong argument however that everyone should be offered the best practice rehabilitation and treatment, encouraged to try it (having been informed about the benefits and risks) and should it fail, be given alternative support options in the future.

It is important to note that this pattern of low levels of engagement is not pervasive. There are many clients offered intensive community services and the pattern varies from clinic to clinic. We have been told by service providers of at least one clinic, that because of its large caseload, manages the majority of its clients using the low intervention strategy described above.

Access to trials of clozapine and intensive rehabilitation

A related matter is the preparedness to prescribe the drug clozapine, an atypical antipsychotic medication that is recommended for people who have treatment resistant psychosis. For some people it can have a significant benefit, and so it is considered desirable to offer a trial to any person disabled by continuing symptoms.

This drug though requires more time from services than the low intervention alternative – the ongoing use of depot medication. There are two principal reasons for this. The first is that the drug can have significant medical side effects so close monitoring and testing is needed particularly during the initial period of the drug being commenced. The second is that, unlike other medications, the drug can only be administered as an oral preparation. This means that, as it is trialled, a client may need to be visited daily to check if medication has been taken. If the medication is effective, after the first few months a person will usually be prepared to take the medication without prompting.

It has been our experience that it can take significant advocacy to mental health teams for clients to be offered clozapine, particularly when the client does not have either a case manager or access to support services to assist with the undertaking of daily visits. We hear similar reports from service providers of a reluctance to consider clozapine because of the limitations in community services' ability to see clients frequently during the start-up period.

Furthermore some of these clients may also need access to a community recovery centre as benefits from clozapine can be optimised by providing quality rehabilitation at the same time.

Key requirements of the new care model

Some of the key outcomes of the new model, if delivered, should address the problems that our clients currently encounter. The rapid provision of care coordinators to all clients will enable a comprehensive plan to be developed and a wider range of non-drug services to be offered to clients. Case management will assist high needs clients requiring a greater range of services.

The provision of interim high level support assist people who may need intensive rehabilitation from a community recovery centre, possibly with clozapine therapy as well. Currently they either wait in hospital or are discharged with only standard supports risking deterioration while waiting for a community recovery place to become available.

While these aspirations are positive, it will require effective redesign of the services so that they can be met.

In the Disability Section of this document we discussed the potential impact of legislation in developing care plans for people with disability. The new *Mental Health Act 2009* has a requirement for a care plan for people receiving involuntary care. This means that at least for people on Community Treatment Orders it will be possible for these plans to be scrutinised by advocates, the Guardianship Board and others. Although a standard for the plans is not proscribed it is generally accepted that the plan is developed with consumers and carers, and that it will list the range of services that should be provided including counselling and rehabilitation.

Conclusion

2009-10 has seen further progress in implementing the Stepping Up report with facilities development, and the preparation of a new Model of Care for Community Services which places them at the centre of new service provision.

During the year our office continued to encounter problems with access to care similar to those described in the Department's own Community Services Review. There also has been little change in the situation on the ground with respect to the areas of concern considered in the 2008-2009 Annual Report – mental health care for Aboriginal and Torres Strait Islander people, early psychosis intervention and the care for people with chronic and complex needs remain of particular concern.

The next year will be a critical time to see new change to the delivery of services and the operation of mental health programs.

Reviewing Programs and Identifying Unmet Need

Supported Residential Facilities

UN Convention on the Rights of Persons with Disabilities

Article 19

Living independently and being included in the community

States Parties to the present Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community, including by ensuring that:

(a) Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement;

(b) Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community;

(c) Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their needs.

Introduction

A place to call home is a fundamental human need and a person's health and quality of life can improve dramatically when housed. The evidence from programs internationally is that housing a person is a necessary first step in treatment, rehabilitation and improved quality of life (for example Pathways to Housing, 2005; Tsemberis, 2004).

SRFs are shared facilities that provide congregate living with meals, care and medication provision. There is significant variation within the sector in the quality of services delivered. There are good operators who demonstrate what can be achieved. They provide clean home style facilities, trained care and support and some offer individual rooms. Yet it still seems more common than not to find SRFs in buildings that are old, poorly heated and cooled, with inadequate space and privacy, and providing shared bedrooms and common bathroom facilities.

Many people are admitted to SRFs because of the lack of alternative affordable and supportive choices. They are a disadvantaged group, are physically sicker and have a higher death rate than the general population.

This section of the Annual Report describes the current problem and what can be done. In doing this, we recognise that there have been extensive past reviews and reports about SRFs that have identified deficiencies. However the fundamental problem of poor quality living conditions in many SRFs identified in previous reviews remains today.

A number of leaders in the SRF industry have shown that more can be achieved by improving buildings and providing greater support. This improvement underscores a case for widespread change in the

remaining parts of the sector. This section argues that law reform is needed to make this change. The existing *Supported Residential Facilities Act 1992* was developed nearly 20 years ago and does not take into account advances in rehabilitation, care provision and understanding of human rights that has occurred since then.

This section steps through the program review issues we have considered, who is currently living in SRFs and the general health of this population.

The people who live in SRFs, and their care needs

The people living within SRFs overwhelmingly fit the criteria for people served by the office of the Public Advocate. Much of our direct knowledge of SRFs comes from OPA's work with guardianship or advocacy clients who live in SRFs.

Information about all SRF residents was obtained from the Department of Families and Communities and provided to our office in de-identified form. A breakdown of age, sex, diagnosis and geographical region was provided. There were 869 people living in SRFs as of June 2009. Details about underlying diagnoses were available for all but 95 of these clients.

Data is illustrated in figure 10. The majority of SRF residents (52% or 452 people) had a primary psychiatric disability. The next largest group were people who had an intellectual disability (17% or 149 people). Other groups included people who had acquired brain injury, autism spectrum disorders and learning difficulties. Of the 869 clients, the SRF Support Program considered that 391 had high and complex needs. In our experience, co-morbidity (two or more diagnoses) is common and this contributes to the extra support needs of those in the high and complex need group. In addition, a significant number of people also have co-morbid medical illnesses.

The combinations of health issues faced by residents means that managers and staff of SRFs are dependent on both the mental health and disability systems to work effectively. This is for two reasons. One is to avoid unnecessary referrals to SRFs by providing access to rehabilitation. The other is to ensure that their residents do not lose a level of service access that would be provided in community housing just because they are in an SRF. However both the mental health and disability systems are undergoing reform, and have significant unmet demand which negatively impacts on this client group.

The Office of the Public Advocate has direct experience of this in guardianship appointments for accommodation for people who may be placed in SRFs. For example decisions about SRF accommodation are requested for younger people in their twenties and who require supervision of medication. In some cases, the applicant for guardianship (in these instances it is usually a mental health clinician) hopes that a guardian will consent to SRF accommodation when the person themselves or their carers do not agree to this. In other cases the opposite applies. Applicants hope that a guardian will refuse to consent to an SRF and instead put pressure back on their managers for more funding and non-government services to be allocated to an individual so that they can live at home with family or in community housing.

In these situations, it is necessary to tease out whether recommendations for SRF accommodation are based on best practice, or on a narrower view about what is possible with existing resources.

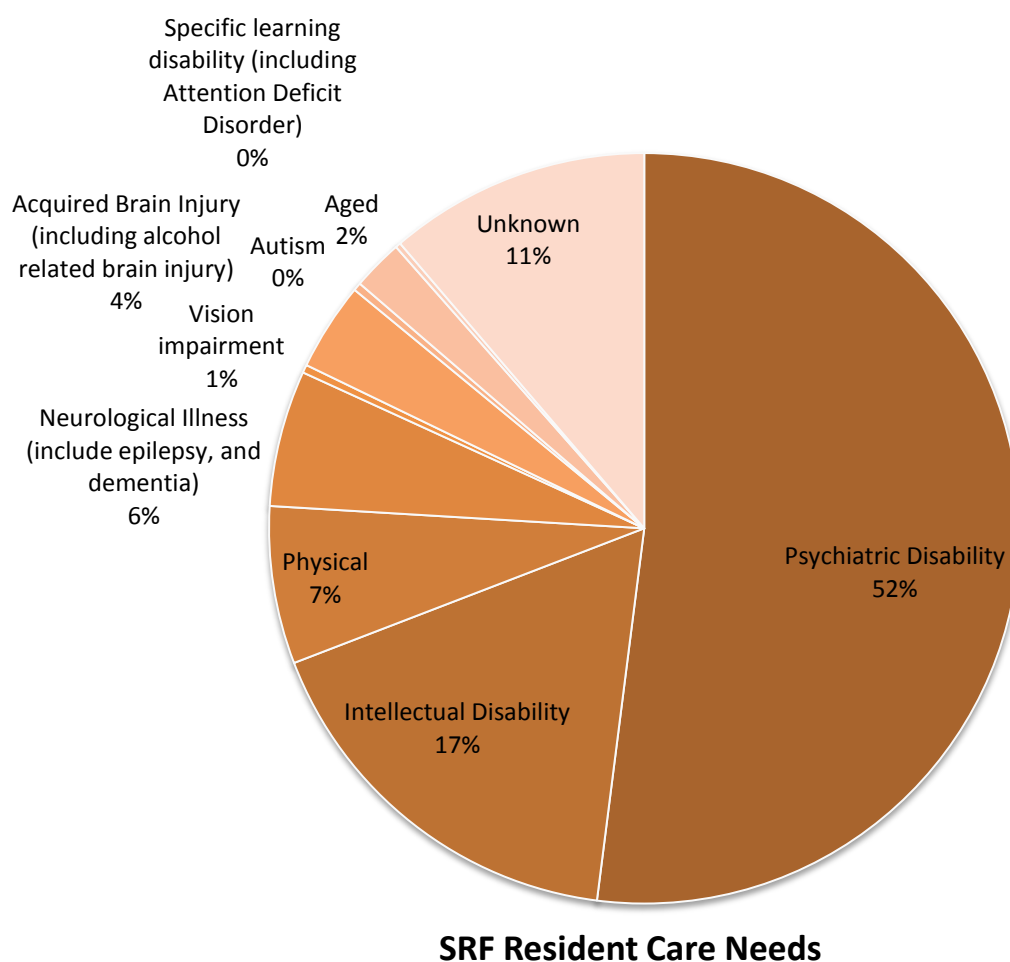


Figure 13. Residents with a disability in SRFs as of June 2009 (869 clients)

Intake procedures that now determine who is eligible for SRF care

In 2009 the Department of Families and Communities established an SRF Intake process requiring assessment and approval by the SRF Intake and Support Team before a person could live in an SRF and receive the Department's subsidy (see financial discussion later). The aim of this single entry point process is to prevent people with inappropriately high support needs entering SRFs. Data from August 2009 showed that in the previous 3 months, the team had screened 126 applicants, and screened out 14, 13 of whom were men who had histories of unsuccessful tenancy, poly substance abuse and verbal and/or physical aggression.

The SRF single entry point seems to have been able to prevent risky placements where higher levels of support are required. Prior to it commencing, we were aware of situations where services wished to discharge people at significant risk of harming others to SRFs, usually with significant professional reservations but driven by a desire to free up a mental health bed when a person no longer required it. In the last year we have not had such situations brought to our attention.

However, the overall intake process is not completely resolved as in mid 2010 there were two emerging issues. The first issue was increasing reports that SRFs have been prepared to accept people without an SRF Single Entry Approval to fill their beds. In these instances the SRF would not receive a government subsidy. We observed examples where SRFs with modern facilities were still in high demand and pleased with the SRF Single entry point, while other SRFs were struggling with vacant beds and frustrated by decisions of the SRF team not to agree to people being admitted to their facility. The second issue involved shortfalls in the staffing of the SRF intake team itself that led to a delay in assessments. Our office understands that this is expected to improve as replacement staff are recruited.

Consideration of the spread of age-groups in SRFs (all residents)

A detailed breakdown based on age and diagnosis is illustrated in figure 11 below.

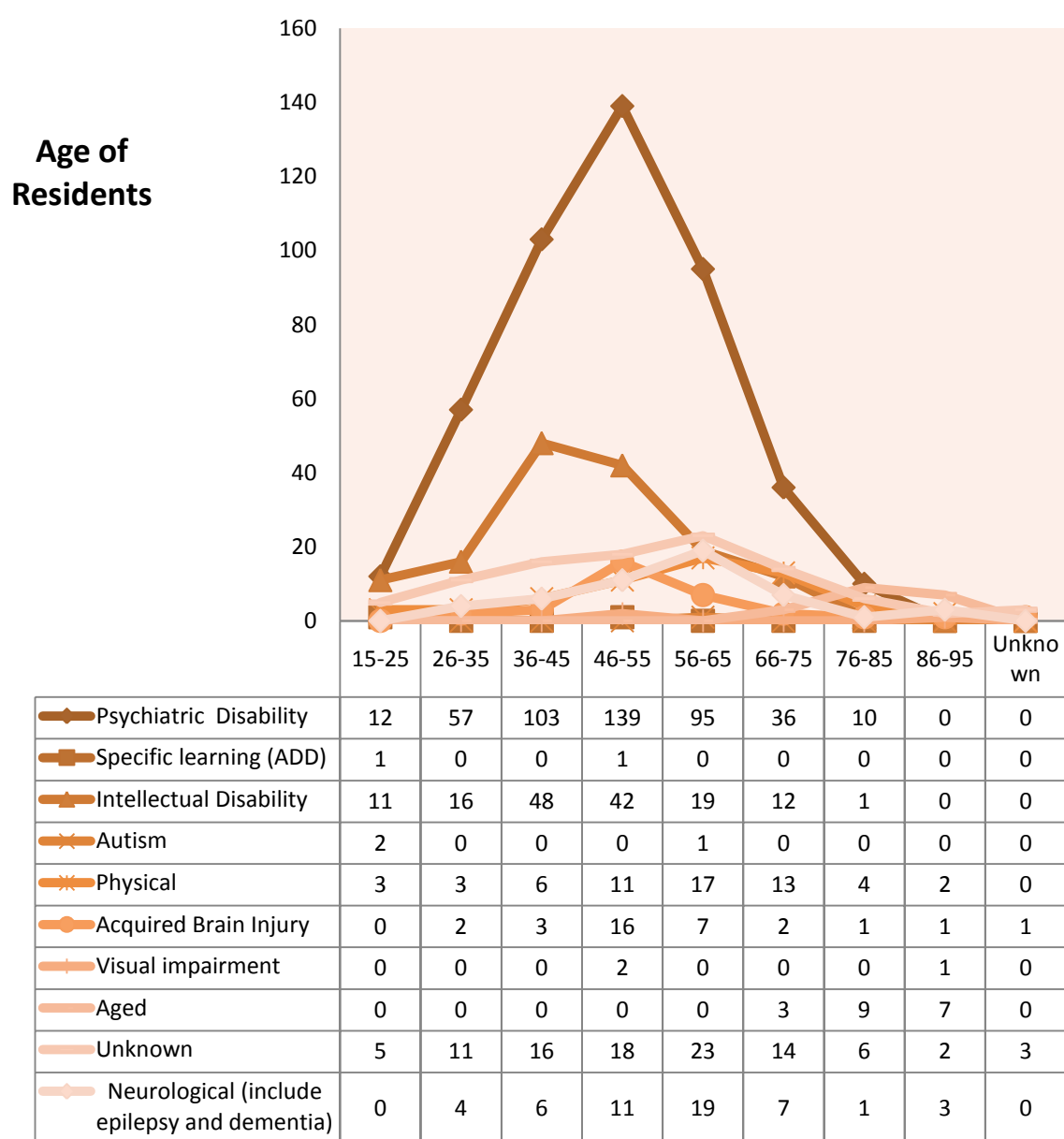


Figure14: Age and diagnosis of SRF Residents

This figure illustrates the significant numbers of people living in SRFs who are in their 30s, 40s and 50s and who have either a mental illness or intellectual disability.

Another feature is the wide spread of ages, and the ongoing acceptance of younger people in their 20s and early 30s into SRFs. Even when younger residents and their families are pleased with the care provided by an SRF provider, having to share a bedroom with a person 20 or 30 years your senior (or junior) in what is to be the person's home indefinitely can be a significant shock for residents and their family.

Some younger people with mental illness require intensive rehabilitation but are sent to an SRF from an acute mental health ward to wait for a vacancy in a community recovery centre. There are risks to recovery because living skills in areas such as meal preparation can be lost while living in an SRF environment. The sometimes subtle early signs of relapse for young people can be missed when a person is living together in a group of other people with long term illness who may have ongoing symptoms themselves.

Are SRF residents homeless?

While many people who live in SRF's would be homeless if the SRF did not exist, they are not considered to be homeless when living in one. Some key definitions are included in the table below:

DEFINITIONS OF HOMELESSNESS	
Primary homelessness	People without conventional accommodation such as those who 'sleep out', or use derelict buildings, cars, railway stations for shelter.
Secondary homelessness	People who frequently move from temporary accommodation such as emergency accommodation, refuges, and temporary shelters. People may use boarding houses or family accommodation just on a temporary basis.
Tertiary homelessness	People who live in rooming houses, boarding houses on medium or long-term where they do not have their own bathroom and kitchen facilities and tenure is not secured by a lease.
Marginally housed:	people in housing situations close to the minimum standard
Source: Originally developed by Chamberlain (1999)	

Figure 15: Definitions of Homelessness

These definitions have significance at both statistical and policy levels. If a person is not considered to be homeless, then there is no need to find alternative accommodation.

Currently, a person living in a boarding house is unequivocally considered to be in a state of tertiary homelessness "because they do not have their own bathroom and kitchen facilities and tenure is not secured by a lease (Department of Health and Ageing, 2006)". This lack of personal facilities also applies in many SRFs, but SRFs are excluded from the homelessness count because the analysts exclude those congregate facilities where 60% or more of residents are in need of assistance with "care activities" (Chamberlain and McKenzie, 2008).

According to these classifications, an SRF resident sharing a bedroom and using a common bathroom would not be considered homeless, even if living in very similar physical circumstances to a resident of boarding house, who would be counted among the 'tertiary' homeless. An SRF resident is not even considered to be marginally housed as the census only applied this definition to people renting caravans at caravan parks and who do not have full time work (ABS, personal communication). It would be more accurate for the next census to count residents of SRFs who are required to share rooms as marginally housed or homeless.

Advances in tackling homelessness

Before discussing the shortfalls in the SRF program in more detail, it is worth reflecting on this state's achievements in tackling primary and secondary homelessness. This demonstrates that difficult social policy problems can be tackled effectively, and that innovative strategies might also be considered to deal with our reliance on shared room SRF accommodation..

There is ample evidence of South Australia's leadership in the area of homelessness including;

(1) the success of the *Street to Home* team which between July 2005, and December 2008, using a Housing First approach , supported 256 people into long term housing,

(2) a reduction in the numbers of people sleeping rough across the state measured in 2006 by the Australian Bureau of Statistics(Social Inclusion Board, 2009) and in the metropolitan area in a 2009 local count (Department of Families and Communities, 2009), and

(3) the development of the exciting new Common Ground unit accommodation in Franklin Street, Light Square and Port Augusta.

Many of the people housed as part of this work have had mental illnesses, a disability or a combination of both. This success reflects the fact that housing was made available (the critical element of "Housing First") and then many non-government and some government organisations supported people once housed.

Photographs of the first Common Ground apartment building (located over the Franklin Street Bus Depot)are illustrated here. One can contemplate the difference between life in one of these bedsit apartments, compared to sharing a bedroom in an old house with a stranger with little privacy. The people who are now offered bed sit apartments may have in the past been placed in boarding houses or SRFs. There is no reason why more current SRF residents could not live in similar homelike surroundings or at least be provided a single room.



Figure 16. Common Ground Adelaide Apartments (from <http://www.commongroundadelaide.org.au/node/22> Accessed 11th September 2010)

Financial Arrangements for SRFs

The operator of an SRF receives two sources of income:

Residents pay up to 79% of a disability support pension for all SRFs. If an SRF charges more than this it would not be eligible for a Board and Care Subsidy provided by the SA Government (with the exception of the one country SRF based at Mt Gambier which can charge 81%).

Following a rise in the disability support pension in March 2010, this corresponds to \$613.30 per fortnight.

The Board and Care subsidy comprises the second source of funds. This was increased by the SA Government in December 2008 at a cost of \$2.26M per year (Minister Rankine, Hansard, House of Assembly, 5 March 2009 page 1897) on top of the original subsidy budget of \$2.16M. This allowed the daily subsidy per resident to be doubled from \$6 to \$12 per day (Carmen, 2009).

Is this enough? It corresponds to an annual subsidy of \$4380 per resident, or \$175,200 per year to the proprietor of a 40 bed SRF (with all beds filled).

The 2003 “Minimum Legal Model”

In 2003 the South Australian Department of Human Services published a financial analysis of Supported Residential Facilities in South Australia (Hunter and Marquette, 2003). The authors costed what they described as a “minimum legal model” which basically replicated the typical structure of the SRFs they had studied, but ensured that the total income covered the expenses of paying staff with “minimum level qualification”, providing suitable hours of care, and costing in the actual rents for premises paid by the SRFs.

The “minimum legal model” was noted by the authors to have non-preferred features. The salary rate for managers was costed at community services level 4 and was not considered appropriate, the food costs were less than a quarter of the costs in a public sector service, and no building improvement funds were allocated beyond what was currently allocated in the industry at that time.

The 2003 “minimum legal model” required a subsidy payment of \$7,500 per resident on top of a payment of 85% of the disability pension (Hunter and Marquette, 2003). In contrast, as noted above, the current financial arrangement in 2010 subsidises a proprietor just \$4380 per year on top of 79% of the pension.

In considering this topic, we have not undertaken any further financial analysis. From our discussions with Department officials, it would seem that the Hunter and Marquette (2003) analysis may have been made assumptions that have overestimated the true costs. Therefore the comparison we have made above between the 2003 “minimum legal model” and current funding while of interest, may not be that useful, if the 2003 figure is an overestimate and the current figure is more accurate.

This suggests that the current payment regime is at a sufficient level to buy the standard of care that is currently being delivered.

In saying this it is acknowledged that different SRF businesses will have different costs, and therefore differing ability to put money back into facilities for clients. In 2003 Hunter and Marquette noted that operators who owned their premises were able to maintain better cash flow than operators who rented a building. Our casual observation (we have not made direct financial enquiries) is that in 2010 this is still the case.

Further financial work has been undertaken in the Department of Families and Communities, who in 2009-10 have been updating the 2003 study and also exploring the option of a purpose built supported residential facility for vulnerable women (Minister Rankine, Hansard, Estimates Committee A 2009 page 177).

Impact of financial factors on the lives of SRF residents

It seems reasonable to conclude that financial factors drive many of the current poor outcomes.

Shared bedrooms

The expectation an adult can live in their own room, and not be required to share with a stranger, is generally accepted. The reason why it does not happen is that, if each person has their own room there will be less people in each facility and the cost per resident would increase. In particular, the fixed costs, such as the salary of a staff member on site on a passive overnight shift will be the same with less resident numbers (Hunter and Marquette, 2003).

Single rooms can provide personal safety, privacy and security of personal belongings. The impact of not having this personal space can be wearing, whether it is fear at night, or just the continual frustration of having belongings taken from a room – such as losing CDs, sunglasses, coffee, craft supplies and then needing to replace them. Not having this safety and security is an additional burden on vulnerable people – one that could be avoided if a single room policy were put in place and funded.

This office contends that the level of the subsidy should be sufficient to provide a single room as a basic human requirement and as a means of providing safety and security for a person and their possessions.

Lack of heating and cooling

The next area related to cost is the maintenance of an adequate temperature in the building (heating and cooling). There is a requirement to heat and cool a common area, but on a cold day or very hot day, it is not possible for all residents to congregate in one place that is heated or cooled. People scatter throughout SRFs and in their rooms. On a hot night some people will bring a mattress into the air-conditioned day room but many will not opt to sweat it out in bedrooms in older buildings that can remain hot from the days heat.

On mid-winter days a guardian can visit some SRFs that are frigidly cold and find residents huddling under doonas in their beds. There can be (in some places) a reluctance to provide heaters and, even when fan heaters have been purchased and stored on site, there can be a reluctance to promote their use. Although other explanations are sometimes offered for this, cost considerations must play a part. There is no question that it is difficult to heat and cool some of these properties. Old large rooms in rented buildings can be expensive to warm with fan heaters. The task can be more difficult if a landlord who is renting a building to an SRF manager has little interest in installing cost efficient heating and cooling. Nevertheless it is

possible. Some operators are able to keep premises warm in winter and cool in summer, and in modern buildings, install air conditioning into the bedrooms of all residents that they can afford to run.

This has been a concern raised with the OPA during the winters of both 2009 and 2010. In summer SRFs have an extreme weather policy to deal with life threatening dangers of heat. This may prevent severe illness, but the constant discomfort, the poor nights' sleep in hot bedrooms must become oppressive. Some residents may also have particular vulnerability to extreme temperature for a number of reasons (including medical illness, disturbed temperature regulation that can be associated with some mental illnesses, and dangers of heat associated with particular medications.)

Variable food nutrition and palatability

The last area is food. Private SRFs need to budget very carefully. Some astute operators are able to maintain pantries, fridges and cool rooms well stocked with healthy foods, and present meals using recipes that are appealing to residents. Others seem to struggle to fill their refrigerator with discount meat and groceries and present more basic food with less alternatives – often high carbohydrate meals and snacks. This is not ideal for people who are on medication that can increase weight, and it increases the risks of diabetes and raised blood lipids.

One of the complaints that this office hears from residents is dissatisfaction with food. Some would like the opportunity to prepare their own meals and some tire of repetitive menus. Residents who are undertaking rehabilitation and those purchasing from local shops may need the opportunity to develop skills in food purchasing and cooking.

Risk of dying in an SRF

The risk of deaths in SRFs was first raised with us just after the extreme heat of South Australia's heat wave in early 2009.

As a population, people with a mental illness or a disability who live in SRFs are at high risk. While some of this risk may be a reflection of poor health over a lifetime, the risk could be reduced by better access to health care.

Gaps in general health care exist across the mental health and disability sectors, not just SRFs. However because SRF residents may have less contact with their mental health or disability workers than people living in other more intensive settings, the risk of a health need being missed potentially be greater. Recently, there has been a concerted effort to provide better access to health care for SRF residents in SA. In spite of these relative improvements, more can be done to ensure care is provided and coordinated.

Increased risk of death for people with a mental illness or disability (not specific to SRFs)

This information below is not specific to an SRF population, but it is reasonable to assume that many people who enter SRFs and then continue to live in these settings would carry these risks.

Evidence to support the greater mortality risk for people with mental illness and disability generally comes from key studies interstate. Western Australia in particular has excellent linked data systems that allow for population based research. In 2001 the report "Duty of Care", described a death rate for people with mental illness that was 2.5 times higher than the general population (Coghlan et al, 2001). The most significant factor in excess mortality was cardiovascular disease. The study demonstrated that people with a mental illness had lower hospitalisation rates for many medical conditions, suggesting that people with mental illness do not receive the same level of medical care for a particular condition compared to the general population (Coghlan et al, 2001).

The following year, another study in WA examined the influence of intellectual disability on life expectancy (Bittles et al, 2002). This study described a highly significant negative association between survival and the severity of intellectual disability. For people with mild, moderate and severe levels of intellectual disability there was a 50% possibility that they would survive to 74 years, 68 years and 59 years respectively (Bittles et al, 2002). Health problems include a greater tendency to obesity, less physical fitness and a predisposition to psychiatric disorders, osteoporosis, thyroid disorders, heart disease, sensory impairment and early onset dementia (Bittles et al, 2002).

In 2008, the Queensland Office of the Public Advocate took this broad issue up as a national advocacy issue, publishing a review "In Sickness and in Health" (Howard, 2008). This review recommended simplified and timely access to low cost health care and dental care, and targeted health education and promotion strategies. The matter was put forward to the National Health Reform Commission Report which noted major gaps in access to primary care and specialist care for people with a disability. It recommended that people with a disability be able to enrol with a single primary health care provider to allow for continuity, coordination and multidisciplinary care (National Health Reform Commission, 2009).

A further insight of the added health risks for people with an intellectual disability comes from the publication in November 2009 of Disability Services Victoria review of client mortality (Intellectual Disability) 2006-2007 (Medical Committee on Client Mortality, 2009). This report described the delivery of health care to residents in community disability accommodation, but it is reasonable to consider that some of the same issues might also apply to the healthcare delivered to people with intellectual disabilities in SRFs, even though people in SRF's as a group may be more able to seek their own care. The Victorian group reviewed the deaths of 42 people who had intellectual disabilities and who lived in accommodation operated by Disability Services. The deaths occurred between 2001 and 2006. The Committee has reviewed the lifetime health care and deaths of 458 people as part of its overall work.

In this report, the Victorian Committee expressed ongoing concerns about the delivery of medical care to people with intellectual disabilities, medical care which is now mainstreamed. These related to the sophistication, specialist involvement, and energy and urgency in health care management. It concluded that care provided to this group was less assertive and less inclined to involve specialists than would be expected for the general population.

Residents of South Australian SRFs receive their medical care from local GPs. There has been a concerted effort to make sure that all SRF residents have a local GP. For some residents this may mean having a regular GP who knows them well. For others it will mean visits to the local medical centre which may or may not have good communication channels with the SRF staff and government services.

In summary it can be concluded that SRFs provide housing to people who are at high risk of poor health. The residents are also at greater risk of not accessing the full range of health care that they require, so therefore one would expect health outcomes to be worse.

Identifying the number of deaths in South Australian SRFs

Our office endeavoured to determine the number of deaths in South Australian SRFs. Deaths in SRFs are reportable to the Coroner under provisions of the Coroners Act (2003). We made a request to the National Coroners' Information System for a database search of deaths occurring in SRFs in South Australia between 1st July 2000-1st June 2009. This request was supported by Coroner Mark Johns.

It is possible that there is underreporting of SRF deaths - for example when a person who lives in an SRF but dies away from the SRF. This possibility was also considered when SRF regulations were updated in 2009 by the Department of Families and Communities. The new regulations stipulate that the Coroner must be informed of the resident's death and made it clear that this applies if the death occurs at the facility or elsewhere. While this regulation duplicates the provision in the Coroner's Act, it was included in the document that the SRF sector is more familiar with as an added reminder.

It is only possible to report a general impression from this data. Actual numbers of death were small, and the data from older age groups was confounded because some of the street addresses for SRF's were also the address of co-located aged care facilities which would be expected to report a significant number of deaths. For this reason we have not reported the actual data in this report, or been able to calculate a definitive death rate. A limited comparison of the deaths

for younger people suggested an increased mortality rate as would be expected for this population of people, based on the interstate data. Further analysis of mortality data will occur in the next year.

Problems already identified in SRFs

Concerns about the suitability of SRF accommodation have been well documented over the last 10 years and are confirmed by the direct experience of our staff when visiting clients living in many of these facilities. Although there has been improvement in some areas, progress overall to substantially improve the lives of SRF residents has been lacking.

In 2003 the then Department of Human Services in a report entitled “Somewhere to Call Home, Supported Residential Facilities: the sector, its clientele and its future” made a number of findings in relation to facilities, and whether a standard is still met (Doyle et al, 2003). Some of the findings are relevant today and include:

- *“The predominance of shared bedrooms is one of the consequences of the use of this older style of building – less than half the residents have sole use of their bedroom”.*

In 2010 newer facilities are providing single bedrooms, but there are many older facilities where the majority of residents share. This leads to a loss of privacy, a loss of a sense of safety at night, and a loss of security of belongings.

- *“The mix of residents within facilities, which is likely to create difficulties in fairly large congregate living environments”*

In 2010 there remains a mix of age groups and care needs in many SRFs which is reflected in the overall statistics for the sector. This can create issues for residents such as the concerns of younger residents about living with older residents (and vice versa) and inevitable complaints of disturbance from noise and disruptive behaviour when residents share confined spaces.

- *“The built form of facilities (old properties, not purpose built) which does not support quality care.”*

In 2010 many SRFs continue to operate from older buildings although some are newly built. While fire safety standards are now met, which was not the case in 2003, older buildings still have constrained layouts, and ongoing significant maintenance needs which can affect the day to day lives of residents even when repairs are prompt.

- *The research indicates that the model of supported accommodation fails to meet a range of disability standards, principles and expectations in relation to privacy, dignity, consumer choice and decision making, community participation, independence, rehabilitation, skill development, housing quality and health care.*

In 2010 it is possible to point to improvements in each of these areas, and examples of individual facilities that have significantly addressed a number of these issues.

Nevertheless the lives of many SRF residents remain substantially the same as they did in 2003 and many people are failed in a number of these areas described by the Department in 2003 including privacy, dignity, choice, participation, independence and rehabilitation.

In November 2003 the Social Development Committee of the Legislative Council reported on Supported Accommodation (Social Development Committee, 2003).

The committee observed that the use of SRFs is hiding the real need for appropriate supported accommodation, and that the large number of people with psychiatric disabilities living in SRFs (54% of the then 1200 SRF residents at the time) reflects the severe shortage of suitable community accommodation in the mental health sector. Inequities were noted between the lives of people with disabilities who lived in SRFs and those residents in accommodation funded by the Commonwealth-State disability agreement.

Since that time there has been additional State Government funding to the SRF sector which has provided SRF residents with additional services, as well as providing a fire safety subsidy and board and care subsidy (Minister Rankine, Hansard, Estimates A, 29 June 2009, page 177). A SRF Ministerial Advisory Committee was established in April 2003, and this group has tracked both progress and work to be done in its Annual Reports since then.

That committee has identified the following key standards that it considers essential to maintaining the sector (Ministerial Advisory Committee, 2008)

- Resident choices in all aspects of their lives (diet, surroundings, activities)
- Single occupancy, having own space and privacy
- Environment and location, having pleasant surroundings, close to community connections and networks
- Security, physical, personal, medical
- Regular medication review
- Choice of food; catering for individual taste, requirement, choice
- Equitable access to personal support and health care
- Ability to move within the sector as residents' needs/choice changes
- Avoid overly institutionalising clients, while acknowledging some residents require a certain level of routine
- Access to rehabilitative services
- Rigorous and ongoing health assessment to allow early identification of changing needs and provide intervention
- Funding packages remain with the resident and move with them if/when they chose to move, within the sector
- Same status as everyone else in the disability sector.

These priorities are consistent with the observations of our guardians working with clients in SRFs.

Legislation, Regulation and Guidelines

SRFs are legislated for under the *Supported Residential Facilities Act 1992*, and the accompanying regulations which were updated in September 2009. The Supported Residential Facilities Advisory Committee has produced guidelines and standards to assist proprietors, regulators (local government) and residents (Supported Residential Advisory Committee, 1997).

In our experience, the variable quality of care within the sector is generally acknowledged. However there are a range of views about what needs to change to improve the lives of SRF residents. These include:

- *Industry self development* – SRF operators who are leaders in the field have already shown that buildings can be improved, and better support programs implemented.
- *Tougher regulations* – this view is that SRF standards would improve if key regulatory requirements were toughened. The *Supported Residential Facilities Regulations 2009* were mostly unchanged from the previous 1994 requirements. More stringent definitions in many areas including those related to privacy and temperature in dwellings would allow inspectors to demand more.
- *More systematic enforcement* – The SRF Act is enforced by local government health inspectors. Some people consider local government health inspectors to be inadequately resourced and trained to effectively perform this role. More resources to local government, or the creation of a state wide standards inspectorate are some of the proposed solutions.
- *Community visitors* – These visitors would bring community expectations about accommodation standards into SRFs. They could tackle issues that might be poorly defined in regulations but nevertheless be unacceptable by a general community standard. Community visitors could also visit on a monthly basis, get to know residents, and give them reassurance that if they raise a matter it will be followed up and monitored over time.

There is currently little discussion about the potential need for new legislation. However, in 2006, the Supported Accommodation Task Group of the Department of Families and Communities recommended the need (amongst other needs) for:

- Better legislation to protect people with disabilities who are living in supported accommodation to afford them appropriate standards of accommodation and support (Disability SA, 2006).

That year the Department's Supported Accommodation Task Group released a consultation paper suggesting that new Accommodation Legislation be developed to cover all forms of accommodation used by people who have a disability – not just SRFs (Supported

Accommodation Task Group, 2006). This group noted that the existing *Supported Residential Facilities Act 1992* is not strong enough to give adequate protection (Supported Accommodation Task Group, 2006).

A Departmental paper the same year suggested that new legislation could be built on 4 cornerstones. This is illustrated in the following diagram using information from that document (Department of Families and Communities, 2006).

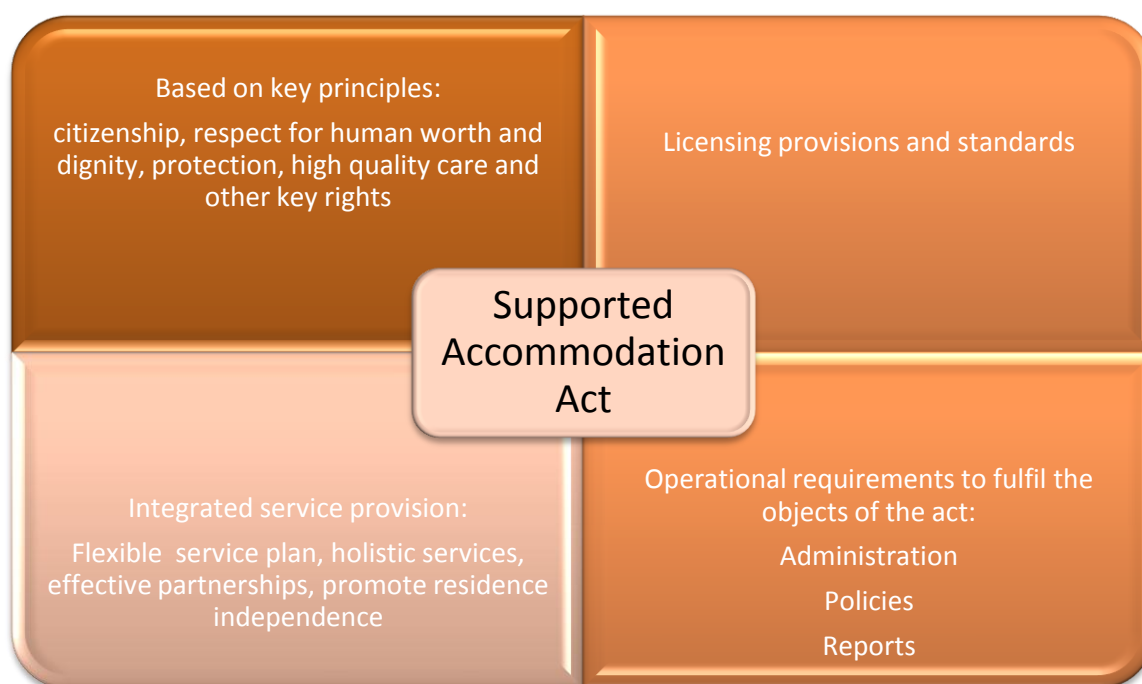


Figure 17: Department of Families and Communities (2006)– the 4 cornerstones of a new Accommodation Act for South Australia

It is this office's view that new legislation is still required. Many of the current debates about sector self improvement, regulation and enforcement stem from the legislation, so therefore it is reasonable to expect that new legislation could drive improvements in these areas.

The *SRF Act 1992* is old legislation. When it was introduced the then Minister for the Aged, Don Hopgood noted that the residents of supported residential facilities are increasingly frail or persons with an intellectual, physical or psychiatric disability (House of Assembly, Hansard, 11 August 1992 page 70). The Bill was to move the focus away from the physical inspection of facilities and to provide for a more balanced approach related to the provision of care for residents.

In many respects these expectations still apply. However, since 1992 there are a number of key developments in areas of rights, disability policy, service design and care planning. Modern legislation could do the following:

- Better describe the rights of people with disabilities in accordance with the UN Convention on the Rights of Persons with Disabilities.
- Recognise that SRFs are care providers, and therefore create a legislated expectation that a personal support plan is developed and maintained and accessible to the resident and service providers.
- Define health and support standards for care.
- Legislate for the provision of a Community Visitors Scheme.

In conclusion

Elsewhere in this report we have made the case for new Disability legislation. Our office considers the *Supported Residential Facilities Act 1992* to be in essence, disability service legislation (rather than legislation about buildings) and is similarly in need of an update to introduce similar provisions.

The government's plans for a new Accommodation Act has not progressed since 2006, but much of the thinking of the four cornerstones could still be applied to SRF care.

It is our view that updating SRF legislation is justifiable based on the needs of SRF residents alone. The previous proposed reform wished to expand a new Accommodation Act to Boarding Houses. Irrespective of whether or not this is done (we have not reviewed the situation with respect to boarding houses), SRF residents still need new legislation to protect rights, and ensure that adequate rehabilitation and care is provided.

There are also concerns about the current regulations and their enforcement, a solution to these concerns would also come if any future new regulations are based on new legislation that is clearer about the rights of SRF residents, the care that they should receive, and the protections that should be in place.

Program Review and Unmet Needs: *Protecting Vulnerable Adults*

Introduction

In last year's annual report this office raised concerns regarding the efficacy of adult protection systems in South Australia and the over reliance on guardianship services for this purpose. Drawing on our own guardianship and advocacy work, the experience of other jurisdictions, research and developments elsewhere, we concluded that-

- the extent of abuse and neglect of vulnerable people occurring in the past and present is unknown.
- South Australia does not have many of the basic protection mechanisms in place for vulnerable adults that are present in other jurisdictions in Australia.
- responsibility for adult protection needs to be broadened across health and social services providers, with an emphasis on team work and partnership between each other and the law.
- the focus needs to be on vulnerability and risk rather than mental incapacity, and
- adult protection needs to be seen as everyone's responsibility and that the current over-emphasis on adult guardianship as a key response carries many risks.

We suggested that South Australia needs a systemic response to protecting vulnerable adults, driven by across government policy and direction and involving strong links between a range of services, interest bodies and the community.

This year the OPA has continued to be alarmed by a number of ongoing safety and security risks for vulnerable clients. We are regularly in contact with members of the community and service providers who are seeking advice, guidance and solutions that afford financial and personal protection to vulnerable adults.

Update - a contemporary approach to adult protection

During the year our office met with the Office for Ageing to discuss the implications of the United Nations Convention on the Rights of Persons with Disabilities and, in particular, our proposed Supported Decision Making Research Trial. Central to these discussions was the felt need for a contemporary approach to safeguarding vulnerable adults by finding ways of ensuring that a person is safe (such as through practical social work interventions), legal interventions that are directed towards the perpetrator rather than the victim, and that avoids guardianship whenever it is reasonable to do so. As a consequence of this meeting, our office submitted a proposal and framework for developing such a strategy, focussing in the first instance on the needs of older South Australians and building on the 'kick start' initiatives of the Department of Families and Communities.

It is this office's view that universal protection strategies are needed to protect *any* adult in any situation where they are vulnerable to abuse or exploitation and are unable to protect

themselves from this harm. A universal strategy better honours the ‘presumption of capacity’ principle and avoids needlessly categorising people as being unable to protect themselves or make their own safeguarding decisions simply as a consequence of their disability or age.

Most but not all who are at risk or vulnerable come from disadvantaged demographic groups, for example, people with a mental illness, older and homeless people and people with disabilities. The multiple social and economic disadvantages experienced by people in these situations can create and exacerbate vulnerability. Particularly relevant is abuse that arises from neglect, omission or discrimination. Poor financial circumstances, isolation, a perceived lack of credibility and cognitive or communication impairment can combine to pose major challenges, including loss of legal rights, which these people often cannot address by themselves.

The risk of abuse increases not only with age or cognitive loss, but also with, isolation, lack of social networks, conflict with family and friends, mental health needs and frailty. It notes that people are also at risk of harm or abuse because they are perceived, due to their personal situations, as easy targets. This is further weight to the argument for a broader definition of vulnerable adults that is not limited to mental incapacity and a universal approach to intervention.

A number of factors currently combine to create both an opportunity and an urgency for the development of a protection strategy.

- Australia has signed up to the United Nation’s Convention and Optional Protocol on the Rights of Persons with Disabilities.
- Reform is proposed at state and national levels in disability and aged care services and therefore the policy area is dynamic.
- In South Australia, a raft of legislation is aimed at providing appropriate safeguards for people who cannot fully care for themselves or participate in ordinary community life without support. The mental health legislation was recently reviewed and amended and advance directives legislation is still under review. Harmonising the various policy goals and directions will avoid the risk of developments being at cross purpose.

This office suggests that work needs to be undertaken now to improve protection of the rights and interests of vulnerable adults in order to better respond to the predicted increase in the number of potentially vulnerable people and our changing community structures, expectations and social and economic conditions.

Our view is that South Australia should examine how it can best ensure adults are safe from abuse or harm, and develop whole of government policy to this end.

The aim would be to look at both preventative and intervention strategies across the spectrum of possible abuse(s) and consider the role, function and relationships of all government and

non-government service providers in preventing or intervening to stop abuse. This would also involve local government, the broader community and specific interest and advocacy groups.

Our proposal to the Office for Ageing is that this state requires a framework which includes the following key elements and objectives:

- A focus on prevention, as well as protection.
- An agreed vision for adult protection in South Australia -the starting point being existing policy goals that envision a society where people.
 - live and age positively, with their wellbeing being maintained and improved wherever possible.
 - stay in charge of their lives for as long as possible.
 - enjoy independence, choice and control as citizens, consumers and users of services.
 - have easy access to a range of inclusive and supportive community networks.
 - have options, information and support to make their own safeguarding decisions and if they are unable to do so themselves.
 - are kept safe from harm, abuse, neglect and exploitation.
- A joined up approach to ensure that in any situation of suspected abuse there is a coordinated and consistent response at both a system and individual level, involving
 - (a) at a system level across the state, and in each region:
 - a common policy framework across government supported by key partners in aged care, social services, health, housing, and the law
 - defined organisational responsibility for acting on adult protection matters.
 - a network of local and state-wide groups to ensure effective communication and coordination between services
 - (b) so that at an individual level:
 - there is a defined responsibility for identifying and responding to abuse
 - that there will be effective systems of coordination between local services
 - quality monitoring systems to ensure review of positive outcomes and, negative incidents, for improvement.
- Multi agency knowledge and practices that identify and respond to situations requiring intervention as early as possible.
- Appropriate safeguarding measures that are cognisant of personal autonomy, choice and rights and embrace the principles of personalisation and Supported Decision Making.

The result should be safeguards that

- are responsive, graduated and personalised;
- keep autonomy, rights, self-determination and choice paramount;
- focus on peoples abilities; and
- build and maintain individual capacity, community inclusion and citizenship.

Community Visitor Schemes

In last year's report we identified that community visitors were used as one of a range of protection strategies in other Australian jurisdictions. We outlined the benefits of such a scheme to South Australia. We also welcomed the establishment of a Community Visitor Scheme(CVS) in the *Mental Health Act 2009* for visiting declared approved and limited treatment centres in metropolitan and regional South Australia.

The *Mental Health Act 2009* provides for a Community Visitors Scheme and details the powers and functions of a principal community visitor and community visitors. The Scheme will provide visiting, advocacy and inspection services to promote and protect the rights and wellbeing of people with a mental illness and covers;-

- *Facility visiting and inspection services* - Approved treatment centres (determined by the Minister under part 12 Division 5 of the *Mental Health Act 2009*) will be visited and inspected once a month by 2 or more visitors.
- *Individual visiting and advocacy services*- A patient, carer, guardian, medical agent, carer or friend of a patient can request to see a community visitor, who will have authority to visit and to advocate for the resolution of issues raised by them (or others), concerning the control, care or treatment of a patient.
- *Systems Advocacy*- Feedback on systems issues, matters of concern relating to the organisation or delivery of mental health services in South Australia will be referred to the Minister via the Principal Community Visitor, the Chief Psychiatrist or any other appropriate person or body.

Similar schemes in other States and Territories are provided under the auspice of an agency independent of health and in several states, this is the Public Advocate offices. As this was SA Health's preference, with Ministerial approval, OPA was approached to auspice the South Australian scheme.

OPA collaborated with SA Health to develop a model and budget for the Community Visitors Scheme.

This is a very important development. There has been long standing support for such a scheme by South Australian consumers and advocacy groups. Their view, which this office shares, is that such a scheme needs to be broadened to cover disability accommodation, supported residential facilities and a wider range of mental health inpatient facilities.

Vulnerable adults in disability settings.

This year OPA has worked closely with the Health and Community Services Complaints Commissioner to advocate for improved Disability SA policies so that their vulnerable clients and those of services funded by them are offered better protections and remedies.

Together these statutory bodies have raised a number of safety matters with the service providers concerned and with the Minister for Disability. We are aware that the Health and Community Services Complaints Commissioner has dealt with a number of matters where there have been allegations of sexual or physical abuse by a staff member, and as a result of their investigations, have concluded that these events did happen although the police may not have been able to lay charges. This year our offices have worked together on individual matters concerning abuse and assault of vulnerable people under the Public Advocate's guardianship.

The office of the Health and Community Complaints Commissioner and the Office of the Public Advocate have also communicated closely with the Minister's Disability Advisory Council which has taken a strong interest in this topic.

There have been two key actions taken in 2009-2010 by the Department and the Minister, that are particularly encouraging.

- The Department agreed to develop a single policy on the prevention and response to abuse, to apply to both government operated and government funded services. Drafts of this new policy have been provided to both the HCSCC and the OPA for comment, and the Department has dedicated resources to quickly finalising this. The policy will give greater prominence to the risks to clients, hopefully increasing awareness in the disability sector.
- In June 2010 Minister Rankine gave a reference to the Minister's Disability Advisory Council to consider adult protection matters for people living with disability in the broadest sense. This will provide the Minister with advice on possible mechanisms and processes for the protection of people with disabilities wherever they may be. This office and the Health and Community Services Complaints Commissioner have attended the Minister's Disability Advisory Council to discuss this work, which we understand is intended to be a broader response than the work already underway in Disability SA.

Promoting Rights and Interests

Guardianship and Administration Act 1993

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

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

Overview

In this section of the report we have chosen to focus on Restrictive Practices in Disability Settings, and Supported Decision Making. We also provide follow up comment on Forensic Mental Health care issues from last year's Annual Report.

These topics need to be considered along side the discussion about unmet needs in other sections of the report. Last year we put advocacy issues in the context of negative rights and positive rights. To recap, positive rights are those that allow people to choose and pursue their aims and goals in life. For a person who has a disability this may require access to good support services. Negative rights refer to the imposition of restrictions such as seclusion or restraint or the loss of autonomy over personal decision making.

So, for example, a person provided accommodation that is overcrowded and unsuitable may then become agitated and need restraint. With respect to decision making, a person who does not have others to help make decisions may then be placed under guardianship.

Promoting Rights and Interests

Restrictive Practices in Disability Settings

Introduction

There has been nationwide concern about the use of restrictive practices in disability settings. This has come from a number of consumer and professional organisations. It is worth briefly noting some of these developments this year.

In May 2010, the Australian Society for the Study of Intellectual Disabilities (ASSID) released its position statement on restrictive practices (ASSID, 2010).

This expert organization asserts that restrictive practices are

- Unethical & inconsistent with internationally accepted human rights
- Ineffective in bringing about positive, long-term behaviour change
- A cause of both physical and psychological harm for persons subject to restrictive practices
- A cause of both physical and psychological harm to those persons applying restrictive practices

In August 2010, the Australian Psychological Society called for the end of unnecessary restraint of people with intellectual disabilities. The President of that society, Professor Bob Montgomery pointed out that the belief that restraint protects people with a disability and those caring for them is misguided, and instead the opposite is true – injuries and assaults are more likely to occur when these practices are used (Australian Psychological Society, 2010). This society has worked closely in this area with the Victorian Governments Office of the Senior Practitioner and ASSID.

Locally this year the Julia Farr Association has brought together people with knowledge in this area from South Australia to discuss how practices can change. The Public Advocate was invited to a key discussion meeting that is part of this initiative.

In the OPA Annual Report 2008-2009 described restrictive practices as they relate to our work as advocates and guardians. This followed a 2009 one day conference convened by ASSID and SACID (the South Australian Council for Intellectual Disability) to discuss this topic. In our discussion a link was drawn between the provision of effective services on one hand and the ability to avoid the use of restrictive practices on the other. Providing necessary support, rehabilitation and therapy services, along with suitable accommodation can make restrictive practices unnecessary. Conversely, if people are cared for in understaffed and crowded settings, and do not have access to skilled assessments and therapy (in particular positive behaviour support plans), then otherwise avoidable restraint and seclusion will occur. Last year's Annual Report also suggested that the use of chemical restraint may be under recognised in South Australia compared to Victoria.

Nationally strategies to reduce and eliminate restrictive practice have focussed on a number of areas, including

- Prevention based on changing cultures in disability provider organisations.
- The provision of Positive Behaviour Support and other similar evidence based practices to find alternatives to restraint and seclusion for individuals.
- Education, training and research in this area of practice.
- The development of legislation that sets expectations for assessment, development and implementation of positive behaviour support plans, and which provider transparency when these practices are applied.

The two Australian jurisdictions that have led law reform in this area are Queensland and Victoria. Both states have specific legislative provisions to protect the rights of people who use disability services. Queensland achieved this through the Queensland *Disability Services Act 2006* and amendments to the *Guardianship and Administration Act 2000*, and Victoria through provisions in the Victorian *Disability Act 2006*.

The Queensland approach has created a significant role for “guardians for restrictive practice”, while the Victorian approach aims to improve practice through creating authorised program officers in disability organisations, independent officers to meet with people who may be restrained and the creation of a Senior Practitioner in Disability.

The Office of the Senior Practitioner was established in Victoria in 2007 to implement new provisions in that state’s *Disability Act 2006*. Amendments to the *Guardianship and Administration Act 2000* in Queensland came into force in 2008 introducing the new role for guardians for restrictive practices. It is now possible to gain some impressions about the implementation of the two approaches.

One criticism is that while these new strategies interstate have principally provided a mechanism to authorise and monitor restrictive practices, the steps needed to reduce and eliminate these practices requires more fundamental change in how services are provided.

While there is validity in this, new legislation has provided clear mechanisms in both states to raise assessment standards, increase the use of and quality of behaviour support plans, and provided greater transparency in these settings when rights are lost.

Both states’ strategies have also sought to create cultural change in services through training, education, and research. In Queensland there has been an investment in a specialist response service to assist providers with positive behaviour support. These teams have professionals from a range of disciplines including psychology, occupational therapy and speech and language pathology (Disability QLD, 2008). Their work is supported by a university based Centre of Excellence in Behaviour Support based at the University of Queensland (University of Queensland, 2010). Victoria created the Office of the Senior Practitioner which has had similar roles promoting cultural change, and funding research within organisations.

The Victorian Senior Practitioner provides clinical leadership to the sector as well as monitoring and auditing the use of restrictive practices, and instigating review.

In contrast, South Australia has neither legislated protections to specifically address the use of restrictive practices within disability services, nor specific initiatives to systematically reduce their use on the scale or with the independence of the work interstate. There are committed SA policy makers and practitioners within both Disability SA and the non-government centre who wish to improve practice. However, they operate though without the legislative and resource backing that has made this a major reform issue elsewhere. Because of this it is difficult to accurately gauge the extent of the problem in our own state.

Public reporting is one strategy to make sure restrictive practices are identified and that use is minimised. The requirement to report forces providers to ask a key question – is this a restrictive practice, and what else could have been done to avoid it. Taking the example of chemical restraint, in South Australia, it is far too easy for people with a disability to be prescribed significant doses of antipsychotic medication (even though they are not psychotic) without a full consideration of what else could have been done and without an analysis of other factors that may affect the need to sedate a person (eg staffing levels, the quality of the environment). There are no routine external checks to balance, on the one hand the claimed benefits of sedation with antipsychotic medication and, on the other, the significant side effects ranging from sedation, mental slowing, to weight gain and diabetes.

There is also a risk that without an established mechanism to challenge and review decisions to restrain and seclude individuals, poor practices will be accepted as appropriate because , when a dramatic episode of violent behaviour occurs, the restrictions seem superficially reasonable at the time .

For example, in a situation where a young man with an intellectual disability acts up, and is then held down and locked in his room, it may seem that staff had no other choice. Yet the best practice strategies interstate make all concerned look at the wider picture – why the person behaves the way that they do, how needs can be better met, and new behaviours supported.

Without data, it is difficult to make a formal quantitative conclusion about the extent of restrictive practices in this state. Based on our offices contact with disability rights advocates, people with disabilities, their carers, and dedicated professionals in both government and non-government services we conclude:

- That the use of avoidable restrictive practices is a significant problem in South Australia and is largely hidden because of a lack of rigorous checking and accountability measures.
- The extensive checks and balances to minimise the use of force that occur in reform states are not routinely and systematically applied in South Australia.
- There is a high likelihood that people with disability and their service providers are unnecessarily traumatised by the use of these practices..

What model should South Australia implement?

This section compares the approaches in Queensland and Victoria to the existing situation in South Australia. The purpose is two-fold.

First is to consider possible directions for South Australia. Should the approval of restrictive practices be addressed in this state through a strategy that relies on guardianship for many decisions (the Queensland approach) or a strategy based in disability services with an independent senior practitioner (the Victorian way), or could there be benefit in having a combination of both approaches?

Second, our office in South Australia recognises that there are actions that we can take now even without legislation. While the extent of these actions is limited in scope and in the power to implement them, there is no reason why at a policy level our office cannot require for our clients similar assessments and plans to those required by legislation in other states. This strategy is not a replacement for legislation, and compared to the legislative schemes in place elsewhere, a policy solution is incomplete. Nevertheless a trial of new Restrictive Practice Safeguards in Guardianship will commence from our office in the next financial year.

The approaches in QLD and Victoria have many similarities but are also divergent in a number of key areas. It is helpful to compare these strategies to recognise gaps in what currently occurs in South Australia, and to choose from the alternatives. Our analysis has identified shortcomings in each of the approaches but views about which is the better approach are clearly a topic of debate. Also in making this critique we wish to take nothing away from the excellent pioneering work in both states.

Details of the comparison are illustrated in figure 18

Restrictive practice legislation in both Queensland and Victoria focus on users of the specialist disability system. There would seem to be few disadvantages in imposing this limitation in the use of restrictive practices as it disallows a broader system use of restrictive practices in people who have a disability. It is reasonable that the use of such practices for people with a disability be limited to skilled government and non-government specialist providers who are trained and supported to do this work, and who are also seeking to reduce the use of these practices.

In Victoria restrictive practice provisions operate in addition to and alongside enforcement powers under their Guardianship and Administration Act 1986 (section 26) that are similar in effect to South Australia's provisions. It should be possible for South Australia to consider such a combination. Restrictive practices legislation can add additional scrutiny and protection around the use of existing enforcement power legislation but not necessarily replace it.

It is also worth noting that guardianship enforcement powers, such as detention and the use of force as is reasonably necessary, may need to be applied to a broader population than disability service users alone. For example, such powers are used with some older people with dementia who may need to be detained in the closed ward of a nursing home, and people with a mental illness who may be required to stay at a particular address for supported accommodation unless given permission to leave (the door may be unlocked, but the person would know that police would be called if they left). This discussion does not consider such uses. Instead it

contemplated that the current broad application be still available, but that specific practices are defined, and that there be greater approval requirements before restrictive interventions are offered by a specialist disability service.

Based on this comparison, South Australia should

- **have new specific provisions for restrictive practices administered by specialist disability services (Disability SA operated or funded services).**
- **Retain Guardianship enforcement powers but recognise that these provisions alone provide insufficient protection to prevent the avoidable use of restrictive practices unless there are additional and complementary restrictive practice protections.**

Figure 18: Restrictive Practices – Cross Jurisdictional Comparison

<i>Restrictive Practice</i>	Queensland ¹	Victoria	South Australia
<i>Scope of protection</i>	<p>Applies to individuals who have an intellectual disability or cognitive disability who are clients of a disability service that receives funds from the Department to provide a service (ie both Disability services operated and funded services)</p> <p>Practices and responsibilities of services are defined in the Disability Services Act 2006.</p> <p>The Guardianship & Administration Act (2000)² permits the appointment of a “guardian for a restrictive practice matter”</p>	<p>Applies to clients of disability service providers approved to provide restrictive interventions by the Secretary of the Department.</p> <p>The Disability Act (2006) provides provisions for restrictive interventions (Part 7)</p> <p>The Guardianship and Administration Act (1986) provides for powers to enforce a guardianship order (Section 26). This would include the use of restrictive practices.</p>	<p>No specific provisions for clients of disability services.</p> <p>No overall statutory approach to the use of restrictive practices in people who have a disability.</p> <p>Guardianship and Administration Act (1993) provides special powers (Section 32) to place, detain and or use force as may be reasonably necessary.</p> <p>This applies to people under guardianship when health or safety of the person or the safety of others would be seriously at risk.</p>
<i>Restrictive Practices that can be authorised</i>	<p>Containment</p> <p>Seclusion</p> <p>Chemical Restraint</p> <p>Mechanical Restraint</p> <p>Physical Restraint</p> <p>Access to Objects that can cause harm</p>	<p>Detention and treatment (Supervised treatment orders)</p> <p>Seclusion</p> <p>Chemical Restraint</p> <p>Mechanical Restraint</p>	<p>Detention</p> <p>Physical restraint</p> <p>In addition, in practice, a guardian with special powers may authorise mechanical restraint and a guardian with health powers, chemical restraint.</p>

¹ Queensland Disability and Community Services, <http://www.disability.qld.gov.au/key-projects/positive-futures/legislation/authorisation.html> Accessed 19th August 2010 and Queensland Civil and Administrative Tribunal, Restrictive Practice Types, <http://www.qcat.qld.gov.au/restrictive-practice-types.htm> Accessed 19th August 2010

² Guardianship and Administration Act (2000) Chapter 5B Restrictive Practices, <http://www.legislation.qld.gov.au/LEGISLTN/CURRENT/G/GuardAdminA00.pdf> Accessed 20th August 2010

Which practices should be defined and who should provide authorisation?

A comparison between states is illustrated in Table II.

Lack of definition of restrictive practices in South Australia

This comparison demonstrates the lack of legislated definitions of restrictive practices in South Australia, and in particular the lack of formal authorisation processes for the specific practices of seclusion and chemical restraint.

The existing SA requirement for a tribunal to authorise detention is similar to other states. However the SA enforcement power that is used currently to authorise physical and mechanical restraint for people with a disability is described as to “..use such force as may be reasonably necessary for the purpose of ensuring the proper medical or dental treatment, day-to-day care and well-being of the person.” There is no distinction between physical and mechanical restraint and there is no definition of seclusion. The provision of medication for chemical restraint is consented to by a health guardian, in the same way that consent would be provided for routine medication, and there are no special legislated requirements to be met when considering this intrusion.

In contrast, the reforms interstate have clearly defined each form of specific practice to be authorized. Critically there is a legislative requirement that a behavioural support plan be in place. An effective behaviour support plan means that the extent and duration of use of restrictive practices will be minimised, or that the use of the restriction may be prevented altogether.

The Guardianship Act or the Disability Act Route?

The comparison between Queensland and Victoria illustrates a divergence in legislative approach, Queensland basing its law reform on both the Disability Services Act (2006) and reforms to the Guardianship and Administration Act (2000), and Victoria basing its reform in its Disability Act (2006). With respect to approval and consent for the use of restrictive practices, both states require a tribunal approval for some practices, but overall the Queensland systems can be characterised as a guardianship based approach where as the Victorian system can be characterised as relying on services to approve practices with rigorous checking by an Senior Practitioner. Which is likely to deliver the best results?

In South Australia we could pursue either direction or seek to have elements of both.

Guardianship and Administration Act's (for example in SA, QLD and Victoria) are in place to provide guardianship and administration. The legislation is principally concerned with decision making. In contrast Disability Acts (such as the current Disability Services Act 1993) are concerned with the funding and provision of services.

Many of the reform changes that need to occur relate to the provision of services. These include having adequate accommodation for people with behaviour support needs, undertaking appropriate skilled assessments, and providing effective governance arrangements to prevent restrictive practices and improve them when required. In this context, restrictive practice oversight requirements can fit well into a Disability Act which can outline a suite of measures to

prevent these practices, authorise services that can use these practices, require behaviour support plans, and allow for an independent review of these plans.

On the other hand, the final consent to a restrictive practice can and arguably should rest with a guardian who has enforcement powers authorised by a Guardianship tribunal. As a principle of this jurisdiction, there is a separation between the provision of services and the provision of substitute decision making. This can be best met by having an independent guardian giving consent.

While the Victorian approach has a significant strength in giving clear restrictive practice roles to people within the disability system, arguably, it may have gone too far in this direction, by effectively giving powers of consent directly to service providers rather than giving powers to a guardian to provide this consent. In particular, the Victorian Disability Act (2006) allows for a Supervised Treatment Order to be made by the tribunal, which permits the detention and treatment of a person. In so far as there is no guardian appointed, the appointment by the tribunal gives powers directly to the service provider. This is in contrast to the tribunal appointing a guardian with enforcement powers, who then has responsibility for making a substitute decision about how the powers are applied.

The situation created by this new Supervised Treatment Order provision is similar to the operation of Mental Health Law in Australia – long term involuntary mental health detention orders are made by tribunals, and the power to consent to treatment is given to the service provider. At the present time internationally there is one view that mental health law should be more similar in its operation to guardianship law with a focus on client capacity and a role for substitute decision makers.

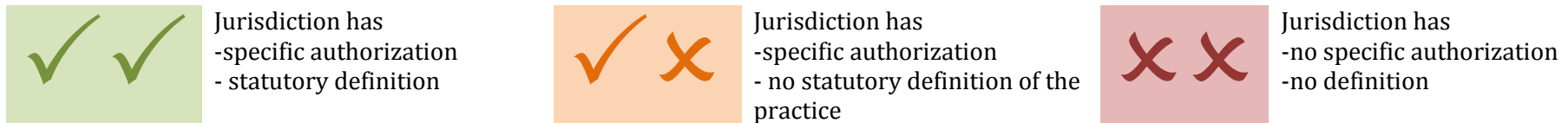
In this context, it could be argued that, if the Queensland approach has extended the Guardianship and Administration Act too far in seeking to supervise disability services through guardianship strategies, then the Victorian approach has gone too far in the opposite direction. By creating supervised treatment orders, it has used the Disability Act to deal with matters of consent that might properly be considered under Guardianship, and allowed the tribunal to appoint service providers with powers that could be better given to an independent guardian.

In the previous section we suggested that restrictive practice reforms need to span both reforms to the Disability Act, and the retention of provisions in Guardianship for enforcement powers. This is further delineated below through separating measures to prevent, reduce and approve the use of restrictive practices, from the consent to their use.

Therefore the model that we recommend for South Australia would:

- **Have restrictive practice definitions described in a reformed Disability Act.**
- **Have provisions within the Disability Act that consider the prevention of restrictive practices, and for education and research in this area.**
- **Have the process of checking the quality of plans and approving them separated from the process of consent.**
- **Have an independent Senior Practitioner check and approve plans (legislated under the Disability Act)**
- **Have a guardian appointed by the Guardianship Board to consent to the use of the restrictive practice (Guardianship and Administration Act).**

Figure 19: Authorisation and Definitions of Restrictive Practices in each jurisdiction



<i>Restrictive Practice</i>	Queensland	Victoria	South Australia
<i>Containment or Detention</i>	<p>An adult is unable to physically leave the place where they receive disability services. This may include locking doors, windows or gates. It is not considered containment if an adult has a lack of road safety skills and a door is locked to prevent them wandering close to a road.</p> <p>✓ ✓</p>	<p>Includes -</p> <p>(a) physically locking a person in any premises; and</p> <p>(b) constantly supervising or escorting a person to prevent the person from exercising freedom of movement.</p> <p>Detention provisions exist in the Disability Act (2006) under a <i>Supervised Treatment Order</i> which enable the detention of a person for the purpose of compulsory treatment who; has an intellectual disability, is receiving residential services, and who poses a significant risk of serious harm to others.</p> <p>✓ ✓</p>	<p>Authorised under section 32 of the Guardianship and Administration Act (1993)</p> <p>No statutory definition in the Guardianship and Administration Act (1993)</p> <p>Not considered in the Disability Services Act 1993.</p> <p>✓ ✗</p>

<i>Restrictive Practice</i>	Queensland	Victoria	South Australia
<i>Seclusion</i>	<p>An adult is unable to physically leave a room or area where they receive disability services. This may include locking doors, windows or gates. The adult is placed on their own, at any time of the day or night.</p> <p>✓ ✓</p>	<p>Means the sole confinement of a person with a disability at any hours of the day or night-</p> <p>(a) in any room in the premises where disability services are being provided of which the doors and windows cannot be opened by the person from the inside, or</p> <p>(b) in any room in the premises where disability services are being provided of which the doors and windows are locked from the outside, or</p> <p>(c) to a part of any premises in which disability services are being provided.</p> <p>✓ ✓</p>	<p>Not considered in the Guardianship and Administration Act (1993) or Disability Services Act 1993.</p> <p>In practice seclusion is authorised when a guardian has been provided special powers “section 32.”</p> <p>Not considered in the Guardianship and Administration Act (1993) or Disability Services Act 1993.</p> <p>✗ ✗</p>
<i>Chemical restraint</i>	<p>The use of medication to control the adult’s behaviour. This does not include using medication for treating a diagnosed mental illness or physical condition.</p> <p>✓ ✓</p>	<p>Means the use, for the primary purpose of the behavioural control of a person with a disability, of a chemical substance to control or subdue the person but does not include the use of a drug prescribed by a registered medical practitioner for the treatment, or to enable the treatment, of a mental illness or a physical illness or physical condition.</p> <p>✓ ✓</p>	<p>Not considered in the Guardianship and Administration Act (1993) or Disability Services Act 1993.</p> <p>Consent to medication can be provided by a guardian with health powers, an enduring guardian, or a medical power of attorney (under the Consent to Medical Treatment and Palliative Care Act 1995)</p> <p>✗ ✗</p>

<i>Restrictive Practice</i>	Queensland	Victoria	South Australia
<i>Physical restraint</i>	<p>The use of any part of another person's body to restrict the free movement of the adult with the aim of controlling the adult's behaviour.</p> <p>✓ ✓</p>	<p>Not considered by the Disability Act (2006) The Act does give the Senior Practitioner the ability to declare other restrictive interventions. It is likely that this will occur with respect to physical restraint to overcome this anomaly in the Victorian Act.</p> <p>✗ ✗</p>	<p>Authorised under section 32 of the Guardianship and Administration Act (1993)</p> <p>No statutory definition of restraint in the Guardianship and Administration Act (1993)</p> <p>✓ ✗</p>
<i>Mechanical restraint</i>	<p>The use of a device to either restrict the free movement of an adult or to prevent or reduce self-injurious behaviour.</p> <p>✓ ✓</p>	<p>Means the use, for the primary purpose of the behavioural control of a person with a disability, of devices to prevent, restrict or subdue a person's movement but does not include the use of devices – (a) for therapeutic purposes; or (b) to enable the safe transportation of the person.</p> <p>✓ ✓</p>	<p>Not considered in the Guardianship and Administration Act (1993) or Disability Services Act 1993.</p> <p>In practice mechanical restraint is authorised when a guardian has been provided special powers "section 32."</p> <p>✗ ✗</p>
<i>Restricting Access to an Object</i>	<p>Limiting the adult's access to an object, for example a kitchen drawer with knives, at a place where the adult receives disability services. This can prevent the adult using the object to cause harm to themselves or others.</p> <p>✓ ✓</p>	<p>Not considered by the Disability Act (2006)</p> <p>✗ ✗</p>	<p>Not considered in the Guardianship and Administration Act (1993) or Disability Services Act 1993.</p> <p>✗ ✗</p>

<i>Restrictive Practice</i>	Queensland	Victoria	South Australia
<i>Supervised Treatment Order under the Disability Act</i>	Not considered in the Disability Services Act (2006) or the Guardianship and Administration Act (2000) ✗ ✗	Means a civil order made by the tribunal under the Disability Act (2006). Components include detention and supervised treatment ✓ ✓	Not considered in the Guardianship and Administration Act (1993) or Disability Services Act 1993. ✗ ✗

What is considered when approving and consenting to Restrictive Practices

Table III describes who provides authority for each form of restrictive practice in the comparison jurisdictions. For Victoria and Queensland legislated arrangements are described. In South Australia, where no restrictive practices legislation exists, approvals are described through guardianship enforcement powers and in policy. Therefore the table is supplemented with the approving authority described in the Disability SA guideline document Assessing, Planning and Using Restraints (Policy number GUI-STR-001-2008.) which was approved by Disability SA in May 2010.

Queensland

The Queensland reform has a significant role for the Tribunal in that state. Only the tribunal can approve the use of seclusion or detention, and the Tribunal appoints guardians for restrictive practices who are appropriately gives the task of consenting to other restrictive practices. However the Act places the onus on guardians for restrictive practice to make judgements about the quality and suitability of the behaviour support plans.

The Act requires that Guardians for restrictive practices consider the following having reviewed the behaviour support plan (Guardianship and Administration Act, 2000):

The guardian may give the consent only if satisfied—

(a) the adult's behaviour has previously resulted in harm to the adult or others; and

(b) there is a reasonable likelihood that, if the consent is not given, the adult's behaviour will cause harm to the adult or others; and

(c) using the restrictive practice in compliance with the positive behaviour support plan mentioned in subsection (2) is the least restrictive way of ensuring the safety of the adult or others; and

(d) the adult has been adequately assessed for developing or changing the positive behaviour support plan; and

(e) use of the restrictive practice is supported by the recommendations of the person who assessed the adult;

and

(f) if the restrictive practice is chemical restraint—in developing the positive behaviour support plan, the relevant service provider consulted the adult's treating doctor; and

(g) if the positive behaviour support plan is implemented—

(i) the risk of the adult's behaviour causing harm will be reduced or eliminated; and

(ii) the adult's quality of life will be improved in the long term; and

(h) the observations and monitoring provided for under the positive behaviour support plan are appropriate.

In giving consent to any decision guardians can have an important role asking questions, and if required, seeking a second opinion. However, in this complex and controversial area of practice, it is difficult for a guardian who likely to limited or no experience in this specialist area, to challenge the recommendation of the service providers. These challenges may need to be about both the recommendations to restrict an individual and the entire practice model of a disability provider. In contrast the Victorian approach has created the Senior Practitioner to take on this role who has specific technical knowledge and expertise in this area.

The Queensland Adult Guardian's Annual Report describes the number of restrictive practice appointments in that state during the first year of operation of the amended legislation. There were a total of 134 positive behaviour support clients (Adult Guardian, 2009). This figure does not include approvals made by private guardians appointed to this role.

Victoria

The approval in Victoria is given by an authorised program officer within an organisation. This may be a manager, senior clinician, or in many non-government organisations, it is the Chief Executive Officer. The Victorian Disability Act also requires that an independent person explain the use of restrictive practices to the person who will be subject to those practices. There is a manual to brief the independent person on their role, this includes the opportunity to contact the Office of the Public Advocate.

In Victoria all behaviour support plans are scrutinised by staff of the Office of the Senior Practitioner. The Annual Report 2008-2009 of the Office of the Senior Practitioner indicates that 1357 behaviour support plans were reviewed to determine if they complied to Victoria's Disability Act 2006. In their first Annual Report an even greater number of behaviour support plans were reviewed -1521 in all (Office of the Senior Practitioner, 2009). This office receives information about who was consulted when the plan was developed, who approved the plan within the disability organisation, and details of the use of the restrictive intervention. While 97% of plans specified the type of restraint and seclusion to be used, only 65% contained evidence that the restrictive intervention was necessary to prevent harm to self or to others, and only in 31% of cases was there evidence that the restrictive intervention was the least restrictive option, that is evidence that other less restrictive measures had been tried.

From the raw numbers alone it would seem that the Victorian measures have led to a relative rapid uptake of the use of plans and their independent review by the Senior Practitioner. Our impression is that the process may have been slower during the transition period in Queensland with providers having difficulty complying.

The Victorian Office of the Senior Practitioner also conducts in depth reviews of plans, based on three elements of good practice. These are

- *evidence that recent assessments (especially the use of functional behaviour assessments) provided a good understanding of the problem*
- *evidence the intervention was based on the assessment findings*
- *evidence that the plan would be monitored and reviewed to evaluate the effectiveness of the interventions included in the plan (Office of the Senior Practitioner, 2010).*

That office has led the implementation of an evidence based review of the quality of behaviour support plans.

Diana Browning Wright in California has described six key concepts in behaviour support planning that have become the basis of the Behaviour Support Plan Quality Evaluation Scoring Guide (Browning Wright et al, 2006). These are:

- *Function.* All behaviour serves a purpose even problem behaviour. Therefore the plan should identify the function of the problem behaviour
- *Environment.* Behaviour is related to the context and environment in which it occurs. Therefore the plan must identify environmental features that support the problem behaviour.
- Two key strands: Introduce both *environmental change* and *support new behaviour* to replace the problem behaviour.
- *Reinforcement.* Of new behaviours must be identified
- *Response to recurrence* of problem behaviours eg prompting replacement behaviour, distraction, redirection.
- *Communication* must be between all stakeholders and should be frequent.

While the Californian work was with school children who needed behavioural assistance, the application of similar principles for adults has been considered valid, and Australian results using this approach are now being reported internationally (Webber and McVilly, 2010).

South Australia

In comparison, in South Australia there are no similar independent processes of review. This is illustrated in Table III, with an illustrative guideline. Restrictive practices are approved by a “senior manager” within Disability SA. Detention or physical restraint is “prescribed” by a service unit manager, seclusion by a psychologist or psychiatrist, chemical restraint by a

medical officer, general practitioner or psychiatrist, and the mechanical restraints of cuffing or strapping are not to be used for behavioural purposes.

The Guideline itself is not being criticised as part of this analysis. Our issue is the need to have parliament define what restrictive practices are, and then have a systematic independent scrutiny of their use which is also mandated in legislation.

In contrast to the approval of “Senior Managers” in SA, in Victoria the plan would be signed off by an authorised person within the person’s service (who may be a senior manager), and then reviewed by the Office of the Senior Practitioner whose staff are better placed in their expert independent role to assess the plans for legislative compliance and make alternative suggestions.

Combining this information with our earlier recommendation to have restrictive practice provisions in the Disability Act, and consent provisions in the Guardianship and Administration Act, it would be difficult to envisage such a system working effectively without the creation of an independent office of the Senior Practitioner.

The aim of our suggested approach is to create a strategy that has all of the professional protections that currently exist in Victoria, while still retaining the role of guardian who can either consent or not consent to the recommended intervention in the usual way that a guardian might make any decision. This does leave open the possibility that there may at times be conflict between professionals and guardian, but if it were to occur this it could be considered by the Board – as occurs now for other decisions where a professional may be concerned for the welfare of a protected person if a guardian does not follow professional advice.

Therefore our recommendations:

- **Consistent with our recommendation in last year’s Annual Report, South Australia would benefit from the creation of the statutory position of Senior Practitioner to lead change to reduce and eliminate where possible restrictive practices.**
- **The requirement for behaviour plans and the process for their approval should be defined in legislation, in a new Disability Act, rather than in guidelines as is now the case.**
- **Existing Disability guidelines requiring Senior Managers to approve restrictive practices in SA, could be replaced by vesting accountability in an Authorised Program Officer based within organisations approved to use restrictive practices.**
- **A Senior Practitioner be established to review decisions, ensure legislative compliance and consider the technical and professional adequacy of the plans put forward.**
- **The final consent however to implement such plans approved as above should rest with a suitable guardian appointed by the Guardianship Board for this purpose.**

This process of review and approval and consent is illustrated in the following diagram.

Proposed Restrictive Practice Flow Chart.

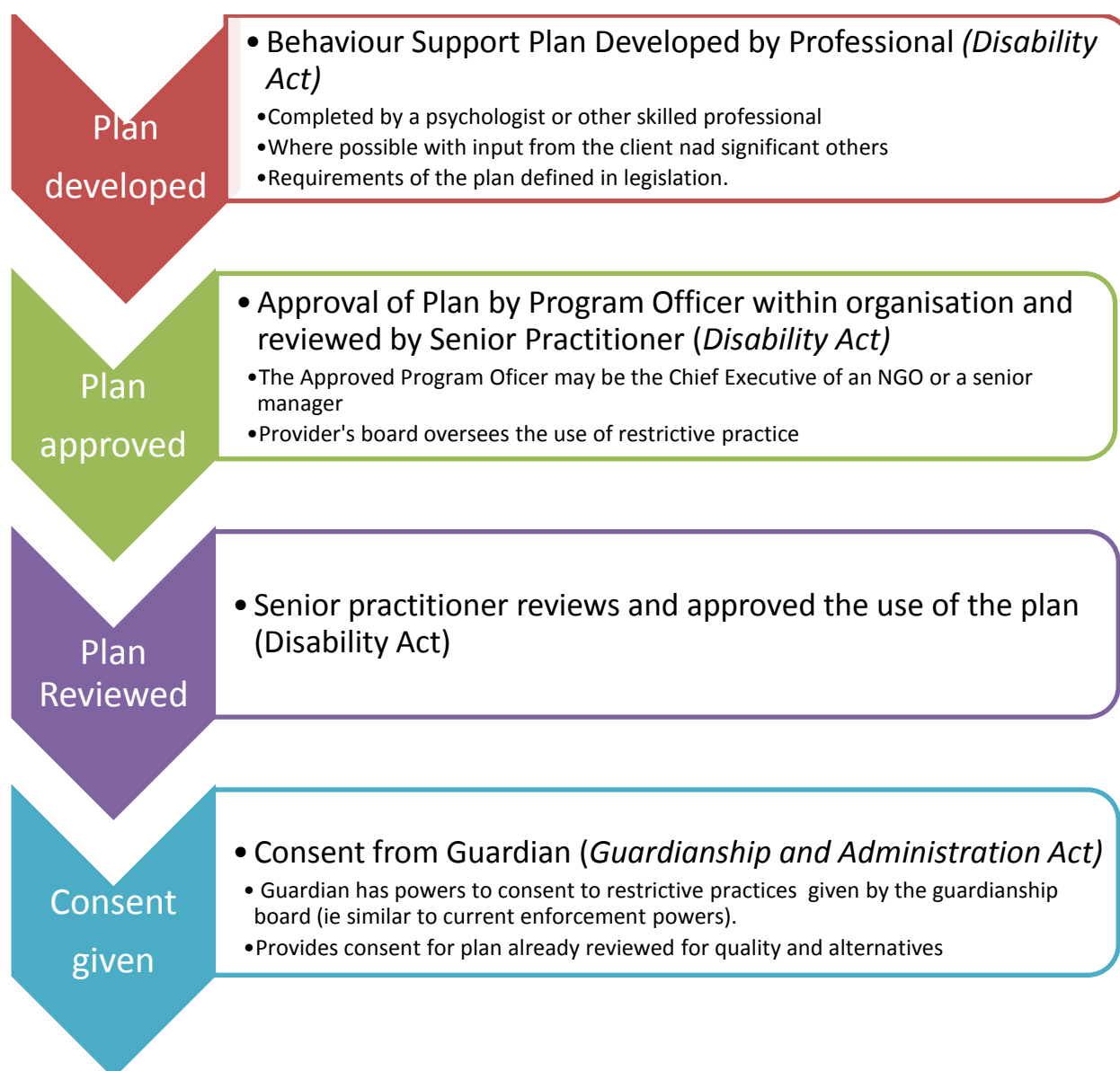


Figure 20: Authorisation for use of restrictive practice

This table describes the legislative authorisation for Queensland and Victoria. As South Australia does not have a specific legislated regime for restrictive practices, information is given for both the use of Guardianship and Administration Act 1993 enforcement powers, as well as an example of a Disability SA Guideline, which is used in Disability SA operated residential services (GUI-STR-001-2008. which was approved in May 2010.)

Restrictive practice	Queensland	Victoria	South Australia
<i>Containment or Detention</i>	<p><i>Tribunal</i> Queensland Civil and Administrative Tribunal (Guardianship and Administration Act 2000, Section 80V)</p>	<p><i>Tribunal</i> Victorian Civil and Administrative Tribunal (Disability Act 2006, Section 191) On application from an Authorised Program Officer within a disability organisation for a supervised treatment order.</p> <p>Order supervised by the Senior Practitioner</p>	<p><i>Tribunal</i> Guardianship Board (Guardianship and Administration Act 1993, Section 32) On application from a guardian.</p> <p><i>Disability SA Guideline: Prescribed by a Service Unit Manager Approved by Senior Manager</i></p>
<i>Seclusion</i>	<p><i>Tribunal</i> Queensland Civil and Administrative Tribunal (Guardianship and Administration Act 2000, Section 80V)</p>	<p><i>Authorised Program Officer</i> Use of restraint or seclusion within a behaviour plan must be approved by an authorised program officer (based within the organisation.) The need for restraint or seclusion is explained to the person by an <i>independent person</i>. <i>Senior Practitioner</i></p>	<p>Not considered in the Guardianship and Administration Act (1993) or Disability Services Act 1993.</p> <p>In practice Tribunal approval for section 32 special powers will be used to authorise seclusion</p> <p><i>Disability SA Guideline:</i></p>

Restrictive practice	Queensland	Victoria	South Australia
		<p>The Senior Practitioner is provided a copy of the behaviour management plan. <i>Civil and Administrative Tribunal</i> A person can request a review from a tribunal.</p>	<p><i>Prescribed by a psychologist or a psychiatrist</i> <i>Approved by Senior Manager</i></p>
<i>Physical restraint</i>	<p><i>Guardian for restrictive practice matters</i> appointed by the Queensland Civil and Administrative Tribunal OR if the person is also subject to a containment/seclusion approval by the Tribunal the use of the restraint complies with the approval.</p> <p>Decisions of the guardian are subject to review by the Queensland Civil and Administrative Tribunal.</p>	<p>Not considered in the Disability Act (2006)</p> <p>In practice an authorised program officer would give approval as per seclusion above.</p>	<p>Tribunal Guardianship Board (Guardianship and Administration Act 1993, Section 32) On application from a guardian for Section 32 (c) – use such force as may be reasonably necessary</p> <p><i>Disability SA Guideline:</i> <i>Forced holding of a person:</i> <i>Prescribed by a Service Unit Manager</i> <i>Approved by Senior Manager</i></p>
<i>Mechanical restraint</i>	<p><i>Guardian for restrictive practice matters</i> The same approval process applies as for physical restraint.</p>	<p><i>Authorised Program Officer</i> As above for seclusion</p>	<p>Not considered in the Guardianship and Administration Act (1993) or Disability Services Act 1993.</p> <p>In practice Tribunal approval for section 32 special powers will be used to authorise mechanical restraint <i>Disability SA Guideline</i> <i>Cuffing or strapping:</i></p>

Restrictive practice	Queensland	Victoria	South Australia
			<p><i>Not to be used for behavioural management</i></p> <p><i>Prescribed by physiotherapist, occupational therapist or registered nurse. Notify regional manager if restraint risk assessed as extreme</i></p>
<i>Chemical restraint</i>	<p><i>Guardian for restrictive practice matters</i></p> <p>As above for seclusion</p>	<p><i>Authorised Program Officer</i></p> <p>As above for seclusion</p>	<p>Not considered in the Guardianship and Administration Act (1993) or Disability Services Act 1993.</p> <p>In practice a guardian for health care will consent to the administration of sedative medication.</p> <p><i>Disability SA Guideline:</i> <i>Prescribed by a medical officer, general practitioner or a psychiatrist</i> <i>Approved by Senior Manager</i></p>
<i>Restricting Access to objects</i>	<p>An informal decision maker (for example, a member of the adult's support network) if there is no guardian for restrictive practice matters</p>	<p>Not considered in the Disability Act (2006)</p>	<p>Not considered in the Guardianship and Administration Act (1993) or Disability Services Act 1993.</p> <p><i>Disability SA Guideline:</i> <i>Personal belongings not to be withheld</i></p>

OPA Improvement Strategy

The restrictive practices section of the Annual Report has identified gaps in legislated protections to prevent and minimise restrictive practices. The case for law reform has been made and measures suggested for Disability Services in order to prevent restrictive practices and approve plans for their use. The role of guardians in consenting to restrictive practices has also been identified.

Additional measures can be taken at a policy level now within our office whilst awaiting legislative reform. We consider that it is better to take some action now, rather than wait for legislation in the future. Without a legislative framework however there will be a number of limitations on actions that can be taken. These include:

- Any policy based system will require cooperation from providers who will have their own policies, (a legislated standard would provide a non-negotiable basis for insisting that certain requirements be met).
- The impact of our practice changes will be limited to people who are in contact with the Office of the Public Advocate (either under public guardianship, have a private guardian who seeks advice from this Office or who approach us for advocacy assistance).
- An interim system would not have the Senior Practitioner role in place to review behavioural plans and lead change.

It is our office's intention to pursue a more rigorous process of justifying restrictive practices which require consent of a guardian. This interim approach is different to the optimal model we have described earlier in this section. It will be based more on the Guardianship for Restrictive Practice model from Queensland rather than the Disability Services model from Victoria, simply because we have the ability to define guardianship requirements but not service delivery requirements. The office is developing a the Restrictive Practice consent policy and procedure which will be used for guardianship clients. It is anticipated that, following consultation, this office will commence using these consent requirements in 2011.

Next year's Annual Report will report on this process using strategies such as

An analysis of restrictive practices data (as in Part B this year)

An audit of restrictive practice approvals.

Interviews with people affected by this policy (people subject to restrictive practices, their carers and service providers).

Promoting Rights and Interests

Supported Decision Making

Introduction

To promote Equal Recognition Under the Law (a key principle in the UN Convention on the Rights of Persons with Disabilities), our office has planned a trial of Supported Decision Making. We believe that a trial such as this can inform future law reform.

The drive towards Supported Decision Making is an international one. The United Nations Disability Secretariat has suggested that Supported Decision Making could be offered as an alternative to guardianship, but in South Australia, as elsewhere in Australia, there are generally no formal systems for setting up support arrangements.

The Supported Decision Making Trial has been developed to study how Supported Decision Making might operate as an alternative to guardianship just as the United Nations suggests it should. However in talking with Canadian practitioners we were impressed that there can be real benefits when a Supported Decision Making agreement is set up ahead of time – before problems develop and guardianship considered. Supported Decision Making may work best as an early intervention measure. For example people in their late teens and early twenties can benefit by setting up a support agreement just as they become old enough make their own decisions.

Some of the work of the Supported Decision Making trial will be with people who would otherwise have been guardianship clients. We will provide assistance to people we might have helped through guardianship but do it differently. On the other hand the early intervention trial would require our office to recruit clients that we would not normally see. For this reason a funding partner would be needed.

An application was submitted to the Julia Farr MS McLeod Benevolent Fund in early 2010 which was successful. Planning occurred in the first half of 2010. An overview of the trial follows. The work of the committee is described after that.

The role of the Public Advocate in promoting reform

The Public Advocate has had a defined role finding alternatives to guardianship, and promoting community responsibility in this area, since the inception of the *Guardianship and Administration Act*.

Supported Decision Making encapsulates this. There are benefits in our office overseeing a closely monitored trial of Supported Decision Making. However in the future, if law reform provides for the widespread use of Supported Decision Making, then it is likely that the task of assisting people set up agreements would be done by community organisations. For example, *Nidus*, the highly regarded organisation in British Columbia that assists people set up agreements is a non-government organisation.



The Supported Decision Making Trial

A Collaboration
between the
Office of the Public
Advocate
and the Julia Farr MS
McLeod Benevolent Fund



Synopsis of the Supported Decision Making Research Trial

The first hypothesis is that Supported Decision Making will provide an effective alternative to substituted decision making, enabling people to avoid loss of their legal rights and /or government intervention.

A second hypothesis is that as an outcome of Supported Decision Making people living with a disability will enjoy a range of other benefits related to community inclusion and autonomy.

The aims of the pilot are to:

Develop effective ways of enabling people to make supported decisions within an appropriate safeguarding framework.

Identify and provide the range and forms of support that can support people to make their own decisions.

Develop practice guidelines for Supported Decision Making

Promote awareness and strategies to assist agencies and service providers to work within a Supported Decision Making framework so that people with disabilities can exercise their legal capacity.

Inform the principles for and a clear policy framework for Supported Decision Making

The Trial will have two arms. -

An alternative to guardianship arm (20 people will be enrolled). This will be offered to people who would otherwise be placed under public guardianship. It may include some people who have been subject to guardianship but can have their order revoked if an alternative arrangement is in place.

An early intervention arm (20 people to be enrolled). Example of people who may participate include young adults, and people who have more recently acquired a disability. The Julia Farr M S McLeod Benevolent Fund grant will be used to set up Supported Decision Making agreements.

A common evaluation strategy will be applied to both arms of the trial.

The South Australian Supported Decision Making Committee

In early 2010 the Supported Decision Making Committee was established to guide our work.

This Committee has been formed under the provision of the *Guardianship and Administration Act 1993 Section 21(3)* which allows the Public Advocate to establish committees for the purpose of providing him or her with advice in relation to the performance of any of his or her functions.

The committee acts as a Project Control Group for the project. As an official committee its deliberations are reported in the Annual Report. It also provides an opportunity to explain further some of the considerations that have led to the trial being designed as it has.

The committee brings together a mix of knowledge from both lived experience and professional practice. The members are:

John Brayley (Chair)	Public Advocate
Ian Cummins	Person with a lived experience of a disability & Disability Advocate
Dell Stagg	Carer of a person with a disability & Chair of the South Australian Council of Intellectual Disability
Robbi Williams	Chief Executive, Julia Farr Group
Margaret Brown	University of South Australia
Ian Bidmeade	Legal practitioner
Helen Mares	Assistant Public Advocate
Julie-Anne Harris	Senior Advocate/Guardian
Elly Nitschke	Senior Advocate/Guardian
Di Chartres	Executive (2010 Churchill Fellow studying Supported Decision Making)
Two persons with a lived experience of disability	To be recruited (Additional positions to the committee added in July 2010)
External reviewer and commentator	Barbara Carter Victorian Office of the Public Advocate

The full terms of reference and membership of this committee are included at the end of this section.

Ian Bidmeade has been unable to be present due to ill health, and will attend meetings from late 2010.

During its first 6 months the committee developed and confirmed its Terms of Reference which also serves as objectives for the project.

The following themes were discussed –

Decision making

- *Potential barriers to the project*
 - *Disempowerment.* One of the community members on our committee noted that some people with disabilities had been taught as they grew up in institutional settings that they should not speak up, and that they were not able to make decisions for themselves. For this reason people had learned to depend on others, so now needed to gain confidence that they could take control back. This led to an appreciation by the committee of the breadth of personal support that may be required, and that, if done well, decision making skills could develop along the way, as people gain new confidence in decision making, and need less assistance with the more decisions that are made.
 - *Organisation risk management.* Guardianship can provide organisations and institutions clarity in managing risks, that may be preferred over allowing the person themselves to make decisions.
 - *Confusion in decision making options.* In South Australia there is significant confusion in the community about the different types of advanced directives. While a Supported Decision Making agreement is not an advanced directive, the differences would need to be explained to the community when there was already significant confusion.
- *The distinction between Supported Decision Making and “informal arrangement”s.* The *Guardianship and Administration Act (1993)* currently allows the recognition of informal arrangements as an alternative to guardianship. These arrangements are not defined and are not synonymous with Supported Decision Making. It is possible for a person to be an informal substitute decision maker – this occurs frequently already when parents of adult children with severe and profound disabilities make decisions for their family member without the need for a guardianship appointment (this existing situation is explained in OPA Fact Sheet 23 available on our website). In contrast, the Supported Decision Making approach is to provide assistance setting up support agreements. These agreements do not permit substitute decisions.
- *The decision making moment.* One of our committee members summarised these objectives from a disability rights perspective. At the time that the a decision is made, this moment should
 - *Uphold a person’s personal authority*
 - *Be framed in the context of citizenship (including full and equal recognition before the law)*
 - *Be an opportunity for capacity building and affirmation.*

People who will be offered Supported Decision Making as part of the trial

- The committee considered who might be recruited to each of the two arms and the process of recruitment. The intervention would be offered to people who have a disability due to a brain injury, neurological disease and intellectual disability. For the early intervention group people will be offered Supported Decision Making before issues arise – for example when a person with an intellectual disability turns 18, or an adult of any age who has experienced a brain injury leaves hospital
- *Exclusion of financial decision making from the trial.* Although Supported Decision Making can be applied to financial and legal decisions, these were excluded from the trial, although it was recognised that many accommodation and lifestyle decisions may have a financial element.
- *Focus on adults with disability and exclusion of people with dementia from the trial.* The committee endorsed a recommendation from the office to not include people with a deteriorating course (for example older people with dementia) in this initial trial. There are conflicting approaches to the inclusion or exclusion of this group in different Canadian provinces. A key feature of a Supported Decision Making agreement is that the supported person should be able to end it themselves if they are dissatisfied with it. This may not be possible if a person has deteriorating capacity due to dementia.
- *Recruitment.* The committee considered how people would be recruited to the trial. A key criteria is that the person must be aware that they will be making the decisions and not the supporter. They must also wish to be supported by another person or persons, and that there is evidence of a trusting relationship. The decision to join the project has to be their own. The committee considered a concern raised that because some people with disabilities have a fear of guardianship that they might opt for the Supported Decision Making project, even though this may not be their preference either. Strategies for independent referral to the project and separating roles between different staff members in the Office of the Public Advocate were discussed as a way to avoid this problem.

Supporters & Monitors

- *The necessary skills for supporters.* A related issue discussed was the level of judgement that supporters would require to support but not take over and become substitute decision makers. This will be addressed in the preparation of parties prior to commencing an agreement.
- *The role of paid staff as supporters* was discussed. One topic canvassed was whether paid staff could take on this role. The view was that for the trial they should not, however at times it may be appropriate for a staff member to act as a supporter for decisions that do not specifically relate to the service that they provide. For example, a trusted accommodation worker may provide support to a person who needs to make a decision about a medical procedure when the accommodation service has no involvement in the provision of the medical care. However, it is intended that this will not be part of the initial trial as paid staff will not have a role.

- OPA staff will act as a resource to the parties but will not act as supporters. The preference is for there to be a natural community relationship for the support. There is the potential that some people who have become isolated may obtain support from community agencies who are already undertaking work to create community connections for people who experience a disability.
- Monitors will similarly come from the community.

Project Management Considerations

The committee considered

- The ethics committee application. This has been completed and will be considered by the ethics committee when our evaluators have been appointed.
- The development of consumer information sheets about Supported Decision Making and the project.
- The development of an evaluation framework.
- The skills required for a practitioner/project officer to be appointed to oversee the early intervention arm of the trial.
- The future expansion of the committee to include two more people with lived experience of disability.

The potential benefits of this project are listed below.

Specific Benefits

1. Adults living with a disability (ALWD)

- Improved Self esteem
- Confidence in decision making
- Confidence in rights
- Improved decision making skills
- Increase in areas of decision making
- Increase in support networks
- Personal empowerment
- Ease of transacting personal business

2. Carers and decision making supporters

- Understanding of the rights of ALWD
- ALWD exercising rights in greater range of areas
- Adult to adult interaction is evident
- ALWD have positive relationships with parents/carers
- Decrease in substituted decision making
- Ease of transacting business on behalf of ALWD

3. Wider Community

- ALWD's rights & personal choices upheld
- Greater inclusion/participation in life of the community
- Less barriers to personal decision making
- Greater acceptance of ALWD's decisions
- Less administrative / bureaucratic processes and interventions

4. Service providers

- More person centred and accountability to the person with a disability
- Increase in provider knowledge and acceptance of supported decision making
- Respectful of the wishes & personal choice of ALWD
- More flexibility in provision of supports by providers

5. Systems

- Policy changes, including more acceptance of SDM in existing processes and practices accepting of SDM
- SDM best practice identified and in place
- Tools and resources in place that facilitate supported decision making

Terms of Reference
Office of the Public Advocate -Supported Decision Making Committee

This committee has been established by the Public Advocate under the provision of the Guardianship and Administration Act 1993 Section 21(3). This provision allows the Public Advocate to establish committees for the purpose of providing him or her with advice in relation to the performance of any of his or her functions.

1. Objectives of the committee:

This committee will act as a project control group for the trial of Supported Decision Making. This will be to fulfil the following objectives:

- a. To advance the implementation of Article 12 of the United Nations Convention for the Rights of Disabled Persons "Equality in the Law".
- b. To provide assistance to individuals to exercise autonomy and self determination over their lives through personal decision making.
- c. Develop resources and assistance tools for people who may provide decision support (such as family, carers, friends, circles of support).
- d. Develop Supported Decision Making options that may serve as a guardianship alternative ((consistent with the OPA role of exploring and using alternatives where these help reduce reliance on formal guardianship)
- e. Within guardianship practice promote and develop new systems of Supported Decision Making, so that the use of substitute decisions is limited wherever possible, even for those with a statutory guardian.

2. Participants:

The membership of this committee has been brought together by the Public Advocate to bring a mix of knowledge from both lived experience and professional practice. Membership has been drawn from the community, and the Office of the Public Advocate. The members are:

Chair -John Brayley, Public Advocate

Ian Cummins	Ian Bidmeade
Dell Stagg	Helen Mares
Robbi Williams	Julie-Anne Dowling
Margaret Brown	Elly Nitschke
A person living with a disability	Di Chartres
	A person living with a disability

Barbara Carter, Victorian Office of the Public Advocate is a resource/external reviewer.

3. Reporting:

This group has been established as the principle decision making group for the Supported Decision Making trial. All key decisions will be made in session, although for less significant matters, the opportunity of out-of-session ratification of decisions through group e-mail will be used.

Final accountability for decisions rests with the Public Advocate. The work of this committee will be reported to Parliament in the Annual Report of the OPA. This summary will first be presented to the committee for discussion and endorsement.

4. Life of the committee:

It is expected that the committee in its current form will need to operate for 2 years.

Endorsed in Community 10 March 2010
Additional membership July 2010

Promoting Rights and Interests: *Forensic Mental Health Facilities*

Introduction

Last year's Annual Report highlighted the deficits in South Australia's forensic mental health facilities.

In essence there are two significant problems. The first is the number of beds – there are not enough. The second is the outdated design of the existing facility.

Our office has previously estimated that there should be

60 possibly 65 forensic mental health beds in South Australia (Office of the Public Advocate, 2008). There are currently only 40. People who should be in hospital wait in prison instead. Other people who need to be in hospital, are admitted to community beds in general hospitals and to Glenside. This has a flow on effect to community patients who are waiting for beds that may be occupied by a person who should otherwise be cared for in the forensic facility.

The forensic building was state of the art in the 1980s. At the time it was a building South Australia could be proud of. Since then design developments have occurred. Forensic mental health facilities are now built like hospitals, not gaols. The modern campus style design used in the last 10 years has high technology perimeter fencing to maintain security while keeping the environment inside as therapeutic and hospital like as possible.

More detail on policy and design issues, as well as the experiences of patients at James Nash House can be read in our Annual Report 2009 commencing on page 66 (available on our website).

2009 James Nash Plans

On October 28 2009 the Government announced that James Nash House will be upgraded and expanded with a \$19M redevelopment (Minister for Mental Health, 2009).

\$18M of the funding was to come from the sale of vacant land adjacent to James Nash House, plus \$1M of contingency funds set aside in the 2009 State Budget.

This funding will pay for the relocation of existing forensic beds from Glenside to Oakden. Currently Forensic Mental Health Services operate 30 beds at Oakden, and a further 10 beds on the Glenside Campus (called Grove Closed).



Photographer Tom Lee, *Sunday Mail*



James Nash House, Oakden. Photographer: Tom Lee, *Sunday Mail*

The Glenside redevelopment does not include the rebuilding of existing forensic beds on that site, and the 10 beds currently at Glenside need to move to Oakden. Despite the building program, the total number of forensic beds in the state remains static at 40, which is well short of the 60-65 beds that we estimated were required in 2008.

It is our understanding that approximately \$10M of the new funds will be used to build the 10 beds to be transferred from Glenside, and the remainder of the money will be used for improvement work. This will focus initially on air-conditioning and gas supplies to the existing building. Patients will not necessarily see an obvious improvement in accommodation standards and design from this work. If funds are left over from this initial work other improvements will be made.

The fundamental design of the 30 bed building would not be altered.

In the current 30 bed building, 22 of the beds provide prison cell type sleeping accommodation. The remaining 8 are in a more domestic like unit, similar to those interstate, but even that unit is small compared to modern units and does not have easy access to outside grounds.

A completely new facility would have hospital style bedrooms, more communal space, and greater outdoor access. The architectural design of new buildings provides improved lines of sight for staff and in built electronic security so that patients can move more freely around the facility with less need for staff escorts.

A modern facility would however have greater recurrent costs. James Nash House, unlike most facilities in Australia, locks patients in their rooms overnight. The ability to lock patients in cells allows the facility to employ a skeleton staff of nurses – as few as 4 on duty for the entire facility. If it was run like a hospital overnight, then patients would not be locked in individual rooms, and overnight staffing levels would need to increase to the level used in psychiatric wards generally. Our office has not calculated what these additional costs would be, however they are costs already borne by forensic facilities interstate as a reasonable cost.

From the perspective of our office we consider that it should be possible to rebuild James Nash House entirely, and expand its size. While this would require more than double the existing capital funding, and may increase recurrent nursing costs overnight, it could still be better value in the long run than the current interim solution.

The need for a complete redevelopment

It is worth recapping that recognition of the need to rebuild James Nash House has been long standing and widely held.

In South Australia in the early 2000s, the late Margaret Tobin, the then Director of Mental Health had a pivotal role in getting others to recognise the need to improve conditions for forensic patients. She was particularly concerned about the conditions for young people in forensic mental health care and women. She brought facilities design experts to this state from New Zealand to give presentations on facility development. These described what had been done in visionary New Zealand facilities to humanise conditions, while maintaining security. This moved the discussion in this state from one focussed on bed numbers to the design of the facility as well.

This was taken up by the then Minister for Health, Lea Stevens. She was asked a parliamentary question based on concerns about James Nash House expressed by former Public Advocate, John Harley in the OPA Annual Report. . She noted in response (Hansard, 22 October 2003)

These are very serious issues which have a long history, certainly predating this government. The deficits in the James Nash House services that have been identified by the Public Advocate have been documented previously in numerous reports and reviews made to the previous minister dating back at least to 1999. The newly appointed Director of Mental Health, Dr Jonathan Phillips, has identified reform of forensic mental health services as a key priority.

Dr Phillips had engaged Dr David Chaplow the Director of Mental Health for New Zealand to assist with planning.

Prior to 2007 \$16.5M of new funding had been allocated to rebuild it (Minister for Mental Health, 2007). This funding was given up when the plan was changed that year to build James Nash House at Mobilong.

Further statements about the inadequacy of the current James Nash House were made by then Mental Health Minister Gail Gago, when announcing the Mobilong plan to rebuild James Nash.

Minister Gago said

This is a once-off opportunity to build a modern new mental health forensic treatment complex offering a range of recovery services, one that will be completely different from the current design of James Nash House which resembles a prison

She went on to say,

Since James Nash House was built more than 20 years ago, the design of modern forensic facilities overseas and interstate has moved from correctional and custodial type layouts to secure mental health complexes with a focus on assisting people to get better

The reason for citing this history is to make the point that the deficits that are now being raised have been well recognised by the Department and the Government. There was a plan to rebuild the facility on its existing site and the current development proposals fall far short of the recognised needs. This plan could be restarted now that the alternative Mobilong development will not proceed.

The current situation

The photographs on the previous pages give an indication of the correctional nature of the James Nash House construction. We do not have photographs of the interior.

The current building does serve its purpose to a degree. Patients much prefer to be there than in prison, even though some prisons offer better buildings and more space than James Nash. This is because patients know they are in hospital, and are there for treatment rather than incarceration.

Staff and patients have also taken time to make the best of the surroundings that they do have with art work, decorations, the provision of exercise equipment, herb and vegetable gardens,

and an activity program. Many of these personal touches can give a positive impression to the visitor, but should not cover up the fundamental deficits in the buildings. The bedrooms (cells) are repainted and patients put up their own decorations.

None of this though can overcome the lack of space (particularly when all patients are together inside sharing the common area of the largest of the units), the poor design relationships between different areas and the limited lines of sight. The latter mean more staff escorts are required as patients move about the building or out to the largest of the outside exercise areas.

None of these concerns about James Nash House are new. Just because patients and staff can make the best of it, is not a reason to continue with a situation that has been recognised as inadequate for at least 7 years. Of course the lack of bed number, and the unjust waits in prison for admission have been recognised as a problem for longer than that.

The Office of the Public Advocate will continue to argue for the redevelopment on the Oakden site - a redevelopment that should have automatically been put back on the governments capital works program but this has not occurred.

Raising Matters with the Minister

Guardianship and Administration Act 1993

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

- (1) The Public Advocate may, at any time, raise with the Minister and the Attorney-General any concerns he or she may have over any matter arising out of or relating to the performance of his or her functions under this Act or any other Act.
- (2) If the Public Advocate so requests, the Attorney-General must cause a report of any matter raised by the Public Advocate under subsection (1) to be laid as soon as practicable before both Houses of Parliament.
- (3) The annual report furnished by the Public Advocate under this Act must include a summary of any matters raised by the Public Advocate under subsection (1).

During 2009-2010 the Public Advocate met with relevant Ministers and Members of Parliament in an advocacy role.

The Public Advocate sought appointments with Ministers to discuss a range of legislative, policy and funding issues. The frequency of these meetings has generally been on a quarterly basis with the Minister for Mental Health and Minister for Disability with other appointments reflecting particular issues of relevance to this office's mandate..

Meetings with Ministers:

Attorney General

Minister for Disability

Minister for Mental Health and Substance Abuse

Meetings with Members of Parliament:

Duncan McFetridge, Shadow Minister for Mental Health & Substance Abuse

During the year no formal matters were raised with Ministers using the provisions of Section 22 (1) and therefore required to be included in this report under Section 22 (3).

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

Guardianship and Administration Act 1993

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

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

Advice about the Act was provided through:

- The enquiry service
- Education sessions

This work is reported in Part B of this Report.

Monitor Legislation

Guardianship and Administration Act 1993

Guardianship and Administration Act 1993

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

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

Introduction

The 2008-2009 OPA Annual Report considered the implications of Article 12 of the UN Convention on the Rights of Persons with Disabilities on existing practices, made recommendations for new principles to be added to the *Guardianship and Administration Act 1993* and introduced a new Stepped Model of Substitute and Supported Decision Making.

UN Convention on the Rights of Persons with Disabilities

Article 12

Equal recognition before the law

1. States Parties reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law.
2. States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.
3. States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.
4. States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity

Article 12 continued

respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests.

5. Subject to the provisions of this article, States Parties shall take all appropriate and effective measures to ensure the equal right of persons with disabilities to own or inherit property, to control their own financial affairs and to have equal access to bank loans, mortgages and other forms of financial credit, and shall ensure that persons with disabilities are not arbitrarily deprived of their property.

The three additions to the current principles were that:

- there should be a clear statement that adults will be presumed to have capacity (in line with the UN Convention on the Rights of Persons with Disabilities),
- a statement that mental capacity is decision specific, and
- a requirement, before a substitute decision maker is appointed, that all practicable steps be taken to help a person make their own decisions.

The table below combines current principles contained in the *Guardianship and Administration Act 1993* with those recommended by this office. They provide an interim strategy towards practice change but this falls short of a complete review of Guardianship and Administration legislation in this state.

A proposal for additional Section 5 principles Guardianship and Administration Act 1993. Existing principles, plus new suggested principles in italics.

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

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

Figure 21

This office continues to advocate for these recommended changes to the Act.

More importantly however, we consider that the case for a full review of the *Guardianship and Administration Act 1993* also exists. We hope that this case will gain significant momentum over the next one to two years, particularly given the growing interest from the disability sector in Supported Decision Making. Based on experiences overseas (in particular in Canada) the driver for this is likely to come from people interested in disability rights, namely people with the lived experience of disabilities and their families and friends.

Legislative Reform

The section of this year's report on Promoting Rights and Interests describes the details of the trial of Supported Decision Making. The results of this trial may inform law reform.

Reformed legislation in this area could have the following features (based on Canadian experience):

- New legislation could promote Supported Decision Making as the primary intervention for people who need assistance with decision making.
- It could provide for statutory recognition of Supported Decision Making agreements so that they are acknowledged widely by health services, disability providers, financial institutions and in the community generally.
- In addition, a greater range of appointment options should be available to tribunals so that the level of intervention could be better matched to clients. This might include the ability to require a person to enter into a Supported Decision Making agreement, or to appoint a second person as a "co-decision maker". (Descriptions of these interventions are in the earlier section of this report).
- It would still include provision of guardianship as an intervention of last resort, but establishing guardianship would not be the primary purpose of the Act. Instead, a tribunal could have a suite of different solutions to offer people it seeks to help.

The existing Victorian law reform process of their Guardianship and Administration is likely to have a flow on to the thinking in other jurisdictions, including our own.

Stepped Model of Supported and Substitute Decision Making

This Stepped Model was revised in 2010 (as illustrated on the next page). This model provides context to both the Supported Decision Making trial and helps in recognising gaps in what is available now and might be considered for future legislative reform.

The 2010 version is more generic than our first attempt at charting the model in 2009. It expands on different forms of supported and substitute decision making and unlike last year's model is not specific to South Australia.

Not all definitions are agreed in the literature (for example some authors use the terms Assisted and Supported Decision Making interchangeably) but this model can be used as a useful schema.

Autonomous Decision Making: At the top of the stepped model is autonomous decision making. Even when decision making is autonomous most of us will choose to seek advice and support from others when making an important decision, and at times share decision making with others. For this reason decision making can be seen as “interdependent” as opposed to independent.

Assisted Decision Making. While definitions vary, in assisted decision making a person is regarded as having legal capacity, but requires assistance to collect information to make a decision. This can be communication assistance – for example a person who has had a stroke and may need to communicate with a special device. Perhaps for this reason Assisted Decision Making is commonly piloted by Speech Pathologists. For people who have an intellectual disability Assisted Decision Making may require information to be presented clearly in plain English with the use of diagrams if needed. Assistance can be provided by anyone including service providers. While it may be helpful to have an agreement this is not absolutely necessary.

A non-statutory Supported Decision Making agreement: The appointment of a supporter is made by the person needing support. The person must want to have support making decisions, and have a trusting relationship with someone who will be their supporter. The person also must be able to cancel an agreement at any time if they are unhappy with its operation. Agreements can also specify a third person – a “monitor” – who can check to ensure that the agreement is operating as it should.

Without a specific law, an agreement acts as a record of the person's wish to receive support from another. It will not give the supporter any additional standing, and a supported person will not be obliged to use the agreement.

This will be the type of agreement used in the South Australian Supported Decision Making trial described earlier in this Annual Report.

A statutory Supported Decision Making agreement : This has most of the same features as a non-statutory agreement, but in jurisdictions that have Supported Decision Making laws, this legal recognition has advantages in safeguarding the supported person, and giving a special status to supporters.

A legislated form of agreement can create obligations on the supporter to act in the interests of the supported person, and also give their role legal recognition so that health services and community agencies can share information directly with supporters. Legislation can also include protections from liability for supporters and other parties assisting a person to make

decisions provided that such actions are not in breach of the supporter's duty to the supported person.

A supported person is expected to use the agreement – if they wish to make decisions outside it then a person should cancel the agreement. The agreement is a significant document that cannot be ignored.

A tribunal appointed Supported Decision Making arrangement: Unlike the agreements already described, a person would not have the option of ending an agreement unilaterally as only the tribunal has the power to do this, and would be required to seek support in making decisions while the agreement is in place.

Representational Agreement: Such agreements are intended primarily to provide Supported Decision Making, and a person appoints their supporters through signing an agreement document as described previously. However, representational agreements also permit the supporter to make a substitute decision if the supported person is unable to make a decision themselves – for example, if the person became unwell and is in hospital. This model, as practiced in British Columbia allows for both supported and substitute decision making.

A tribunal appointed Co-decision maker This is an arrangement used in Alberta. If an adult needs support with decisions a co-decision maker can be appointed by a court. The co-decision maker, who is usually a family member or close friend, and the adult, need to agree on major decisions. If there is a disagreement the decision of the adult (not the co-decision maker) takes precedence. If the arrangement is not working it may be followed up by the Public Guardian to determine if another person should be appointed co-decision maker or another form of decision making support is required. In Victoria, the Office of the Public Advocate in that state has called for the creation of co-decision maker appointments.

Monitors are an important element of the Canadian framework. As noted it is common for a third person to be appointed in a monitor role. In our Trial each supported person will also nominate a 'monitor' to assist with the process (rather than the making of actual decisions). The monitor will also take action if they consider that the Supported Decision Making process is not working.

Conclusion

The Stepped Model:

- Consideration of alternatives for law reform. As a general principle, our office considers that there should be a range of options available, so that there is more likely to be a "step" that best suits each individual and their support requirements. This could also create more appointment options for tribunals.
- Provides context for the Supported Decision Making trial. Only one form of agreement will be tested, and unlike future law reform options, there is not

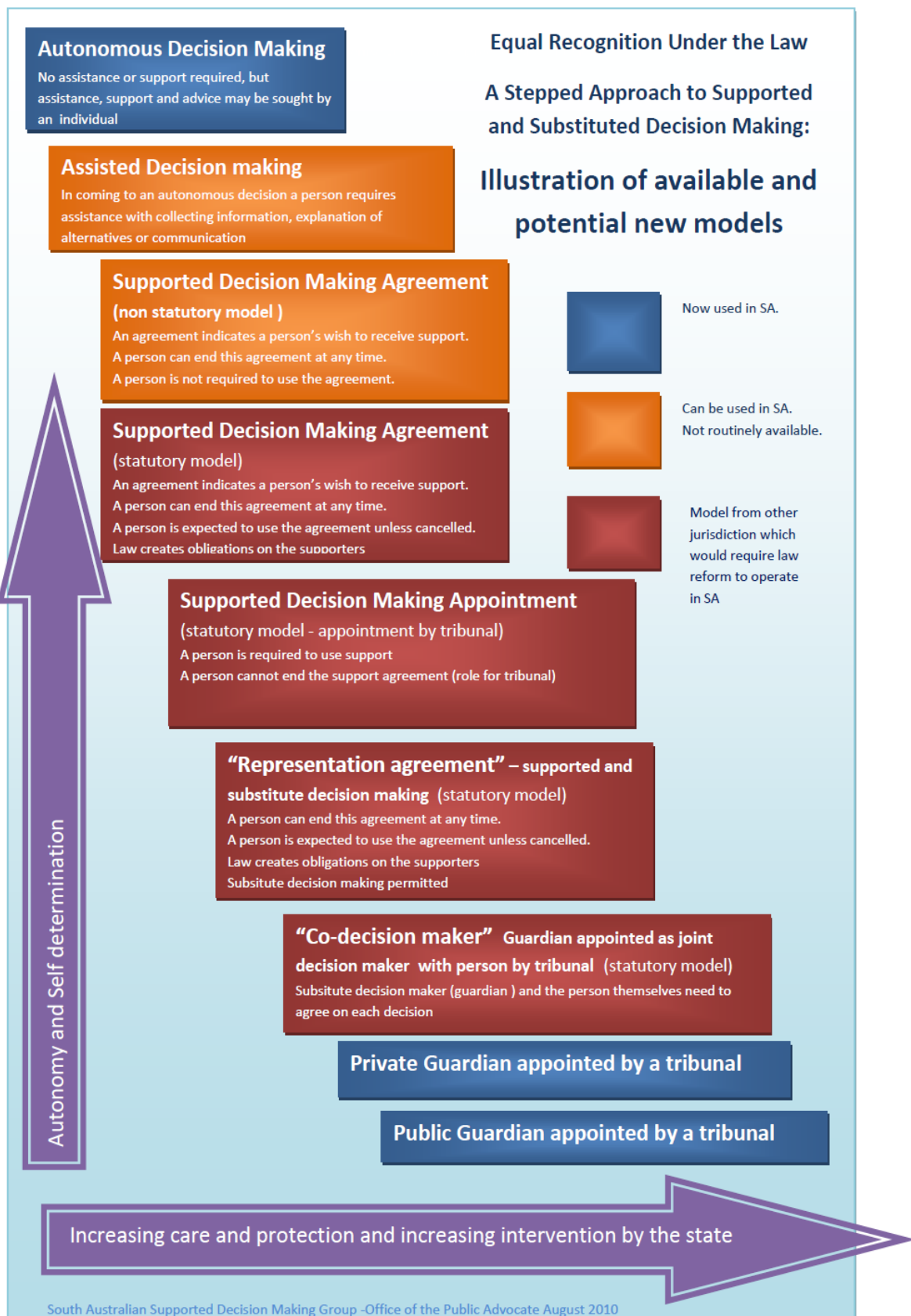


Figure 22

Monitor legislation: Mental Health Acts 1993 and 2009

Introduction

Last year we reported that in late 2008 OPA received \$60,000 from the Australian Rotary Health Research Fund, to undertake research on how decisions are made about involuntary mental health care.

Late in 2009 we were delighted that the second phase of our research was funded by the Australian Rotary Health Research Fund, for a further \$60,000.

This project is titled *'Threshold Test for Involuntary Mental Health Treatment – Reducing Practitioner Variation in Invoking Orders and Implementing the Least Restrictive Option'*.

The threshold test concerns decision making by doctors to detain (or not) or to apply to the Guardianship Board for a Community Treatment Order, so that a person who has a mental illness can receive compulsory community based treatment. The *Mental Health Act 2009* now authorises a broader group of professionals to make initial decisions about detention and compulsory treatment but the same decision making issues still apply.

It is important to reduce variability between practitioners and our research on clinicians' decision making under the *Mental Health Act 1993* should provide information to support improvement of practice standards.

The Project

The research was undertaken in two phases.

Phase 1 involved the analysis of detention forms and community treatment orders that are routinely collected by the Guardianship Board. Detention forms were systematically sampled and their content recorded. They were then compared to the requirements of the (old) Act. A similar analysis of the grounds for seeking community treatment orders was undertaken.



Rotary Partnership Project

Mental Health Law:
Protecting Rights and
Improving Outcomes



Supported by

Australian Rotary Health
Research Fund Grants
2009 and 2010

Phase 2 involved qualitative research collating the views of consumers about detention and involuntary treatment and how decisions were made about them. Consumers, carers and Psychiatrists contributed to this information gathering. Individual consumers and consumer groups showed much interest in this work and were appreciative of the opportunity given to them to be interviewed or to attend a focus group to describe the consumer experience of involuntary care.

The Project Control Group for the research has stayed the same for both phases of the research, namely

- Associate Professor Andrew Alston, an academic lawyer based at Flinders University
- Jennifer Corkhill, Appellants Lawyer
- Dave Tapley, Consumer Advocate
- Jeremy Moore, President of the Guardianship Board
- Margaret Honeyman, Chief Psychiatrist and Chief Advisor in Psychiatry for South Australia;
- Di Chartres, Executive, Attorney General's Department,
- John Brayley, Public Advocate and Chair of the project Control group

The research activities finished in August 2010 and a final report is currently under preparation.

Project observations.

Some of the issues that the research project raised, either during the course of collecting data or in the initial analysis, are described in this section. It should be noted that this is initial commentary from the Office of the Public Advocate rather than the conclusions of the Project Control Group. More formal conclusions will be contained in the final report after data analysis is complete. However these notes do indicate the matters under consideration.

The table below summarises the project.

Research Approach and Sample		
Components	Method	Sample (N)
1. Quantitative research	Systematic analysis of Detention Forms 1 and 2	90
	Systematic analysis of CTO application forms	30
2. Qualitative research	Consumers: semi-structured individual interviews; focus groups	58
	Carers: semi-structured individual interviews; focus groups	19
	Public system psychiatrists: Interviews	11
3. Legal/academic analysis	Case law around issues of involuntary treatment	N/A

Figure 23

Poor quality of clinician's statements that justify the use of detention powers. During the course of the project, it became clear that a number of detention forms that had been analysed were poorly completed. Clinical details entered by doctors could be minimal (at times as short as one or two words), and it was not clear from reading the forms whether the legal criteria for detention were met or not.

In contrast there were other forms completed for patients that clearly explained in everyday language why a person needed to be detained. This demonstrated that the task of succinctly justifying a detention decision can be done well. While the problem of poorly completed forms occurs in a minority of cases (actual statistics are still being calculated) it did occur often enough to generate concern. At this time it is not clear whether the problem is with the actual detention decision making, or with the documentation of the decision making. With limitations of the project design it may turn out not to be possible to separate these issues. The Department of Health were informed of this problem as they were due at the time to commence training for clinical staff in the use of the new Mental Health Act.

Lack of early intervention leading to involuntary care. The preliminary analysis of qualitative responses identified a number of key themes. One was the link between a lack of early intervention services that may prevent future deterioration and the subsequent need for involuntary care – all of which could be avoided if early intervention services had been provided when a person was first unwell and prepared to accept care. The preliminary analysis showed that 39% of consumers and 74% of carers identified this as an issue. All of the 11 psychiatrists interviewed also raised this.

Other key findings: There were significant findings about poor communication with staff during involuntary care. This is being analysed further to look at the nature of the poor communication in more detail as it occurred on different occasions during a person's time receiving care.

Another topic was concern about the way medications are prescribed to involuntary patients and in particular how side effects are recognised and responded to. Even if a person's preference is not to receive any medication, it can still be possible to participate in medication treatment decision making, knowing the constraint of the order which requires medication to be taken.

Carers reported significant problems with the withholding of information from them about relatives receiving involuntary care. This issue is specifically addressed in provisions in the new *Mental Health Act 2009* – the implementation of which will need to be evaluated when this new Act is reviewed.

Part B:

Direct Services

Provided to the Community by the Office of the Public Advocate

Public Guardian

Guardianship and Administration Act 1993

Section 29 —Guardianship orders

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

What is guardianship?

Guardians are appointed by the Guardianship Board (under Section 29 of the *Guardianship and Administration Act 1993*) to make decisions on behalf of individuals who are unable to do so for themselves due to mental incapacity. A person may have a mental incapacity and still be able to make certain decisions in their life on their own or with support. It is important to preserve an individual's legal and personal rights to be in control of their own decision making as far as possible. Guardianship Orders should only be made when this is not possible and there are health or lifestyle issues which require decisions by a legally appointed guardian. The person under guardianship is called a protected person.

The principles of the Act require the Guardianship Board to consider whether or not informal arrangements are working for an individual and to only appoint guardians if there is evidence to the contrary. They also require the Board to consider the least restrictive intrusion into the life of individuals affected by its orders. The Board will consider whether a limited order is sufficient to address the decision making issues.

The Board has provisions for making emergency short term orders for the protection of individuals whose health and wellbeing may be at imminent risk. These orders are called interim orders. The Public Advocate is usually appointed until such time as the matter can be fully considered by the Board. In some cases there are family members who are willing and able to take on this responsibility, in others, the orders simply lapse because the issue requiring attention has been resolved.

When guardianship is considered necessary, the Board will look for a suitable guardian within the family or amongst friends. It is helpful to the Board to know the history of the person with the mental incapacity, their past life choices and likely wishes in order to appoint the best person as guardian. However, some people do not have suitable people in their lives and some families do not have the confidence or ability to take on the role. Individuals appointed by the Board are referred to as Private Guardians. Public guardianship is considered the last resort when all else has been exhausted.

Public guardianship and its operation

The Public Advocate is appointed as guardian of last resort where no suitable private guardian exists or the Board decides on a joint appointment with a private guardian. The Public Advocate delegates some aspects of his authority to employees of the Office of the Public Advocate who in turn become responsible for substitute decision making for particular protected persons. More complex decisions remain the responsibility of the Public Advocate or his senior staff. Concerns about decisions made by delegated guardians or processes used are referred to the Public Advocate who ensures that a review is conducted.

Central to decision making is the application of the principles of the Act to the individual circumstances of each client. . These principles have been reproduced in full in Part A of this report. The paramount consideration must be given to what would, in the opinion of the decision maker, be the wishes of the person if he or she were not mentally incapacitated, but only so far that this is reasonably ascertainable. The present wishes of the person should be considered, and a decision should be least restrictive of the person's rights and autonomy, as is consistent with his or her proper care and protection.

This requires guardians to collect as much information about the person as possible, to understand their life, values and wishes and apply this to the decisions. In this way we can make the decision that the person would have chosen for themselves if still in control of this process.

In addition to the principles contained in the Act the practice of Public Guardianship is practiced in accordance with the United Nations Convention on the Rights of Persons with Disabilities. In October 2009 the Australian Guardianship and Administration Council updated the National Standards of Public Guardianship to be consistent with the convention, in particular Article 12. These standards are accessible from the AGAC website (<http://www.agac.org.au/agac-publications>). The standards note

Accordingly for all people there is a presumption of capacity and all possible efforts should be made to assist a person exercise their own capacity. When a person does not have full legal capacity, such incapacity is decision specific, and therefore a person's decision-making capacity needs to be considered for each and every decision.

Notwithstanding the terms of a guardianship order, delegated guardians will consider whether or not the individual under guardianship can make a decision themselves or with support (a supported decision) rather than the guardian making a substitute decision.

The 2009 Australian Guardianship now also refer to Advocacy:

- *Represented persons have a right to access housing or accommodation, health care, support services, and assistance to participate in the community.*
- *Staff making guardianship decisions will:*
 - *Assess whether all options have been presented to the decision maker by service providers, and seek to recognise when a preferable option has not been presented.*
 - *Make all possible attempts to advocate for the best option so that a decision can be made between meaningful options that improve both quality of life and opportunity for the represented person.*

Such work can comprise a significant part of an advocate/guardians workload.

Team structures

In December 2008 the office commenced a trial of streaming its guardianship work into two teams. The 'short term' team takes on guardianship for people who are likely to require intensive guardianship work for 6 months or less, and also undertakes investigations. Because of the nature of its work, this team tends to provide guardianship for older people. The 'longer term' team tends to have more younger people with an intellectual disability. The two team model has now been adopted on an ongoing basis.

The teams meet weekly to allocate work and monitor issues. Staff review their caseloads regularly with the Senior Advocates/Guardians and clients of both teams are transferred into the short term team's monitoring' caseload when their circumstances stabilise.

The work allocation system is under constant review so that improvements in efficiency and effectiveness can be achieved.



Tarnia White (foreground) and Anna Latimer (rear), Advocate/Guardians in the short term team. Anna is consulting with Senior Advocate/Guardian Elly Nitschke (back to camera).



Maria Atkins (Advocate/Guardian) meets with one of her clients

Guardianship Activity

During 2009-10, the Office of the Public Advocate provided guardianship services under the *Guardianship and Administration Act* on behalf of 705 people (661 in 2008-09). This represents a 6.7% increase over the previous year and a continuing upward trend. In the previous three reporting periods, the increases were 9.6%, 17% and 16% respectively. This is illustrated in figure 24.

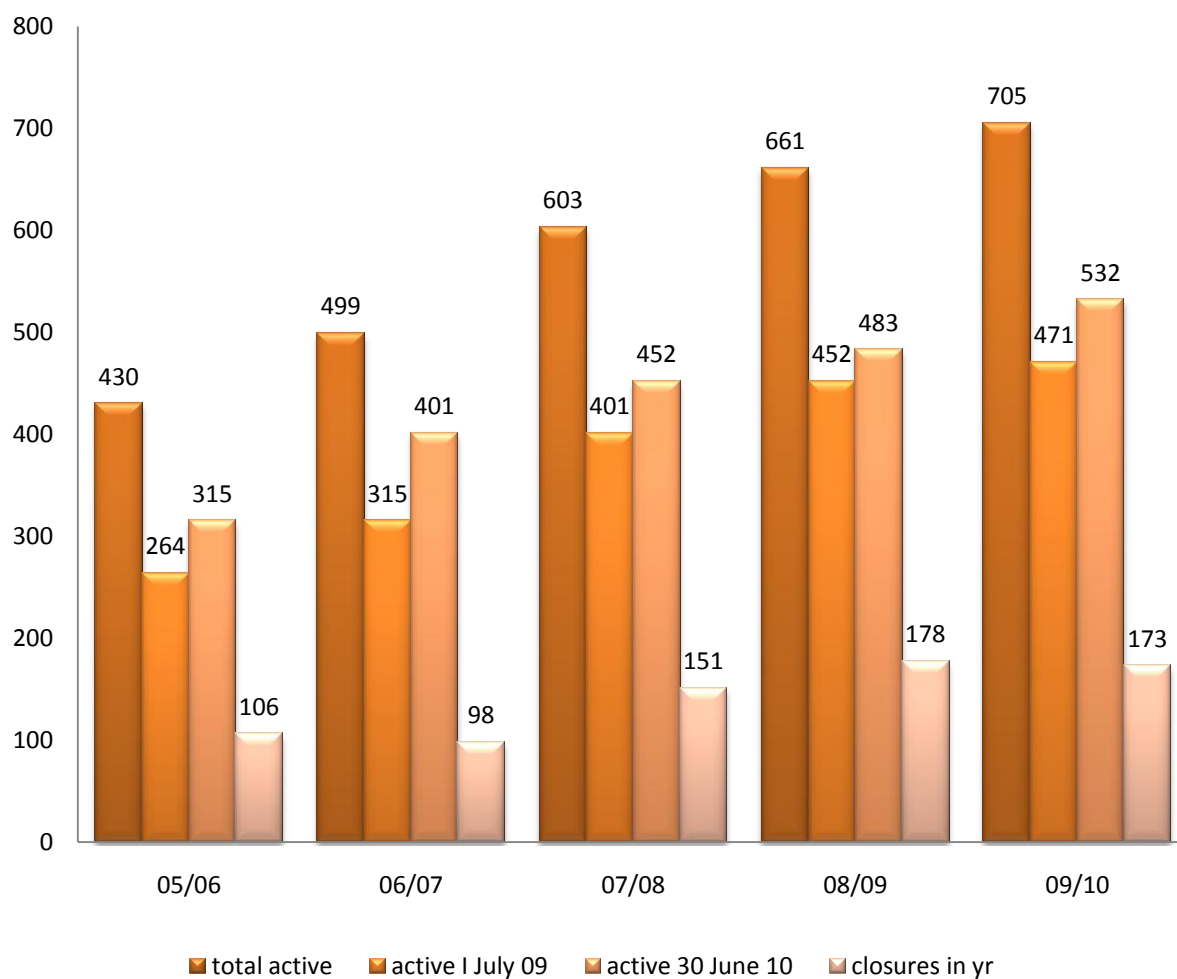


Figure 24: Guardianship Activity 2005 - 2010

The number of active cases managed by the office continues to grow. The rate of growth is largely due to the number of new cases opened each year exceeding the rate of closures.

As at 30 June 2010, there were 532 active guardianship cases compared with 471 at the beginning of the year — a 13% increase in active cases at year end. This represents a 64% increase since 2005-2006.

Active Cases at June 30 2005-2010

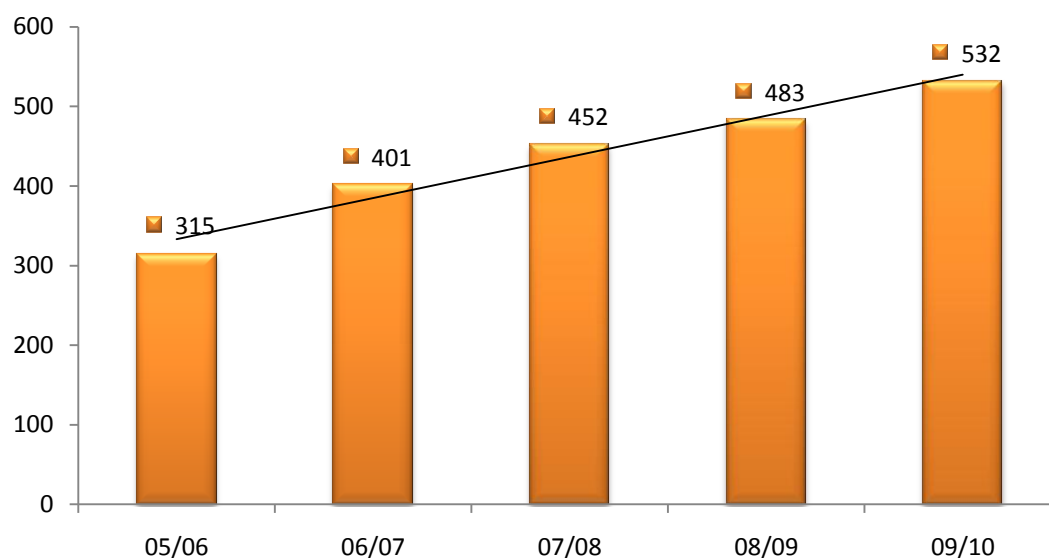


Figure 25: Active cases as at year end

This year 234 new Public Advocate guardianship appointments were made, a 12% increase on last year's figures (209). The following graph shows a continuing upward trend. 133 (57%) were allocated to the short term team in the expectation of a need for short term guardianship only.

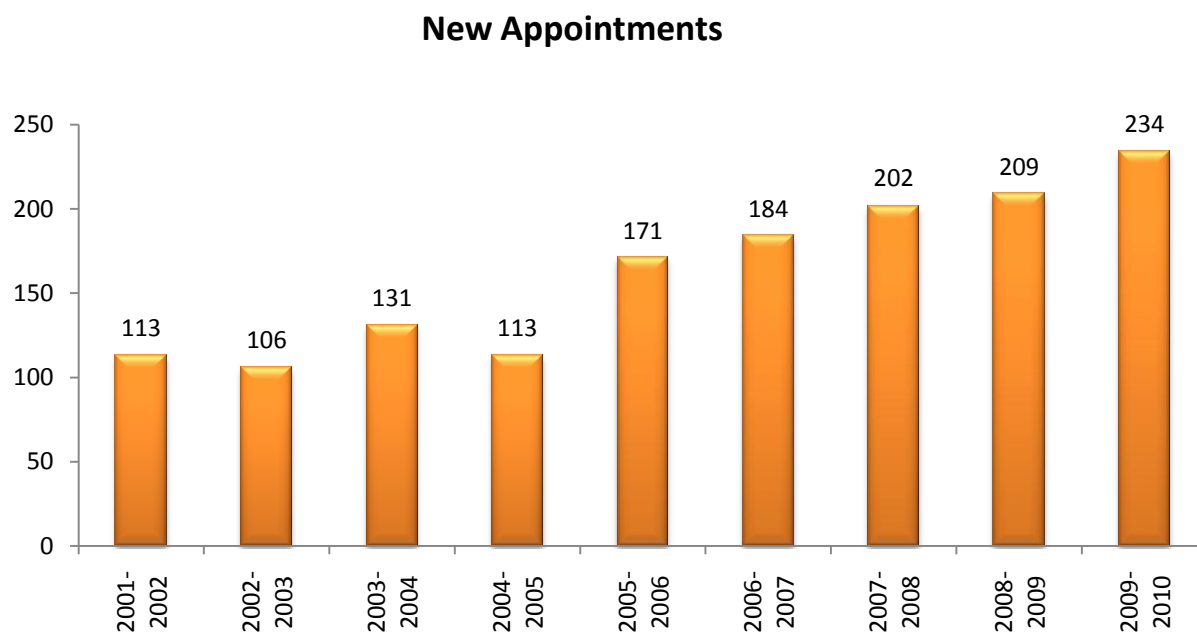


Figure 26: New appointments 2002 - 2010

Of the 234 new appointments, 113 were limited orders, 96 were full orders and 25 were emergency interim orders only, 28 of the 234 involved joint appointments with family members.

During 2009-10, 173 cases were closed — a decrease of 3% (5) when compared to 178 closures in 2008-09. Of the 173 closures, 110 were due to revocation of orders, 40 due to death, and 19 due to private guardians being appointed, 4 were lapsed interim orders. Reason for closure are all illustrated in figure 4. The OPA recommends the Board revoke when satisfied that orders are no longer needed.

The Guardianship Board and the Office of the Public Advocate rely on the responsiveness of each other's systems to reviewing guardianship orders. Delays in these processes extend the length of guardianship for those clients whose orders could be revoked sooner. The Board and the OPA have been working together to improve these processes.

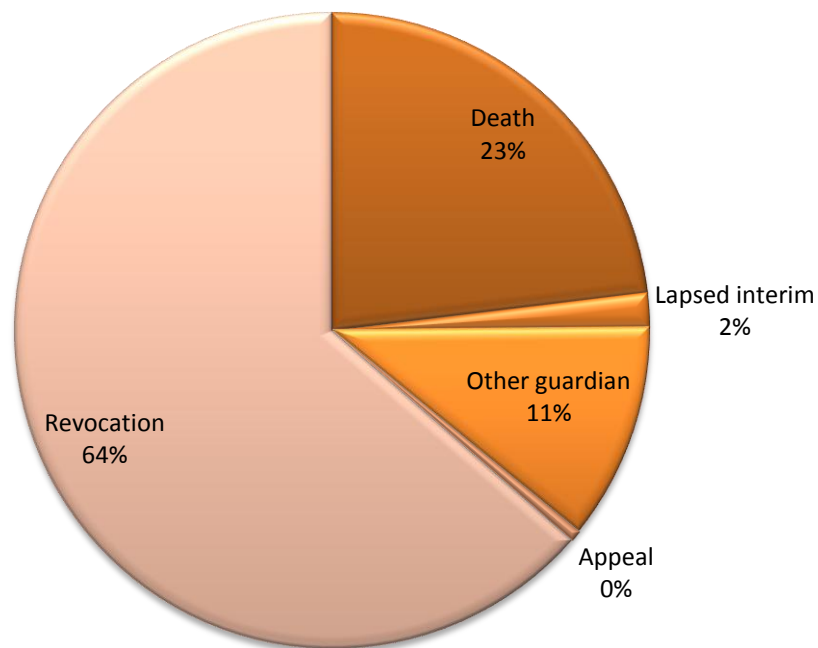


Figure 27: Reasons for closure

The rate of closures in 2009–10 as a percentage of all orders was 24.5 %. This compares to 27% in 2008-09, 25% in 2007-08, 19.6% in 2006-07 and 24.4% in 2005-06. This is illustrated on the next page (Figure 28).

Annual Closures Rate (Percentage of all Public Guardian cases)

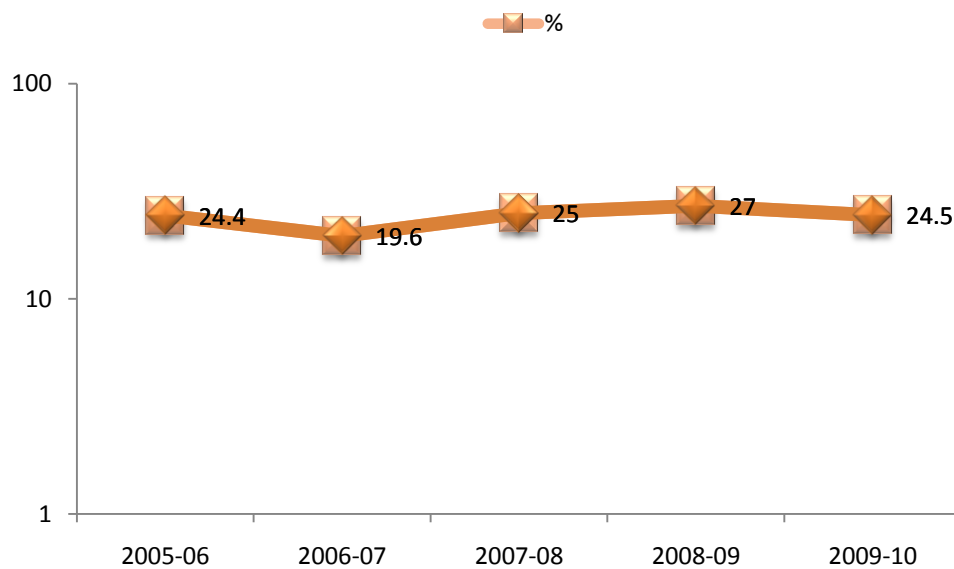


Figure 28: Rate of Guardianship closure

The table below (Figure 29) compares numbers of guardianship cases and closures over a three year period.

Closures as Percent of Guardianship Services Provided			
	2007/2008	2008/2009	2009/2010
Closures	152	178	173
Services	603	661	705
%	25.2	26.9	24.5

Figure 29: Closures 2008 -2010 as % of all guardianships

The next table (Figure 30) compares reasons for closure for a two year period.

Reason for Closures						
Reason	2008/2009			2009/2010		
	Number	% of Closures	% of Guardianship Services	Number	% of Closures	% of Guardianship Services
Revoked	118	66%	18%	110	64%	16%
Deaths	53	30%	8%	40	23%	6%
Private guardian appointed	7	4%	1%	19	11%	3%
Other	-	-	-	4	2%	0.5%
Missing	-	-	1	-	0	1
Closures	178	100%	27%	173	100%	21.5%

Figure 30: Reasons for closure 2008 - 2010

For those clients whose guardianship orders were revoked during the year, 38% were under guardianship for less than 12 months, 68% for less than two years and 82% for less than three years.

The average length of guardianship for closed cases was 1.7yrs (median 1.3yrs). This compares with an average length of 2 years (median 1.3 yrs) in 2008-09 reporting period. Length of guardianship for different age and diagnostic groupings is compared in Figure 8. There is a decline of 4 months on average length of guardianship between the two reporting periods.

The table (Figure 31) below compares age groupings and diagnostic groupings with length of guardianship for those cases closed in 2009-2010. It is interesting to note that clients in the 70 plus years and those with a diagnosis of dementia have shorter lengths of guardianship when

compared with clients who are younger or have a mental health, intellectual disability or dual diagnosis. Clients who have brain injury however have the shortest average length of guardianship. This can be explained by factors such as regaining capacity soon after an injury, the need for interim orders to assist in managing post acute safety and rehabilitation issues and interim orders appointing the Public Advocate transferring to family members at the Board hearing.

Closed Guardianship Cases 2009/2010							
DIAGNOSIS, AGE AND LENGTH (months) OF GUARDIANSHIP							
Diagnosis	Number	Average length (months)	Median Length (months)	Age at end of Order	Number	Average Length (months)	Median Length (months)
Brain Damage	21	16	7.5	<41	37	24	22
Dementia	61	17	14	41<70	57	21	16
Mental Illness	29	24	18.5	>70	79	17	14
Intellectual Disability	25	28	28				
Dual Diagnosis	22	22	20				
Other	15	19	10				
Total	173	20	15		173	20	15

Figure 31: Closed guardianships diagnostic and age profile

Length of Closed Cases 2009-2010

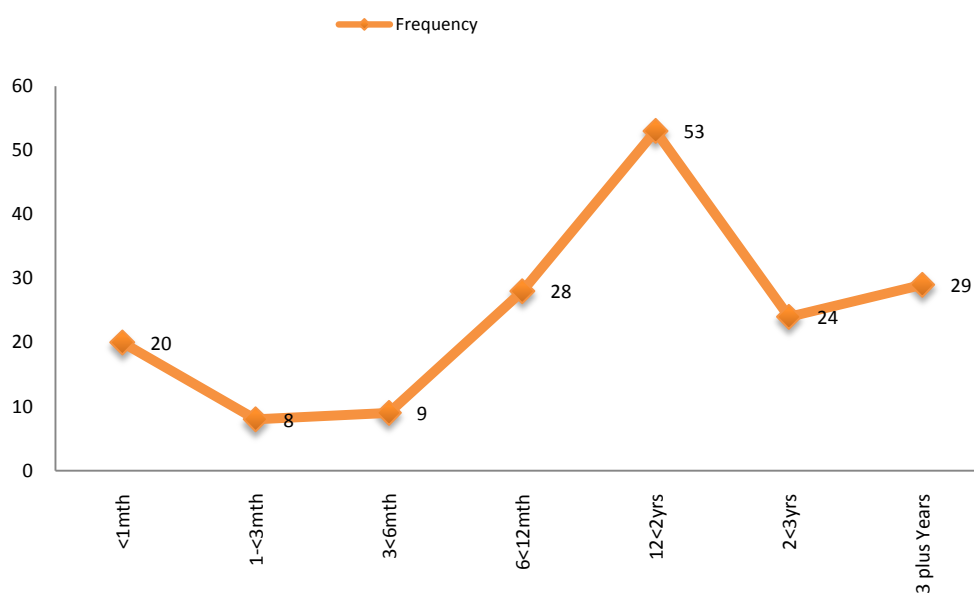


Figure 32: Closed cases by length of guardianship

For the 532 cases open as at 30 June 2010, the average length open was 2.3 years (median 1.6yrs). Note that 26% of these cases had been active for over 3 years. The table below (Figure 10) compares length of guardianship for those cases open at the end of year and those closed during the reporting period.

Length of guardianship cases		
Comparison of length of Guardianship	Open cases 30 June 2010	Closed cases 2009/2010
Average years	2.3	1.7
Median years	1.6	1.3
Less than 12 months	36%	38%
12 months to < 2 years	24%	31%
2 years to < 3 years	14%	14%
3 years plus	26%	17%

Figure 33: Length of guardianship

The graph below compares active cases as at 30 June 2009 and 30 June 2010 and their length as at that date.

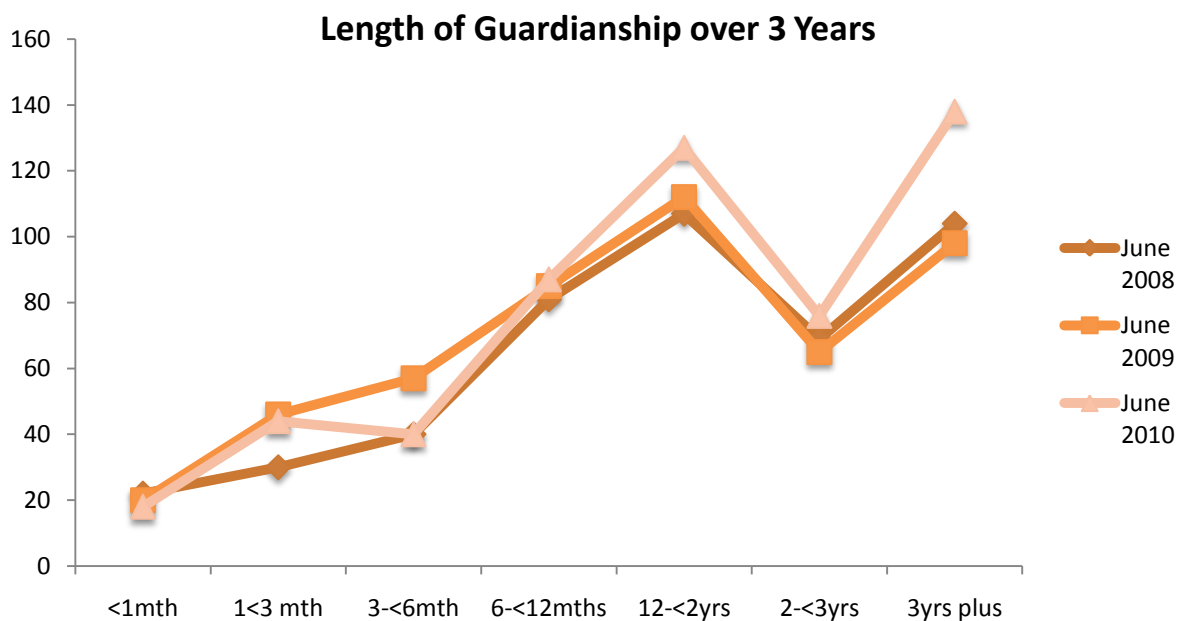


Figure 34: 3yr comparison of Length of guardianship for open cases

The age profile of active, new guardianship and closed cases as at 30 June 2010 is compared in the table below (Figure 35). Note that the over 70s age group accounts for 44% of the new guardianship cases and 46% of those closed. However in the end of year active caseload, their representation reduces. This is in part explained by the higher turnover (shorter length of guardianship) for the older population. Age is calculated at time of closure for clients closed during the year and at time of opening for the other categories.

Age Profile of Closed, Active and New Guardianship Cases 2009–2010				
		Closed Guardianship Cases 2009 - 2010	Active Guardianship Cases 30/06/2010	New Guardianship Cases 2009 - 2010
Age				
< 41 years		21%	29%	21%
41 to 70 years		33%	36%	35 %
> 70 years		46%	35%	44%
Gender			females and males were equally represented.	52% percent of new clients were female.

Figure 35: Age Profile of guardianship clients

Diagnostic profiles are illustrated in the following chart (Figures 36). Clients with dementia as the primary underlying cause of mental incapacity are the biggest category in all cases.

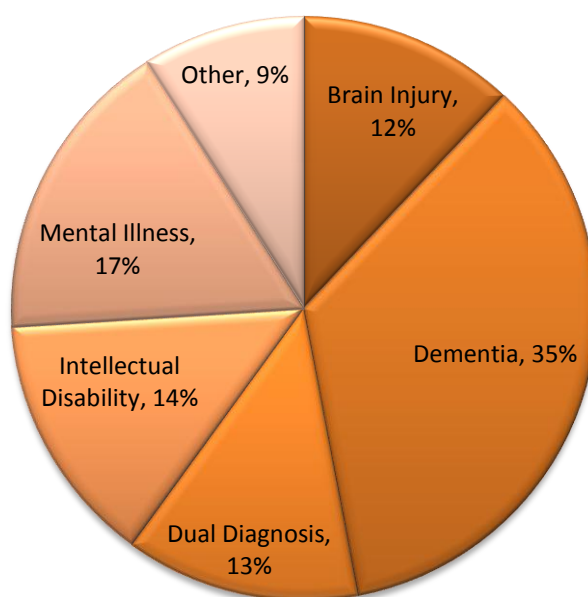


Figure 36: Diagnostic profile all active guardianship cases 2009 - 2010

Use of Enforcement Powers by Guardians

32 - Special powers to place and detain etc protected person

(1) The Board, on application made by the guardian of a protected person -

(a) may, by order, direct that the protected person reside -

(i) with a specified person or in a specified place; or

(ii) with such person or in such place as the guardian from time to time thinks fit

according to the terms of the Board's order; and

(b) may, by order, authorise the detention of the protected person in the place in which he or she will so reside; and

(c) may, by order, authorise the persons from time to time involved in the care of the protected person to use such force as may be reasonably necessary for the purpose of ensuring the proper medical or dental treatment, day-to-day care and well being of the person

A guardian may apply for and be granted special powers under Section 32 (1) (a) of the Guardianship and Administration Act 1993 to give enforceable directions regarding where a person under guardianship will live.

In addition, application can be made by a guardian for the Guardianship Board to authorise the detention of a protected person in that place (s32 (1) (b)) and to authorise the use of reasonable force (s32 (1) (c)) for the purposes outlined above.

The existence of these powers does not automatically lead to their application in practice. The issuing of a formal direction by a guardian to exercise their powers is considered a last resort or emergency strategy when other options are exhausted and there is a need to ensure the health and wellbeing of a protected person or others.

Guardians consent to and monitor the use of s32 powers by service providers. Guardians require evidence of the need to exercise restrictive practices and a plan for their implementation in the least restrictive way possible. During this year, it is proposed that the office upgrade its requirements for authorising restrictive practices. The background to this is described more fully under Section A of this Annual Report on "Restrictive Practices".

An audit of s32 powers reveals the following:

- In 2009 - 2010, 146 active guardianship clients were subject to orders of the Board under section 32 of the Act at some time during the reporting period. This represents 21% of all active guardianship clients for the same period. A proportion of these were made prior to this reporting period and continued into the 2009 - 2010 financial year.
- 98 (67%) of these s32 orders originated at an initial hearing of the Board or within 2 weeks of that first order of guardianship. In some cases, these were issued as a result of an emergency application for guardianship with immediate issues of protection requiring urgent directions.
- 48 (33%) of matters had s32 powers granted later on in the lifetime of the guardianship order.

- 90 of the 146 case (62%) had evidence of formal directions being issued by the guardian at some time during the lifetime of the S32 orders.
- In the case of s32 powers granted at the beginning of guardianships, only 45 (50%) showed evidence of formal directions whereas, in the matters where orders were added later, 45 (94%) involved formal directions.

These results support the notion that guardians are most likely to issue directions when they have specifically requested powers having become familiar with a client's circumstances, and at a time when a particular issue arises. Requests for s32 powers at the beginning of the guardianship period may be speculative based on the views of others, and the need to use them may not eventuate (Figure 15).

A snapshot of initial S32 orders for this sample is shown in the chart below. (Note missing data)

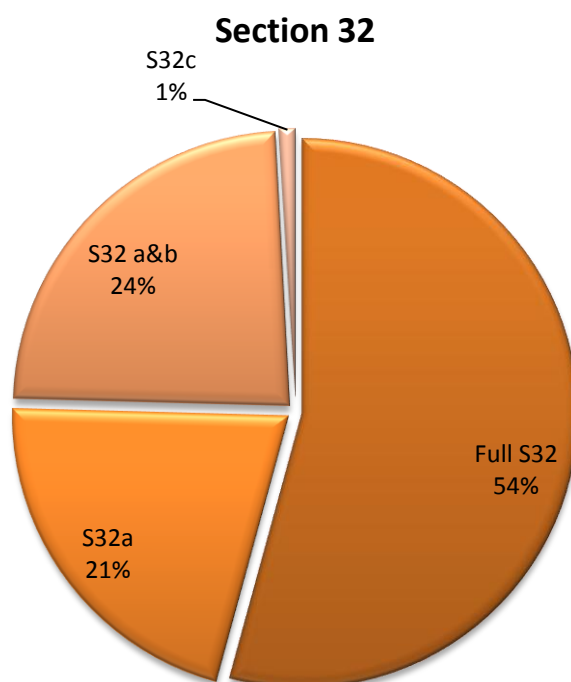


Figure 37: Section 32 Orders

The age and diagnostic profile of clients under s32 powers is represented below (Figure 38 and 39).

Age Profile of Clients under s32 Powers

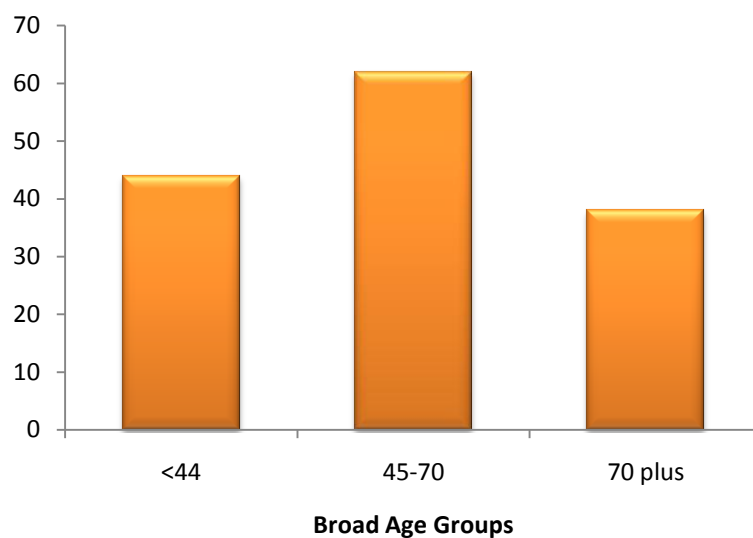


Figure 38: Age Profile of Clients under s32

Diagnostic Profile of Clients under s32 Powers

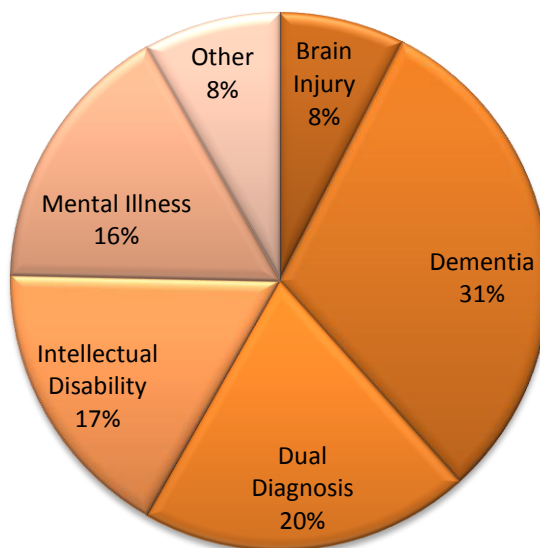


Figure 39: Diagnostic Profile of Clients under s32

For those matters where s32 powers were revoked during the reporting period, 9 (15%) lasted for less than 3 months, 21 (36%) were in place for more than 12 months and 28 (48%) were in force between 3 and 12 months duration.

The mean length of s32 orders was however 505 days with a median length of 294 days. Several clients in the sample had very long periods on s32 orders.

The key reasons for s32 directions were:

- Accommodation: To direct accommodation change or remaining at the same place unless a shift is authorised by the guardian (57 cases- 39%) (s32(a))
- Detention: To direct that a person not leave a premises or to prevent them from being removed (28 cases - 19%) (s32 (1)(b))
- Restraint or force used: To authorise some form of confinement, restraint or pharmacological intervention which could be construed as restraint (14 cases - 10%) (s32 (1)(c))
- A combination of the above and/or health care intervention requiring physical or pharmacological restraint or force to perform the procedure (48 cases -33%)

Rate of Appointment of Public and Private Guardians South Australia

Of 978 applications for consideration of the appointment of a guardian received by the Guardianship Board of South Australia during the 2009-2010 financial year, 234 (24%) resulted in the appointment of the Public Advocate and 196 (20%) a private guardian. 548 (56%) did not lead to the appointment of any guardian.

This compares with last year's figures of 694 applications, 209 (30%) public guardianship appointments and 197 (28%) private guardianship appointments and 288 (41%) where no appointment was made. This data is set out below (Figures 18, 19 and 20).

Despite the significant increase in applications (41%) for guardianship appointments, this did not result in a similar increase in guardianship appointments. Total appointments rose by 6%, the increase being in public guardianship.

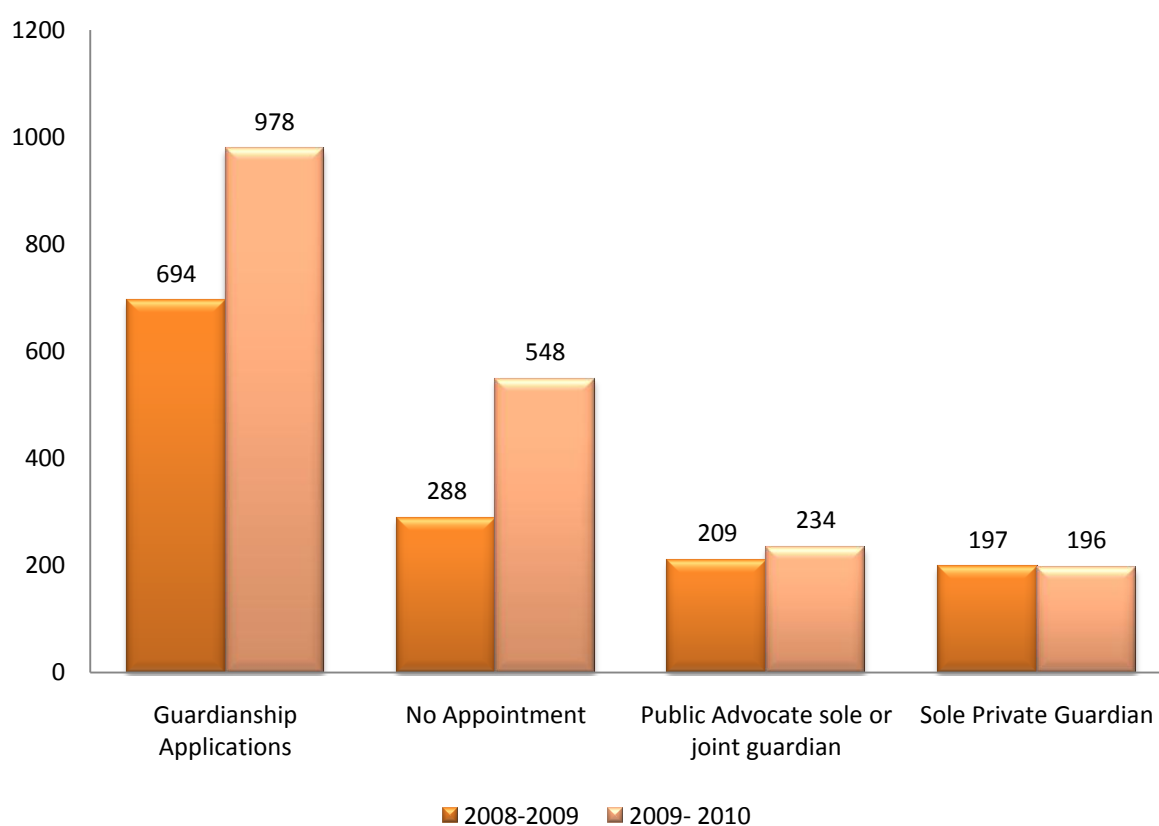


Figure 40: Applications and Appointments

One interpretation is that the Guardianship Board has strengthened its least restrictive approach to the law with 15% less guardianship applications resulting in appointments of public or private guardians. One difficulty in interpreting this data however is the number of applications which may infer that the application is for guardianship, however its prime purpose is for the appointment of an administrator and the applicant's nomination of the need for a guardian on an administration form is incorrect.

This analysis is included in this section of the report as it assists in understanding the rate of referral to our office's guardianship services. The figures reflect decisions made by the

Guardianship Board rather than our office, but we assist the Board in this process where possible. We do this by attending hearings where the Public Advocate is nominated as guardian. Our preparation for this can involve contacting parties to explore other options, such as private guardianship, prior to the hearing.

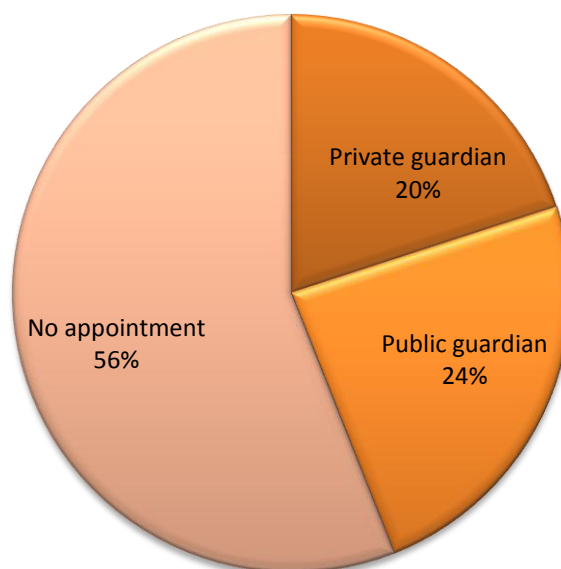


Figure 41: Outcomes of Guardianship Applications 2009-2010

Our office has also compared the South Australian rate of public guardianship with statistics from other Australian jurisdictions.

The data from different states is roughly comparable, but not identical. For example South Australian legislation allows the Public Advocate to be appointed joint guardian together with a private guardian, and for statistical purposes this is considered a “public guardianship”.

The prevalence of guardianship in South Australia is midrange compared to other jurisdictions at 32.6 people under guardianship per 100,000 people in the general population (the range is from 26.1 to 44.1 people per 100,000).

In the context of the number of applications received, the South Australian Guardianship Board appoints the public guardian least often compared to other states, instead preferring to appoint private guardians. The Public Advocate is appointed on 54.4% of occasions. The range nationally is from the lowest 54.4% to the highest 91.9%. The legal and ethical literature about guardianship supports the role of family and friends as guardian, and public officials should only be guardian of last resort. The South Australian statistics therefore would seem to be a positive reflection on the appointment practices here.

There could be a number of reasons that explain the differences between jurisdictions including the different legislation in each state, and the different practices that have developed.

Investigations

Guardianship and Administration Act 1993

Section 28—Investigations by Public Advocate

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

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

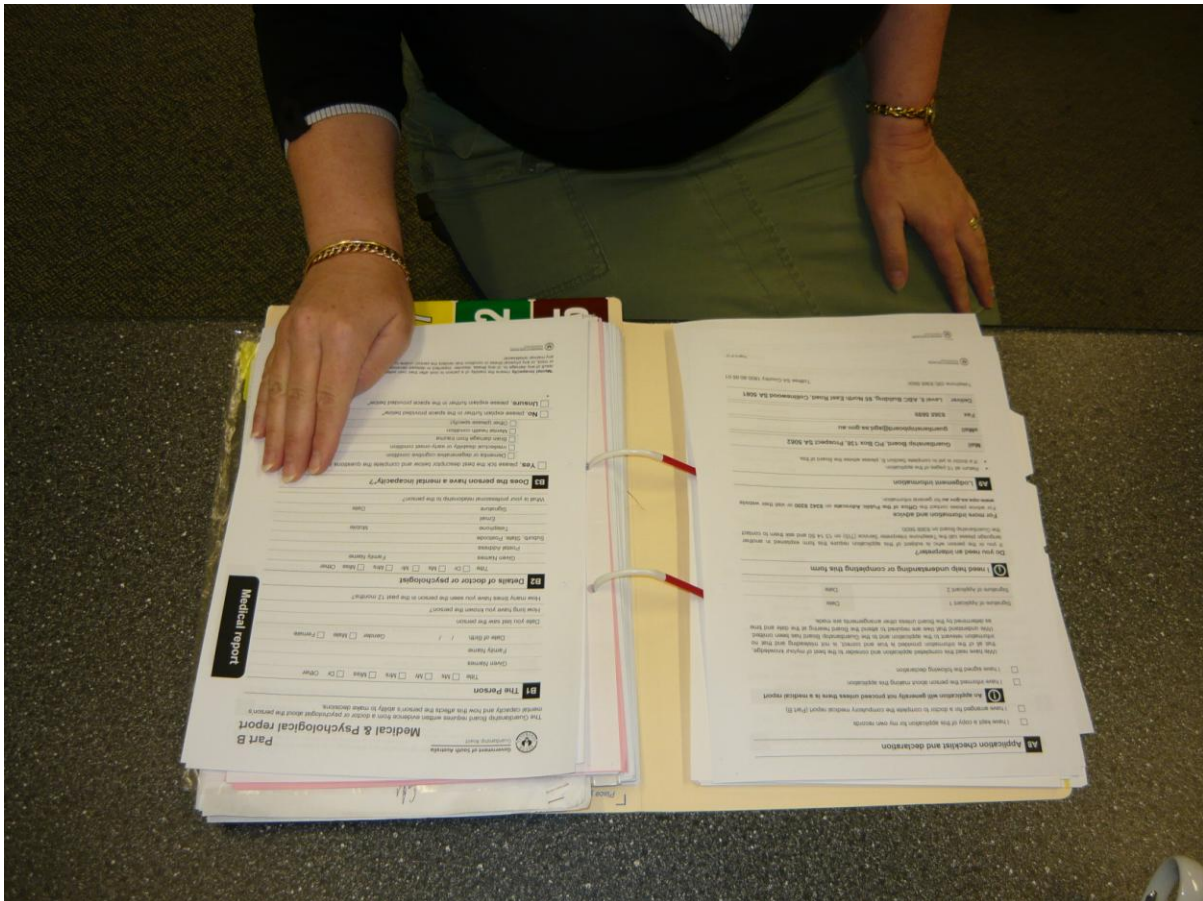
The provisions of section 28 are very broad and could allow an open ended inquiry into all aspects of a person's life. In practice the investigation focuses on particular issues. Social work and advocate/guardians undertake these investigations by contacting all relevant parties to obtain their views, reviewing available documentation and assessing the information obtained.

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

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

Increasingly, staff undertaking these investigations have been requesting that the Board be quite specific about the nature and the extent of the investigation it requests so as to avoid unnecessary intrusion into people's lives, and to minimise delay.

The investigation process however defers the decision making of the Board for an average of 3 months due to the complexities of the investigative processes and the fact that hearings are not rescheduled until the OPA report has been received. In matters where the Board determines that a decision maker needs to be in place on an interim basis, the Public Advocate may be appointed as guardian pending the outcome of the investigation. The OPA separates its decision making and investigative functions in such circumstances by appointing different workers to fulfil each of these roles. By doing so we aim to ensure transparency and procedural fairness in the investigation without compromising the need for timely decisions on behalf of the protected person.



Number of investigations

In 2009-2010 the Office of the Public Advocate responded to 34 requests from the Guardianship Board to investigate matters before the Board.

- 5 were open at the beginning of the reporting period,
- 29 were opened during the year and
- 13 remained open as at 30 June 2010.

Review of Investigation Practices

In 2009-2010, OPA conduct of investigations was reviewed with the aim of clarifying:

- the scope and purpose of investigations
- the extent to which an investigator should reach conclusions / make recommendations to the Board
- what should be included in investigation reports to the Board and how to structure them

It was anticipated this would improve efficiency and consistency in investigation practice, and provide a basis from which other OPA staff could undertake investigations.

The review included obtaining advice from the Crown Solicitor's Office, consulting experienced OPA investigators, receiving feedback from the President of the Guardianship Board and from the Board's members about the usefulness and clarity of investigation reports, surveying a range of recent investigation reports, and considering complaints received about investigations. Investigation practices and approaches used by other agencies were also referred to.

The review identified a number of tensions inherent in advocate/guardians of the Office of the Public Advocate undertaking investigations for the Guardianship Board. These include:

- Divergence between the professional values and expertise of OPA social work staff and the task of investigating and reporting for a fact finding determinative Board.
- Potential difficulties arising in ongoing relationships with parties if the Public Advocate is appointed as guardian after conducting an investigation.
- Timeliness and thoroughness are both important but exert opposing pressures.
- Managing sensitive information and/ or information which is of great importance to a person but not of significance to the application before the Board.
- Varying understandings of what an investigation is / should be, by Board Members, 'interested parties', and OPA staff.
- The Public Advocate is at times directed to undertake investigations requiring expertise beyond that of OPA staff (e.g. clarifying complex financial or legal arrangements).
- OPA has no formal authority to require production of documents or information relevant to the investigation (though the Board does have).

Some practices were changed during the process of the review in response to advice or feedback received. Other changes will be introduced in the next 12 months and described in the Annual Report for 2010- 2011.

The review highlighted the sensitivity and complexity that investigations often involve.

Attendance at initial hearings of applications for Guardianship Orders

Whenever an applicant to the Guardianship Board nominates the Office of the Public Advocate as a potential guardian for an individual, the office will consider the application (known as screening). A staff member from this office will attend the hearing wherever possible.

Preparation for the hearing involves reviewing the written application and, where appropriate, making submissions to the Guardianship Board on the merits of the application, the scope of proposed guardianship decisions and the appropriateness of appointing the Public Advocate as guardian. In some cases, additional information will be obtained from the applicant and family members prior to the hearing and/or the subject of the application will be visited.

Given the office's commitment to the Principles of the Act and, in particular, our focus on autonomy and self determination for individuals who have a disability, alternatives to guardianship will be suggested wherever possible (eg advocacy for services or accommodation). The preservation of natural relationships and the least restrictive approach to guardianship when it is required are also important principles underpinning recommendations for the appointment of a family member as guardian, or advocating for a more limited appointment than initially requested by the applicant.

The Supported Decision Making Project which will commence during the 2010 - 2011 financial year will provide an alternative to guardianship for some clients who have the potential to control their own decision making when provided with appropriate and sensitive support. OPA staff will have the option of recommending a supported decision making approach rather than guardianship orders for suitable individuals who are the subject of applications to the Board.

During 2009-2010, OPA staff reviewed 280 new applications where the Public Advocate was nominated for appointment as guardian. Of these, 151 (54%) were allocated to the short term team and 127 (45%) to the long term team for screening and attendance at hearings.

Combining the number of investigative activities performed in each year, the following picture emerges (Figure 42).

Comparison of Guardianship Applications Screened and Investigations Undertaken 2003-2010

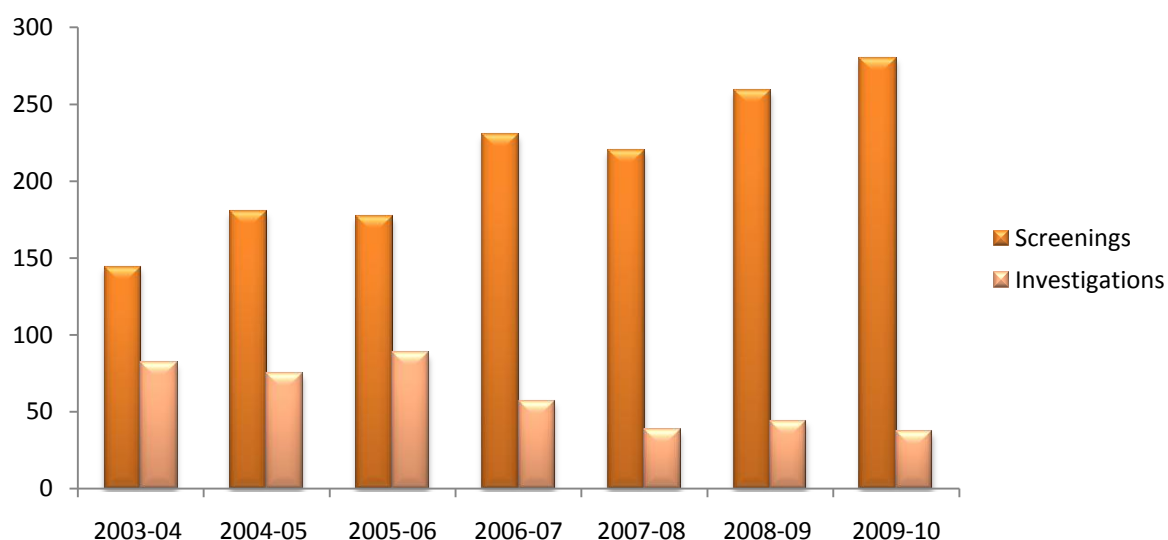


Figure 42: Screenings & Investigations 2003-2010

Whilst the OPA was appointed as sole or joint guardian in 234 matters, it cannot be simply said that 84% of matters reviewed by the OPA prior to an initial hearing led to guardianship appointments for the Public Advocate.

The OPA may be appointed without this review process occurring in matters where

- (a) a private guardian is in place or nominated in the application but the Board decides to appoint the OPA as sole or joint guardian at the hearing.
- (b) after hours emergency matters result in interim guardianship orders.
- (c) administrative processes in either service leading to these applications not being reviewed prior to a Board hearing.

Applications for Warrants by the Public Advocate

Guardianship and Administration Regulations 1995

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

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

- (a) the number of applications for warrants made during the year;
- (b) the age, sex and details of the alleged mental incapacity of the persons to whom the applications related;
- (c) the grounds on which the applications were based;
- (d) the number of applications withdrawn during the year;
- (e) the number of warrants issued during the year;
- (f) the number of warrants refused during the year;
- (g) in relation to warrants issued—
 - (i) the age, sex and details of the mental incapacity of the persons to whom the warrants related;
 - (ii) the grounds on which the warrants were issued;
 - (iii) the action taken under the warrants.

During 2009-2010 there were no applications for warrants made by the Public Advocate. There have been no warrant applications by the Public Advocate in the past decade.

Individual Advocacy

Guardianship and Administration Act 1993

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

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

The Office of the Public Advocate undertakes extensive advocacy for people under guardianship. Advocacy is also undertaken as part of our information and enquiry and advisory service. OPA officers will intervene on behalf of individuals who have a mental incapacity or on behalf of their carers in an attempt to ensure that they receive assistance. This can solve minor issues which might otherwise have led to guardianship or administration applications to the Board.

The OPA works closely with other advocacy services, referring many matters out to these organisations. On occasions, organisations collaborate in order to achieve the best outcomes for clients.

A number of individual advocacy matters are accepted by the OPA each year. There were 56 individual client advocacy matters during 2009-10, 43 of which were new cases. This compares with a total of 44 in 2008-09, 50 in 2007-08 and 59 in 2006-07.

The chart below identifies the diagnostic groupings of individual clients for whom advocacy was provided. In a number of matters, (classified as “other”) a family member/carers was the client receiving assistance with aspects of service provision for their relative. This represents over one third of the individual advocacy clients for whom services were provided during 2009 2010.

Diagnostic Breakdown Advocacy Clients 2009 - 2010

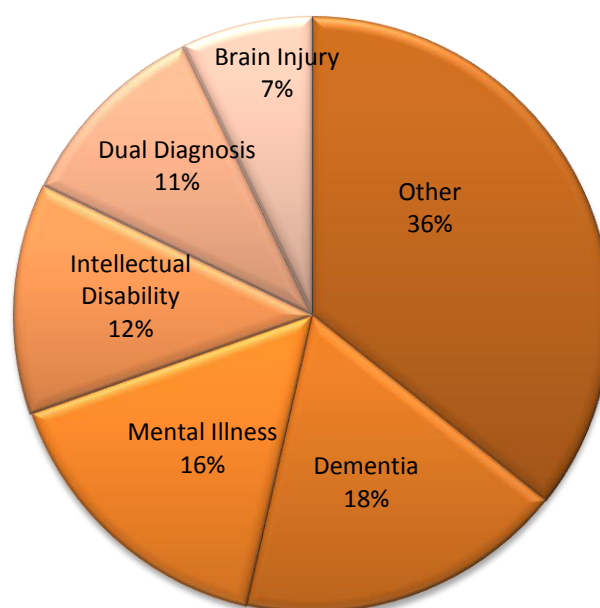


Figure 43: Advocacy Clients and Diagnosis

Advocacy and Guardianship Board Processes

Guardianship and Administration Act 1993

14. Powers and Procedures of the Board

- (9) A person is entitled to appear before the Board—
 - (a) personally or by counsel; or
 - (b) if he or she is the person the subject of the proceedings—
 - (i) by the Public Advocate; or
 - (ii) except where the proceedings are appeal proceedings—by a recognised advocate; or with the permission of the Board, by any other representative

As reported in our previous Annual Report, lack of routine advocacy before the Board for both Guardianship and Mental Health Act matters remains a serious concern. The above extract from the *Guardianship and Administration Act 1993*, indicates that legislators envisaged that the Office of the Public Advocate and other recognised advocates would take an active role in providing individual advocacy before the Board.

This role has never been resourced in this office. By way of example, mental health consumers are routinely advised in writing that the Public Advocate can lodge an appeal on their behalf, but, in reality, the OPA very rarely becomes actively involved in these processes. We do provide information via our enquiry service and will provide information to callers about advocacy agencies that work in this jurisdiction. The Disability Advocacy and Complaints Service of South Australia does provide such advocacy. Their service can be greatly appreciated by those who use it, but they are not expected to be available for all matters.

The legal representation scheme will provide advocacy for those who are subject to orders and party to an appeal before the Board and also at the District Court if appealing the Board decision. However, representation before the Board for all other matters currently relies on the subject of the application/review or a significant person in their lives seeking out assistance. This assistance is not easily obtained despite the need being recognised legislatively. The ability of an individual to exercise this right at a time of acute illness/ stress or disability brings into question the adequacy of natural justice processes within this jurisdiction.

It remains our view that either the current legal representation scheme should be extended to cover all Guardianship Board matters, or a system which ensures that all people have access to a lay advocate from this office or elsewhere should be established.

Advocacy and the Mental Health Act 2009

The right to advocacy assistance for individuals who are receiving treatment and care for mental health issues is further reinforced in new provisions in the *Mental Health Act 2009*. One example is that a patient has the right to involve an advocate in key discussions about their treatment and care with mental health providers. Individuals may choose their guardian, a family member or an advocate to fulfil this role.

Individual advocacy services for people who are in contact with mental health services will hopefully also improve through the introduction of a Community Visitors Scheme to be established under the *Mental Health Act 2009*. As it is proposed to auspice the Scheme within the OPA and implement it during 2010-2011, invaluable systematic information about the quality of services provided will become available and enable this office to more directly influence service standards. This Scheme will provide opportunities for greater engagement with individual clients of the mental health system, as well as additional advocacy mechanisms for those whose individual autonomy and rights are restricted by the detention and treatment provisions of the *Mental Health Act 2009*.

Advocacy remains an important component of how we deliver all of our services, whether it be through our role as guardians or in the course of assisting people with enquiries. These approaches are most suited to the resolution of most problems faced by individuals whose lives are affected by mental incapacity.

Court related matters

In civil legal matters, when a person is unable to instruct a lawyer because of a mental incapacity, the Court may appoint the Public Advocate to 'stand in the shoes of' the person – to be their 'litigation guardian'. The Public Advocate or delegate then instructs the lawyer, on behalf of that person. This involves taking time to get to know the issues involved and the person's views and preferences, understanding and clarifying legal advice and recognising the consequences of particular courses of action. It is likely to involve meetings with the client, and lawyer, reading court documents, attendances at Court, and signing agreements or court documents with or on behalf of the person. The client may not agree with all decisions made and the role can be time consuming and difficult.

A litigation guardian may have particular responsibilities under legislation regulating the particular matter (eg the *Family Law Act*), and the Court's own Act or rules in addition to following the principles of the *Guardianship and Administration Act 1993*. These different duties do not always neatly coincide, requiring awareness of multiple obligations. The litigation guardian acts in the interests of the person, consistent with these obligations. This role falls within the mandate of the Office of the Public Advocate to promote and protect the rights and interests of people with a mental incapacity.

In 2009–2010, nine clients received decision making assistance through court appointments of the Public Advocate or a delegate. Matters involved included actions in the Youth Court, the Federal Magistrate's Court, and the Supreme Court and were about a range of matters, involving care of or contact with children.

In 2009/10 the office developed detailed policy and guidelines for acting as a litigation guardian, and for determining in which matters the Public Advocate will agree to act. This office is grateful to the Office of the Public Advocate in Victoria for providing their comprehensive policy as a model.

A different court related role arises from the provisions of the *Wills Act 1993*, under which the Public Advocate is informed of matters involving applications to the court to alter the wills of people who have lost testamentary capacity.

Advocacy on issues

Part A of the Annual Report highlights some of the systemic issues which have been considered by this office. The Public Advocate and staff have been involved in a number of other matters during this year. The OPA seeks to further the interests of people whose lives are affected by mental incapacity through whatever means possible.

Education

The Office of the Public Advocate responds to requests from organisations and individuals to participate in a range of education activities. These include providing written information for displays, acting as panel members or presenters for conferences and workshops, and attending meetings and education sessions for service providers and members of the public.

There are a number of groups and organisations that conduct education sessions on similar topics to those for which the OPA may be approached. In particular, the provision of information on advance directives is undertaken by a number of organisations. We share responsibility with these organisations and where possible informally coordinate our efforts in an endeavour to respond appropriately to all requests and to spread the commitments between us.

The Office of the Public Advocate accepted 31 of 39 invitations to speak at conferences and meetings during 2009–2010. Refusal is usually based on short notice of requests or the appropriateness of the request to the OPA. Several matters were referred on to the Legal Services Commission which has an advisory role on advance directives, wills and other legal processes. Requests accepted by the office ranged across discussion of the role of the OPA, aspects of legislation affecting the lives of those who have a mental incapacity and advance directives provisions.

The Public Advocate and his staff collaborated with the Guardianship Board and the Public Trustee in order to present a national mental health tribunal conference entitled Rights Responsibilities and Rhetoric, held in Adelaide in October 2009. The Public Advocate was also invited to the Victorian Office of the Public Advocate to present his work on Supported Decision Making.

An important educative function is the provision of factual information suitable to service providers and members of the community, in particular on the provisions of the *Guardianship and Administration Act 1993* and the *Mental Health Act 2009* and the *Consent to Medical Treatment and Palliative Care Act 1995*. A series of Fact Sheets are available on the OPA website and in paper form for distribution as required. During 2009 - 2010 all Fact sheets were reviewed and updated to comply with the provisions of the new Mental Health Act.

Over the past 2 years, the OPA has promoted the use of its website as a vehicle for presenting updates on issues of concern and new events. In an effort to encourage debate and transparency, the Public Advocate displays his Annual Reports, Conference papers and his submissions to relevant inquiries through this medium. The site appears to be well used by the public, receiving an average of 1085 hits per day during January to June 2010. The OPA is now exploring the feasibility of including interactive tools on our website to enable the office to engage in dialogue with service providers and members of the public on its current projects and advocacy on issues of concern.

The Alliance for the Prevention of Elder Abuse

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

Alliance representatives collaborate in delivery of education sessions and also provide cross agency consultancy to find solutions for individual matters of abuse and neglect.

University of South Australia Collaborative Research Project on Mediation

The Office of the Public Advocate continued its commitment to the prevention of abuse of older South Australians by collaborating with the University of South Australia, the Minister for Families and Communities, Relationships Australia, Alzheimer's Australia (SA) and the Guardianship Board to secure an Australian Research Council Linkage Grant. This two-year study aims to design, pilot and evaluate specialised models of older-person centred family mediation for both primary and secondary levels of intervention as strategies to prevent the abuse of older people by their family members, to apply in situations where the older person has capacity, diminished capacity or lacks capacity.

During stage one of the project, the Office of the Public Advocate collaborated with our research partners to develop and distribute a national on-line survey inviting the response of service providers, managers and CEOs to gain specific information which can be used to construct appropriate mediation models. In addition, this office assisted in the development and staffing of a national phone in survey where older people or relevant interested persons could provide information (anonymously) about their experience of financial abuse. The data collected from these surveys is currently being analysed to inform the design of the older-person centred models of mediation which will be trialled in the next stage of the project. This work is consistent with our roles providing alternatives to guardianship. As a member of the Reference Group, the Office of the Public Advocate will provide valuable advice and guidance based on our experience.

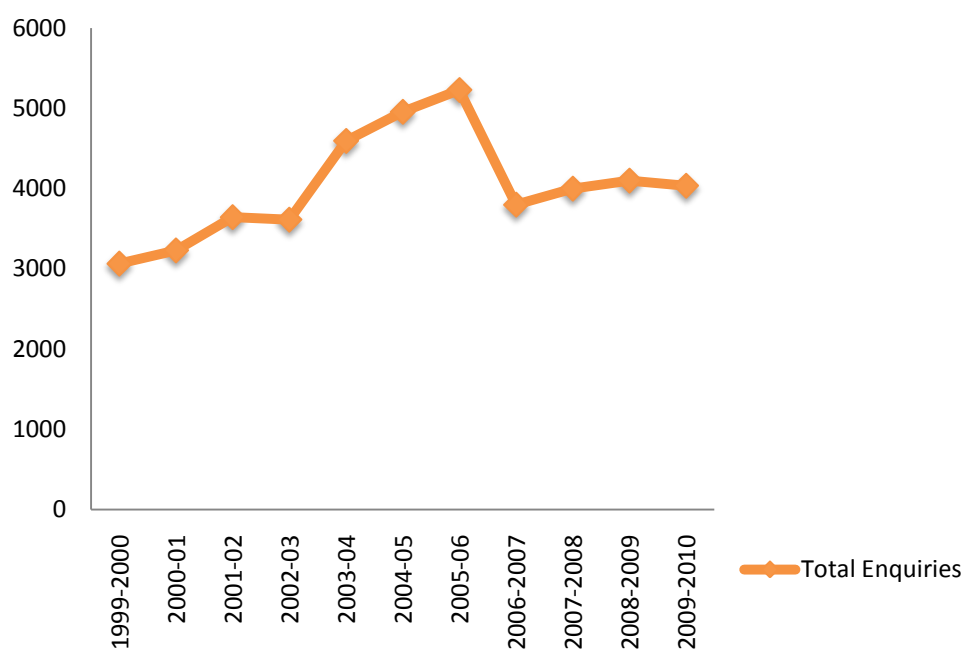
Enquiry Service

During this reporting period, the OPA allocated 1.8 FTE AHP1 staff resources to its enquiry services. This is a 0.5FTE increase in resource allocation. These staff also perform monitoring and review functions for guardianship clients. The time allocated between enquiry and guardianship functions varies according to the demands of both activities.

In addition, a substantial amount of administrative staff time is spent dealing with enquiries from the public. These staff screen and prioritise calls and provide factual information on behalf of the OPA.

Enquiries are made by people who have a disability, their family members, health care professionals and others providing services. Each person contacting the service may call on a number of occasions to make more than one enquiry. Wherever possible follow up calls are linked to the first enquiry for the purposes of continuity and are counted then as one episode of enquiry.

This year, there were 4034 discrete episodes of enquiries. A comparison with previous years is graphed below (Figure 44). The substantial drop in 2006-2007 coincides with a new database recording system which has improved our ability to link callers with their previous enquiries.



Enquiry episodes 1999 – 2010

Figure 44

Common reasons for seeking advice include requesting information about advance directives, guardianship and administration orders, Guardianship Board hearings and mental health appeals. The table below provides a breakdown of issues raised and the disability groupings recorded as part of the enquiry. An individual enquiry may raise more than one issue. As can

be seen from the table below (Figure 45), advance directives and guardianship and administration matters are the most common issues raised.

Enquiries 09 10 - Issues	Number	Percentage of enquiries involving this issue	Disability -identified	Number
Mental health issues	554	14%	Brain damage	267
Guardianship issues	1357	34%	Dementia	1316
Administration issues	1297	32%	Mental Illness	1147
Advance Directives	1265	31%	Intellectual Disability	42
Advocacy	691	17%	Communication	91
Case consultation	257	6%	Other*	535
Complaints	76	2%	Unknown*	750
Consent	198	5%		
Informal arrangements	344	9%		
Information	115	3%		
Inter jurisdiction	29	1%		
Legal	326	8%		
No action	3	0		
Private Guardians	36	1%		
Risk management	74	2%		
Wills estates	77	2%		
Other	89	2%		
Total issues raised	6972			
Discrete Episodes 09 10	4034			

Figure 45 Enquiries 2009 2010 by issues and disability groupings

*some callers do not identify the disability of the person about whom they are ringing. Some enquiries are about advance directive and there is no current disability.

Review of Information and Advisory Service Practices, Procedures and Staffing

The OPA is currently reviewing the way in which it responds to public enquiries. The concerns driving this review are competing demands of responding to enquiries and monitoring stable guardianship cases, staff turnover and a desire to promote an efficient approach to public enquiries without compromising the quality of the advice given.

Several other states have introduced queued answering systems to direct callers to the different functions of their office, 1800 numbers and telephone messages which provide information on common questions as well as directing callers to the website for information.

The office will consider alternative options during 2010- 2011 and implement a trial of changes where practical.

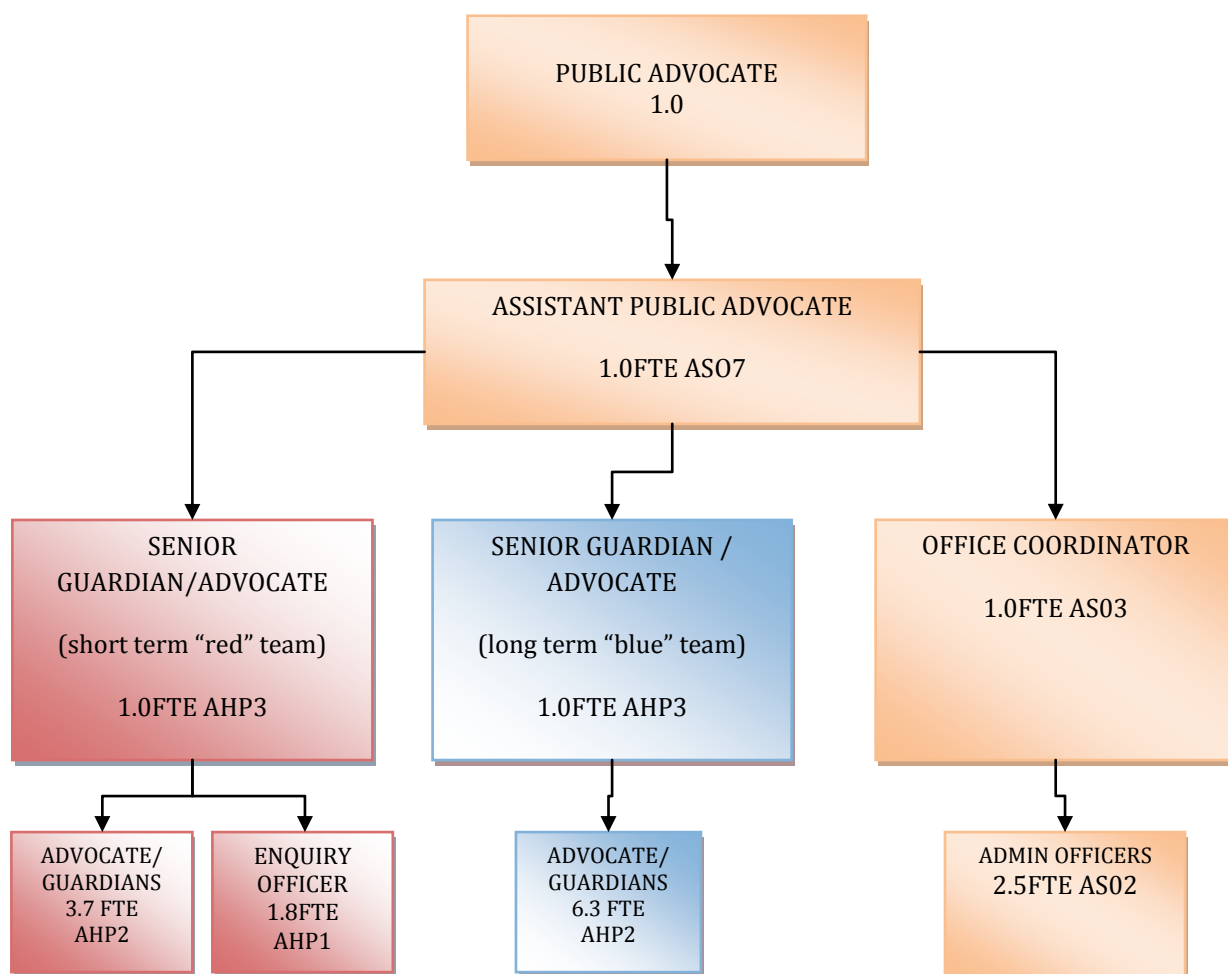
After Hours emergency response

OPA senior staff are rostered on behalf of the OPA and the Guardianship Board. The roster covers 5pm to 9:00am weekdays and 24 hours a day on weekends to respond to public enquiries and emergencies regarding registered clients. Approximately 40 calls per month require attention after hours. These range from requests for emergency guardianship orders and consent to medical treatment to requests for a direction from a guardian. Remote access systems allow the staff member to identify current orders of the Board and recent activities in order to provide the best possible information and advice.

Employment and Human Resources

The OPA received an increase funding for ongoing staffing during 2009 2010 bringing the funded establishment to 19.3FTE. The chart below reflects the deployment of these resources as at 30 June 2010.

Deployment of Funded positions as at 30 June 2010



Additional staffing resources

A full time Executive is funded by the Attorney General's Department and a Project Officer funded by a Rotary Grant were also temporarily assigned to the office to support its planning and review activities. Both positions report directly to the Public Advocate.

Staff of the OPA 2009-2010

Negotiations during the financial year led to a 3FTE increase in the ongoing establishment of the organisation. This represents an 80% increasing in staffing resources over the past 5 years reflecting the increased demand for core services provided by the OPA.

During this year

The following is a list of staff members who worked either full time or part time at the Office of the Public Advocate for some time during 2009-2010.

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

Administration

Trish Bull	Office Coordinator
Cheryl Thomas	Administration Officer
Michelle Howse	Administration Officer
Aileen Vincent	Administration Officer (Part-time)
Di Chartres	Executive

Advocacy, Guardianship, Investigation and Enquiries

Julie-Anne Harris	Senior Advocate /Guardian Long Term Team
Elly Nitschke	Senior Advocate/Guardian Short Term Team
David Cripps	Advocate and Guardian
Karen Bowden	Advocate and Guardian
Maria Atkins	Advocate and Guardian
Bethany Jordan	Advocate and Guardian
Andrew Sarre	Advocate and Guardian
Margi Keville	Advocate and Guardian
Elicia White	Advocate and Guardian
Barbara Robertson	Advocate and Guardian
Rebecca Norman	Advocate and Guardian
Anna Latimer	Advocate and Guardian
Popi Amanatidis	Advocate and Guardian
Tarnia White	Acting Advocate and Guardian
Jenny Fox	Community Enquiry Officer
Passant Ibrahim	Community Enquiry Officer
Rosemary Hillard	Community Enquiry Officer
Melissa Stephenson	Community Enquiry Officer

Sarah Tims
Azade Rodriques

Community Enquiry Officer
Social Work Student

Rotary Research Project

Ellie Rosenfeld

Rotary Senior Research Officer

Occupational health, safety and injury management

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

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

There were no work related claims during this reporting period.

Loss of work time through sick leave was 7.18 days per FTE this year, 6.13 days in sick leave, 1.05 days in family carer leave.

OPA was assisted by the temporary placement of government redeployees during 2009-2010 as well as student placements.

Student Placements

One social work student was attached to the office during the financial year.



Assistant Public Advocate Margaret Farr and Public Advocate John Brayley

Financial Information

The OPA's budget is allocated, managed, audited and reported through the Attorney General's Department. There are two cost centres on which we report - one for the ongoing budget allocation and one for projects.

During 2009 - 2010 the core program expenditure of **the OPA** was as follows:

Income		
Recoveries:	\$ 27,852	
Total Revenue:		\$ 27,852*
Expenditure:		
Employee entitlements	\$1,724,221	
Supplies and Services	\$ 363,071	
Depreciation	\$ 32,336	
Total Expenditure		\$2,119,628

* Recoveries were primarily related to reimbursement of expenditure on client accommodation and activities and payments for sale of manuals.

The Rotary Project expenditure was as follows:

Income		
Grant Funding:	\$59,714*	
<i>Total Revenue</i>		\$59,714
Expenditure		
Employee entitlements	\$78,622	
Supplies and Services	\$9,144	
<i>Total Expenditure</i>		\$87,766

* The remainder of the grant will be received in 2010 2011 reporting period thus covering the expenses incurred in this financial year.

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Appendix A: Requirements to approve Restrictive Interventions

Restrictive practice	Queensland - Approval or Consent	Victoria - Approval or Consent	South Australia Approval or Consent
Requirements (<p><i>Guardian for restrictive practices</i></p> <p>To determine if the use of a restrictive practice is in compliance with a positive behaviour support plan. Consultation required with the adult, Guardian, psychiatrist, service providers</p> <p>The Guardian for restrictive practices must be satisfied:</p> <ul style="list-style-type: none"> -the adult's behaviour has previously resulted in harm to the adult or others; and - there is a reasonable likelihood that, if the consent is not given, the adult's behaviour will cause harm to the adult or others; and -using the restrictive practice is in compliance with the positive behaviour support plan -is the least restrictive way of ensuring the safety of the adult or others; and - the adult has been adequately assessed for developing or changing the positive behaviour support plan; and -use of the restrictive practice is supported by the recommendations of the person who assessed the adult; 	<p><i>Authorised Program Officer</i></p> <p>Can only be used—</p> <ul style="list-style-type: none"> (a) if the use of restraint or seclusion is necessary— (i) to prevent the person from causing physical harm to themselves or any other person; or (ii) to prevent the person from destroying property where to do so could involve the risk of harm to themselves or any other person; and (b) if the use and form of restraint or seclusion is the option which is the least restrictive of the person as is possible in the circumstances; and (c) if the use and form of restraint or seclusion— (i) is included in the person's behaviour management plan; and (ii) is in accordance with the person's behaviour management plan; and (iii) is only applied for the period of time that has been authorised by the Authorised Program Officer <p><i>Independent Person</i></p>	<p><i>Tribunal (Guardianship Board)</i></p> <p>(Guardianship and Administration Act 1993, Section 32) On application from a guardian.</p> <p>The health or safety of the protected person or the safety of others would be seriously at risk.</p>

Restrictive practice	Queensland - Approval or Consent	Victoria - Approval or Consent	South Australia Approval or Consent
	<p>And</p> <ul style="list-style-type: none"> -if the restrictive practice is chemical restraint—in developing the positive behaviour support plan, the relevant service provider consulted the adult’s treating doctor; and - if the positive behaviour support plan is implemented— <ul style="list-style-type: none"> (i) the risk of the adult’s behaviour causing harm will be reduced or eliminated; and (ii) the adult’s quality of life will be improved in the long term; and - the observations and monitoring provided for under the positive behaviour support plan are appropriate. 	<p>independent person is available to explain to a person with a disability</p> <ul style="list-style-type: none"> -the inclusion of the proposed use of restraint or seclusion in the person's proposed behaviour management plan; -that the person with a disability can seek a review of the decision -the independent person may report the matter to the Public Advocate if the person with a disability is not able to understand the use of restraint or seclusion in the person’s plan or if this part of the legislation is not complied with. <p><i>Senior Practitioner</i></p> <p>Provided a copy of the plan within two days by the authorised program officer.</p>	
<i>Preparation of plans and consultation</i>	<p>The assessment must involve</p> <p><i>Containment or seclusion:</i> 2 or more appropriately qualified persons in different disciplines</p> <p><i>Chemical, mechanical, or physical restraint:</i> By at least 1 appropriately qualified person</p>	<p><i>Authorised Program Officer;</i></p> <p>In preparing the behaviour management plan, the disability service provider must consult with—</p> <ul style="list-style-type: none"> (a) the person with a disability; (b) if the person with a disability has a guardian, the guardian; (c) if other disability service providers 	<p>No legislated requirement for a positive behaviour support plan.</p>

Restrictive practice	Queensland - Approval or Consent	Victoria - Approval or Consent	South Australia Approval or Consent
	<p>Restricted access: an assessment by the relevant service provider</p> <p><i>An appropriately qualified person</i> includes behaviour analysts, medical practitioners, psychologists, psychiatrists, speech and language pathologists, occupational therapists, registered nurses, social workers</p>	<p>provide disability services to the person with a disability, a representative of each disability service provider;</p> <p>(d) any other person that the disability service provider considers integral to the development of the behaviour management plan.</p>	
<p><i>Content of Behavioural Management Plan and Positive Behaviour Support Plan</i></p>	<p><i>Assessment should cover:</i></p> <p>Biological factors such as genetic predispositions</p> <p>Psychological or cognitive factors such as low communication skills</p> <p>Social factors such as the adults surrounding</p> <p>Medical conditions</p> <p><i>Recommendations should include strategies for</i></p> <p>Meeting the adult's needs and improving the adult's capacities and quality of life</p> <p>Reducing the intensity, frequency and duration of the adult's behaviour that causes harm to the adult or others</p> <p>Manages the adult's behaviour that causes harm to the adult or others to minimise the risk of harm</p>	<p>Plan is reviewed by Authorised Program Officer and Senior Practitioner.</p> <p>Required content is not specified.</p>	<p>Assessment and management recommendation reviewed by the tribunal.</p> <p>There is no predetermined requirements for qualifications of the assessors or the content of a plan.</p>
Health	Comprehensive health assessment		

Restrictive practice	Queensland - Approval or Consent	Victoria - Approval or Consent	South Australia Approval or Consent
assessment	<p>required</p> <p>Where chemical restraint is used an annual medication review should be conducted</p>		

