

FOREWORD

Advocacy Tasmania Inc. (ATI) is an independent, statewide, non-profit, advocacy service for older people, people with disabilities, people with mental health disorders and their families and carers.

Advocates are available for people in the following client groups:

- People with disabilities
- People living in aged care facilities and potential residents, and people receiving Community Aged Care Packages (CACPs)
- People in receipt of or eligible to receive Home and Community Care services
- People with dementia and memory loss
- People with a mental illness or mental health disorder
- Carers and relatives of all the above groups

Advocacy Tasmania also operates a scheme which provides free, trained volunteers to represent people with mental illness in hearings before the Mental Health Tribunal across the state.

This year we also commenced a national pilot project titled ‘The Rights of People with Dementia and Advocacy Project’. The project aims to link an advocate with a person with dementia or memory loss as soon as possible after diagnosis. Priority is given to people who have little or no active family or friends to support them with decision making and protecting their rights.

The Service’s Mission Statement is:

“Advocacy Tasmania Inc., acting independently at all times, works to both empower and uphold the rights and interests of older people and people with disabilities”.

The Service’s Aims are:

- To provide an equitable, high quality service to all people who use the service across the State

- To assist clients to exercise by providing information and support to self advocate and individual advocacy representation
- To protect and enhance the rights and interests of our client groups through promotion, education and community development
- To identify systemic issues affecting our client groups and to take effective action
- To manage the human and financial resources of the organisation efficiently and effectively, overseen by good governance

The Principles, which guide the Service are:

- a) Advocates work at the direction of clients.
- b) Advocacy is often involved in situations of conflict. Advocates endeavour to avoid confrontational approaches as much as possible.
- c) Confidentiality builds trust between client and advocate. Clients have the right to expect that their issue will be dealt with confidentially.
- d) Advocates must take into consideration the cultural, linguistic and communication needs of clients.
- e) Advocates have a duty of care to not advocate in ways that are illegal or that will significantly harm or disadvantage the client or other people in the client group.
- f) Advocacy works to increase the power and control clients have over their lives.
- g) Advocacy must be independent, with no conflict of interest. It must focus solely on the rights and interests of the client(s).
- h) The service is provided to people in the client group(s) according to need. The service is free and statewide.
- i) Advocacy is on the side of the disadvantaged party. It exists to assist clients. Advocates are not “neutral umpires” or mediators.

The Service receives funding for our four permanent advocacy programs from the Australian Government’s Departments of Health & Ageing, and Family, Community Services and Indigenous Affairs and the State Government’s Department of Health and Human Services under the Disability Services Program, Mental Health Services Program, and Home and Community Care Program. In

2006/07 the Mental Health Tribunal Representation Scheme received funding from Mental Health Services, and the Faculty of Law, University of Tasmania. The new Rights of People with Dementia and Advocacy Project was funded by the Australian Government's Department of Health & Ageing through the Dementia Community Grants Program. The Service wishes to acknowledge the financial support provided by our various funding bodies, without which we could not operate.

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CHAIR'S REPORT

After having been a member of the Board since the organisation's inception 16 years ago it was a little strange to find myself in the Chair's role for the first time this year. Whilst this is my inaugural Chair's Report I am aware that past Chairs have used their report as an opportunity to comment on trends impacting upon the people who use our advocacy services, particularly negative trends regarding the quality and quantity of human service delivery. However, I would like to break with tradition this year and focus on our own background and what we see as the growing need for increased independent advocacy.

The first area I want to comment on is mental health advocacy. As reported in this and previous year's mental health advocacy reports, the demand for this service remains constantly high with 2006/07 case numbers 80% higher than five years ago. This is despite the fact that our books were closed for six weeks in late 2006 for all but the most urgent cases. The one state funded mental health advocate based in our Hobart office finds it extremely difficult to schedule time to visit the north and north west of the state, and consequently relies on phone, email and written communication when providing a service to clients in these regions. We do not believe that this situation is acceptable as it clearly disadvantages these clients. We have made numerous representations to both the State and Australian Governments on this matter, but without any outcome to date. As a minimum Tasmania should have a second mental health advocate's position located in and providing services to people with mental health disorders in the northern half of the state where half the population lives.

A second area of need is disability advocacy. I draw the reader's attention to our Disability Advocacy report and the work our advocates are doing as part of the Living Independently Project (LIP). LIP is the project whereby State Government supported accommodation services are being transferred to the non-government sector. LIP includes funding for two additional advocates* for the life of the project with these positions focussing solely on the people living in the residential facilities. The LIP funding has enabled our advocates to spend more time than they usually have available with their clients and it has been particularly beneficial for our work on behalf of clients with severe and profound disabilities. It has meant that advocates have had the time to get to know the clients well, their likes and dislikes, their modes of communication, and care and support needs. This has allowed identification of issues that need to be addressed for clients and to advocate on their behalf. However, the LIP funding will end in mid 2008 and with it will end this more intense, proactive advocacy involvement. But these clients will be no less disabled or no less vulnerable than they were when LIP commenced. It is our belief that these positions must become recurrent and they

* Advocacy Tasmania and Speak Out have each received LIP funding for one FTE position.

need to continue to focus on those people with severe and profound disabilities who are least able to advocate for themselves.

The third and final advocacy service gap I want to highlight is advocacy for people living with dementia. In October 2006 we commenced a national pilot project titled “The Rights of People with Dementia and Advocacy Project”. This 18 month project is funded by the Dementia Community Grants Program, Australian Government Department of Health and Ageing, and is being carried out in partnership with Alzheimer’s Australia Tasmania. The project is aiming to demonstrate the benefits of linking an advocate to a person recently diagnosed with memory loss and dementia. The advocate’s role is to support, guide and advocate for the person throughout their journey, working to ensure they are able to have maximum say over the decisions and actions affecting their life. It can include assisting the person to put in place legal and paralegal mechanisms such as an enduring power of attorney, enduring guardianship and advanced medical directives; support and advocacy with accessing and using health and community care services; maintaining valued social activities and relationships; and support and guidance to choose a residential aged care service. As you will see when you read the project’s report it is proving to be a very creative, flexible and valuable service innovation. We believe that this pilot needs to be funded as a permanent service and made available across Tasmania, and to this end we will be approaching the State and Federal governments for ongoing funding.

In conclusion I’d just like to add how much I’ve enjoyed my first year as Chair and I’m looking forward to being part of the organisation’s exciting and worthwhile work in 2007/08. I would like to thank all the staff for their dedication and hard work. I would also like to pay tribute to our committed Board who give of their time so willingly. A particular thanks to Helen Hills, our past Chair and Treasurer, who is retiring at this September’s AGM.

Marion Florence
Chair

CEO'S OVERVIEW

Introduction

The Reports which follow, discuss in some depth, the work of the agency over the last year in each of our four Advocacy Programs: Aged Care, Home and Community Care, Disability and Mental Health; our volunteer program – the Mental Health Tribunal Representation Scheme, and our new pilot project on advocacy for people with dementia and memory loss. This section provides a brief statistical overview of the organisation's activities.

Individual Advocacy

Over the last twelve months Advocacy Tasmania provided individual advocacy to **1236** older people, people with disabilities, people with mental health disorders and their families and carers. This can be broken down as follows:

| Program | 2002/03 | 2003/04 | 2004/05 | 2005/06 | 2006/07 |
|----------------|----------------|----------------|----------------|----------------|----------------|
| Disability | 346 | 396 | 482 | 480 | 513 |
| Mental Health | 206 | 240 | 266 | 307 | 271 |
| Aged Care | 167 | 176 | 181 | 210 | 198 |
| HACC | 219 | 209 | 238 | 253 | 215 |
| Dementia | | | | | 39 |
| TOTAL | 938 | 1021 | 1167 | 1250 | 1236 |

There was a slight (1%) decrease in individual advocacy cases this year, with case numbers remaining high, with the organisation sustaining an overall increase of 32% over the last four years. For the first time last year we were faced with the situation of having to close programs to new referrals due to overload. The Disability Program, in particular, reached its capacity in 2004/05 and has remained at this level for the last three years.

At different stages of the year both Aged Care and Mental Health were in the similar positions. The books were closed on new referrals in both our Disability and Mental Health Programs at different stages during the year. Without new advocacy positions the numbers of people assisted is unlikely to increase significantly in 2007/08, and in fact will probably decrease with tighter eligibility criteria needing to be introduced to cope with the volume of referrals.

Mental Health Tribunal Representation Scheme

This year was the third full year of operation of the MHTRS which saw it consolidate as a statewide Scheme. This year **156** people were represented by one of our trained volunteers.

In terms of the Scheme's training and education activities 110 people participated in the training program and 105 people attended information sessions about the Scheme – a total of 215.

Information, Promotion and Education

Information

In 2006/2007 Advocacy Tasmania responded to **310** information inquiries. Many of the calls we did receive were from people wanting information about advocacy and Advocacy Tasmania's services, and this is reflective of a growing community interest in and awareness of 'consumer rights' in relation to human services.

In recent years, previously high numbers of information calls from students have reduced and this has corresponded with a rapid rise in hits on our website. In 2006/07 we received 53555 hits to our website, an increase of 32% in one year.

Education & Promotion

In the year 2005/2006 a total of 4610 people participated in education and other group work sessions facilitated by Advocacy Tasmania staff. In 2006/2007 the number has increased to **5406**, an increase of 17% on last year's total participant numbers. The break-up is as follows

| Program | 2003/04 | 2004/05 | 2005/06 | 2006/07 |
|----------------|----------------|----------------|----------------|----------------|
| Disability | 2195 | 1238 | 777 | 1624 |
| Mental Health | 747 | 361 | 968 | 1043 |
| Aged Care | 1096 | 955 | 1406 | 1185 |
| HACC | 1053 | 837 | 1114 | 1018 |
| MHTR | | | 345 | 215 |
| Dementia | | | | 321 |
| TOTAL | 5091 | 3603 | 4610 | 5406 |

The combined totals for individual advocacy (1236), people assisted with representation (156), information inquiries (310) and education and information session participants (5406) meant that **Advocacy Tasmania directly assisted and informed an impressive 7108 Tasmanians in 2006/2007.**

Ken Hardaker
CEO

AGED CARE

Advocacy

Introduction

The trend of increasing referrals has levelled out as the service has reached its capacity. The raw number of individual advocacy cases handled actually decreased slightly compared with the previous year (i.e. 5%), but the overall time devoted to advocacy case work remained high at around 75 – 80%. As such there was limited time available for education work.

There are a range of reasons for the continued high demand for aged care advocacy services including:

- A growing aged care sector – more consumers and families
- An increased awareness by consumers and families of residents' rights
- An increased awareness of Advocacy Tasmania's role. Referrals from aged care providers have steadily increased.
- Increased use of our website which has resulted in a number of referrals. Overall website hits are 32% greater than last year, with our aged care pages being amongst the most popular on our site.

Advocacy for people in high care continued to make up the bulk of the workload. – over 60% of referrals, but also, generally, the more complex cases involved high care residents.

The proportion of cases where advocacy worked for and with the resident directly (as opposed to working with relatives) also remained high at 75% of cases. The corresponding 25% figure for the percentage of cases where the advocate worked with a resident representative (usually a family member) is roughly equivalent to the % of cases involving clients with dementia.

In general, cases involving caring for people with dementia remained prominent. Issues of 'behaviour management' and 'medication' often presenting with these cases. The numbers of cases with these issues were similar to last year.

Substitute decision-making

As was reported in the first 6 months of this year there were again numerous cases involving confusion or dispute in relation to the authority of a family member to make decisions on behalf of a resident. In a number of cases service providers

made inappropriate assumptions about powers held by someone who was considered the 'next of kin' or someone with a power of attorney (POA). This was not restricted to residents with dementia but included situations of frail residents who still had the capacity to make their own decisions being sidelined with the home relating to a relative with a POA as if they were the resident's appointed guardian. Senior staff of nursing homes need to be clear about the different roles and powers of POAs, enduring guardianship and 'person responsible' and a resident's right to be assumed competent unless proven otherwise. The Tasmanian Guardianship & Administration Board provides an education program to inform human service providers with information and education on these matters and a number of providers have taken advantage of this service.

Complaints Handling

The most consistent trend in relation to complaints about aged care service delivery continues to be poor practices in communicating with residents and families which exacerbates and prolongs complaints. Of the 46 cases coded under 'complaints process' around half involved the resident and/or family feeling that they had not been listened to by the aged care service provider. Even in cases where the provider did listen there was often a consequent failure to take meaningful action or provide feedback about changes to residents/family members.

A number of Residents Committees raised similar complaints, that is, that they had repeatedly raised concerns with management but nothing ever changed.

Overall the response to complaints by providers continues to vary widely. Some have a positive attitude and response to grievances being raised by residents, families and advocates while others are less than welcoming and consequently some residents continue to be reluctant to report their concerns. It will be interesting to see what impact the new Complaints Investigation Scheme investigatory model has on the way providers deal with internal complaints.

Care Issues

Cases involving some very fundamental care issues remained fairly high for the year. This included continence, falls, and personal hygiene. The underlying reason seems to be that while the overall proportion of residents needing high care due to frailty and/or dementia is increasing, levels of staff and skills of staff are not keeping pace.

A small number of very serious cases related to a facility's failure to recognise when a resident needed medical care and the need to take appropriate action or

to arrange a GP referral or hospital admission, even after the matter had been drawn to their attention by the resident, a fellow resident or relative.

Staffing Issues

The data set does not adequately reflect the staffing issues most often raised by residents and family members. One of the most commonly mentioned complaints relates to the lack of staff. Whilst residents in care are significantly more highly dependent and have increasingly complex medical and other psycho-social needs, few providers are staffing facilities to adequately meet these needs. The numbers, quality and turnover of staff at all levels in some facilities often means that residents experience services as depersonalised and far from “homelike”. This can leave many feeling insecure, isolated and depressed. Family members also complain that staffing issues can result in miscommunication, stress and a loss of trust in service providers.

Staff members are also reporting to families and residents that they are short staffed. This has a great impact on such things as continence management. Residents also are disinclined to complain or seek assistance because they have experienced delays in bell response because of the shortages.

Statistics also do not reflect the increasing number of referrals for clients requiring support to complete paperwork for admission to an aged care facility. Most of these referrals are coming from ACAT. Reasons for support include no significant other in their lives to provide assistance, lack of understanding as to how to complete paperwork and physical limitations prohibiting them from actually writing.

Education & Promotion

Face to Face Education Sessions

Overall the numbers of people participating in information and education sessions has remained high at 1185 for the year. The 50 sessions provided translates into virtually one session per week, which, given the continued high demand for advocacy is a good achievement

Tasmanian Elder Abuse Working Party

Advocacy Tasmania has been a member of the TEAWP which is facilitated by the Industry Peak – Aged & Community Services Tasmania (ACST). The Working

Party is looking at strategies for preventing and responding to elder abuse in both residential care and community settings. Advocacy Tasmania represented Tasmania at the Australian Network for the Prevention of Elder Abuse (ANPEA) meeting in Sydney in November 2006.

We are currently working with ACST, COTA and TasCOSS on joint action to press the Tasmanian Government to develop a Tasmanian Elder Abuse Strategy. At present the state government does not have a position on this vital issue.

Tasmanian Aged Care Working Group/Forum

Advocacy Tasmania attended all meetings and raised a number of issues impacting on residents and families in Tasmania e.g. problems with many facilities no longer accepting the 5 step application form which has meant that many potential residents and families are having to fill in multiple applications.

The TACWG has changed its name to the Tasmanian Aged Care Forum as of June 2007.

Rural and Regional travel

ATI visited facilities in most of the more isolated parts of the state during the year including King and Flinders Islands, Dover/Esperence in the far South, NE Tas – St Helens, St Marys, Fingal and Scottsdale, Far NW and West Coast – Smithton, Strahan, Queenstown, Rosebery and Wynyard, the Tasman Peninsula and Central Tasmania – Ouse, Oatlands and Campbell Town.

Residents Committee Support

Normally we are unable to provide ongoing support to individual residents committees, but during the first half of the year we made an exception for Corumbene Nursing Home at New Norfolk who asked for our assistance to reorganise and reinvigorate their Residents Committee. A number of sessions/meetings with the committee were held and good progress made. The committee is now operating independently

Website

Website hits were 32% greater than last year, with our aged care program page and article on Aged Care Advocacy being amongst the most popular on our site.

Our multicultural brochures in Greek, Polish, Chinese, Spanish, Tagalog, German, Dutch, Italian Tigre and Amharic are now all available from our website. The Greek brochure in particular has received many hits. French and Arabic are soon to be added.

Miniposter

A new miniposter was developed. It is approximately half the width and length of a standard poster and fits easily on a noticeboard. The miniposters will be mailed out to all aged care facilities in Tasmania in the new financial year.

Student Lecture

A major lecture was given again this year to nursing students from the University of Tasmania as part of their aged care unit. The lecture covered advocacy for people in residential aged care, with a focus on people with dementia.

HOME AND COMMUNITY CARE

Advocacy

Introduction

In 2006/07 Advocacy Tasmania's Home and Community Care (HACC) Advocacy Program advocated for 214 HACC clients or potential HACC clients statewide. Significant numbers of cases (i.e. 35% of all cases) involved situations where clients experienced difficulty accessing HACC services. Specific problems included lack of adequate and appropriate information about services, the need for advocacy support to access relevant services, insufficient or unsuitable hours, as well as fear of withdrawal of hours. Carer issues such as access to adequate respite and support and lack of ample coordination were also prevalent. In addition to HACC service delivery issues, advocates dealt with a considerable number of housing issues and elder abuse cases as in previous years. These issues have a direct and significant impact on the overall well being of HACC consumers.

Referrals

Referrals came from a wide range of community services, and also a large number were received directly from HACC clients or potential clients and their carers. Unfortunately only a relatively small number of referrals were received from the major HACC service providers. Advocacy Tasmania makes continual efforts to inform and educate industry staff about advocacy services but it has been noticed that referrals from HACC services depend very often on individual workers and their understanding and attitude towards advocacy and consumer rights rather than on referrals which are underpinned by policy directions and the culture of the agency.

Access to services

For many elderly people, including carers, navigating the complex maze of service provision can be a daunting experience especially if they are new to the system and have no assistance.

Clients who are already receiving some services, or are lucky enough to have a well informed GP, have been referred to ACAT, or have sufficient hospital discharge plans and have access to coordinators and case managers, have easier and better access to the appropriate services. HACC advocates often become involved when these avenues have not been sufficient or have failed entirely and clients have been fortunate to be advised of advocacy services.

It is hoped that the consultations with service providers and consumers regarding service access points, which is one of the agenda items of “The Way Forward” the national community care reform agenda, will bring change to achieve a consumer friendly, community care system for all future and existing clients and their carers. Advocacy Tasmania looks forward to the results of the trial project ‘Central Contact Point’ with the Department of Health and Human Services which will provide important information for future developments of access points in Tasmania.

Quality of life and independence of HACC consumers

Elderly people and people with disabilities have the same strong desire to stay independent as the rest of the population. How can this be achieved in a environment characterized by restrictive workplace policies and practices which often are not accommodating of peoples’ wish to maintain independence?

A recent article titled ‘Loosening Boundaries to Promote Independence: Challenging the Quality of Care in HACC Services’ by Pauline Marsh which was published in the newsletter of the Tasmanian Council of Social Services in May/June 2007, describes this dilemma eloquently. The article was informed by consultations with many HACC consumers. , It examines and details the mismatch between inflexible, overregulated service provision and clients’ actual needs and what really happens on the ground.

It states;

“Loosening boundaries would demonstrate a positive conceptual and practical shift in the HACC Program, one that would see a movement away from being a collection of services that employ hidden measures to enable dependency, to one that openly and practically enhances independence through flexibility and client-driven means.”

Advocacy Tasmania would welcome such a shift in HACC service provision to enable clients to have a better quality of life through staying in control of their life circumstances and allowing them to gain from all aspects of service provision including developing healthy and positive relationships with their HACC workers.

Carer Support

Carer support has been an ongoing matter for Advocacy Tasmania over many years and was again so in 2006/07. A large number of HACC clients with high physical care needs are dependent on their continuing care from a primary carer, especially clients with dementia, those who have had a stroke, or who have experienced degenerative diseases. The every day contribution of caring for a

wife/ husband, mother/father, child, aunt /uncle or neighbour/friend without ample back up from support services can have wide reaching consequences for both carer and care recipient.

There is clear research evidence that carers experience poorer physical and mental health than non carers and have a higher risk of mortality (Schulz & Beech 1999). Certain groups of carers are more vulnerable to the negative impacts of caring including carers who care for someone with challenging behaviours, dementia or a high level of daily dependency; and carers who experience family conflict, financial hardships, social isolation or have health problems of their own (Sharlach et.al.2001).

A research project into the well-being of caregivers of elderly people with dementia, by Pot, Deeg, and Van Dyck (1997) showed a great amount of psychological distress on caregivers compared to the general population, with an overall deterioration of psychological well-being.

Advocacy Tasmania sees evidence to support the abovementioned research results experienced by carers frequently. The lack of access to regular support services such as adequate and flexible personal care, flexible in-home respite (i.e. short term and overnight), short term overnight out of home respite, emergency respite and real choices for residential respite, as well as lack of access to case management, puts enormous pressure on carers and the caring relationship.

This can cause high stress-levels for carers, which in turn can lead to depression and carer burn out. Depression often goes undiagnosed because carers might not regularly see their own doctor. Carers often do not take their own health issues serious enough because of overload and lack of adequate assistance. It is vital for carers that their needs and concerns are assessed, monitored and taken into account when assessments for direct service delivery through HACC providers and the Aged Care Assessment Team occur. Advocacy Tasmania hopes that assessment procedures for carers will significantly improve through establishing access points which are knowledgeable about carers' issues and automatically includes carers' needs and responds appropriately.

Housing Issues

Advocacy Tasmania has assisted HACC clients with various housing issues in the last financial year. The breakdown of a client's secure housing can cause major psychological health issues and the timely involvement of an advocate is often instrumental in avoiding premature admittance to residential aged care.

As in previous years many clients are faced with long waiting lists for transfers to a new location or to a more suitable housing option, which is needed due to a

significant change in the person's health. Many flats or houses from Housing Tasmania are not suitable for appropriate modifications to suit the person's individual needs and therefore the client has to wait for long periods until more purpose built housing becomes available. In cases where modification is possible, clients typically experience a system that is unresponsive and slow in completing alterations.

Long waiting times for transfers are particularly detrimental to clients in situations where they go through a breakdown in relationships, which in some cases involves domestic violence or a conflict situation with neighbours where threats, bullying and other violent behaviours are displayed. These situations have an immense impact on our client group and often cause serious health symptoms such as insomnia, anxiety and other psychosomatic syndromes.

Clients living in private rental or who own their homes are rarely eligible for public housing even if their circumstances have radically changed and they experience substantial hardship.

Elder Abuse

Advocacy Tasmania again dealt with a significant number of cases of abuse; the majority of which were emotional/ psychological abuse cases often in combination with financial abuse. This trend is similar to previous years. The lack of access to adequate support for victims of abuse often results in devastating living conditions and a faster deterioration of physical and psychological health for our already frail elderly clients.

A major problem when dealing with elder abuse is accessing vital services to assist the older person without having to go through long waiting times for assessment and allocation of services. Finding appropriate alternative accommodation or emergency respite places is difficult if not impossible especially at a time where clients already feel disempowered, and with few if any real choices available to them.

The wider Elder Abuse debate has gained some momentum over the last year; special legislation has been passed through the Federal Parliament including compulsory reporting for abuse occurring in residential aged care facilities with the intention to protect older Australians cared for in these facilities.

There have been some developments in Tasmania regarding bringing the issue of Elder Abuse to the forefront for the public domain, particularly raising the issue in the community sector. Advocacy Tasmania has been involved in the Elder Abuse Working Party organised by Aged & Community Services Tasmania (ACST) which

resulted in some training about the subject and policy development for service providers.

Advocacy Tasmania also has been working in partnership with TasCOSS, Council on the Ageing and ACST to develop a joint position statement on elder abuse. The statement advocates that the Tasmanian Government develop a Tasmanian Elder Abuse Policy and Strategy. This should include, the establishment of an Elder Abuse Hotline and public awareness campaign, the funding of a lead agency to co-ordinate non-government and government services, training and support to sector workers, as well as specialist support to victims of elder abuse. ATI believes that elder abuse policy development and implementation of an overall Elder Abuse strategy in Tasmania is long overdue.

The importance of the abovementioned Elder Abuse Strategy was confirmed in the outcomes and recommendations of the HACC consumer consultation report, "Safe as Houses: Elderly HACC Clients Describe Experiences of Vulnerability," recently completed by TasCOSS. It describes and reflects upon the many levels of exposure to vulnerability and abuse experienced by elderly people living in our community and makes valuable recommendations regarding many facets of living circumstances for HACC clients and how the HACC Program can make a positive contribution to preventing and responding to vulnerability and abuse.

Advocacy Tasmania also participated in the ANPEA (The Australian Network for the Prevention of Elder Abuse) national meeting where the progress in addressing this important issue was discussed nationally.

Education and Promotion

Consumer and Service Provider Education Sessions

Advocacy Tasmania makes a constant effort to reach as many consumers or potential consumers, carers and service providers statewide as possible in order to provide information and education sessions. This is vital to ensure access and equity for consumers to advocacy services and provide service providers with the necessary knowledge for appropriate referrals. This year 1018 people participated in information and education sessions and Advocacy Tasmania delivered 67 sessions statewide compared to 48 sessions in the last financial year.

This year, advocates visited rural and remote communities including King Island, Flinders Island, West and East Coast, Scottsdale, St. Helens, Tasman Peninsula, Huon Valley, Dover, Derwent Valley and Bruny Island. Most of the state-wide community health centres were also visited and provided with brochures.

Promotion and Liaison

In addition to providing information and education sessions Advocacy Tasmania promotes the service through a range of activities. HACC advocates participate regularly in a number of forums, committees and networks to promote the service actively to the community sector.

Articles about Advocacy Tasmania's HACC advocacy services were reproduced in several publications including the Commonwealth Carelink newsletter, Southern Division of General Practice newsletter, Kingborough Seniors Action Group newsletter, Huon Valley Council newsletter and Southern Cross Community Care staff newsletter.

Consumers with Dementia and National Service Standards

Advocacy Tasmania, in collaboration with Alzheimer's Australia Tasmania (North) and the HACC Program produced "Guidelines for meeting the HACC National Standards for Consumers with Dementia". The guidelines relate specifically to the obligation HACC service providers have under the National HACC Service Standards to support consumers with dementia to identify an advocate of their choice prior to the need arising. The guidelines were distributed to all HACC funded services and ATI advocates promoted the use of the guidelines at regional HACC Forums.

Elder Abuse Education

The Elder Abuse Education Session, which has been provided predominantly to community nurses in previous years, has been requested by various community service providers this year and was well received. The greater awareness of the issue of elder abuse in the community and in particular in the community care sector has brought more interest in the Elder Abuse Education session than before.

The education session includes topics such as categories of abuse, factors contributing to abuse, options for interventions and the pros and cons of mandatory reporting. The education session fills a gap to some degree for a much needed comprehensive approach for elder abuse education in the sector.

DISABILITY

Advocacy

Introduction

In 2006/07 Advocacy Tasmania's Disability Advocacy Program advocated for 513 people with disabilities and their families. The rate of representation has risen yet again on the previous financial year. This year an additional 33 more cases were handled than last year (or a 7% increase) and the increase over the last five years has been 43%. All Advocates in the Disability Program have been working at capacity for more than two years. There was a period in April 2007 when ATI Disability Advocates statewide had no capacity to accept any new referrals, except in cases of abuse or where immediate safety, was an issue.

Unmet Need

The number of clients presenting to Advocacy Tasmania with issues of serious and long-term unmet service needs has doubled over the previous year, to an unequaled 30% of all disability advocacy cases. These cases not only represent a considerable demand on advocates' time but they also tend to be the most complex cases. In addition they are generally our long-term cases - with advocates often needing to represent clients for 2-3 years before the vital services are provided. Of the cases we deal with under the collective code of 'unmet need', the highest number are in the area of 'accommodation' which is discussed in further detail below.

Twenty percent (20%) of ATI's unmet need clients were waiting unacceptably long periods for individual support packages; 15% were unable to obtain day support services, again many of them having to wait for 2-3 years for service and some not obtaining any day services in that time; and 5% of clients unable to obtain respite services either when they required them or not at all. Many families and clients have almost given up hope of ever obtaining day support or respite services. As of 31 May 2007, there were 289 people on the Disability Services Waiting List for individual support packages, 33 people waiting for supported accommodation and 107 waiting for day support services.

Accommodation

The percentage of cases relating to 'accommodation' issues referred to ATI in the last year has remained fairly constant from the previous year, representing 27% of all disability advocacy cases.

The clients from this group that Advocacy Tasmania represented constituted 40% of our clients in the unmet need category (28% awaiting supported accommodation and 12% awaiting Housing Tasmania placement). Many of these people have been waiting for supported and community accommodation for untenable lengths of time and this waiting has resulted in the clients continuing to live in crisis in the community or living permanently in respite, acute hospital or transitional hospital wards for between 6 months and 3 years.

The ongoing deficiency in the State Disability Services budget to provide necessary and vital services to clients in urgent need, results in serious hardship for people with disabilities and their families which is unacceptable in Australia in 2007 where most members of the community enjoy a high standard of living.

Analysis of our accommodation cases also identified a growing trend of clients and families requesting advocacy assistance in situations where people were receiving inadequate hours of staff support while living in a group home or other supported accommodation setting or in tenancy support for people living semi-independently in the community. This was often also associated with complaints from clients of poor quality care and support from staff pointing to a need for better staff training and supervision.

Abuse

There was a small reduction in the percentage of abuse referrals compared to the previous year. It is difficult to comment on whether this represents a reduction in the incidence of abuse or a reduction in people seeking advocacy support during the process. It certainly has been observed that services are much more observant of the procedures of the State Disability Services Abuse Reporting Guidelines and more competent in implementing these Guidelines.

There has been a marked shift in the type of abuse referrals received by our agency in the past year compared to previous years. Previously, we had a much higher percentage (20%) of suspected staff to client abuse reported. This year, more than half the abuse cases reported comprised issues of client to client abuse, more often than not in supported accommodation settings. This is likely to be reflective of one of the trends described above whereby staff are inadequately trained and supervised to meet the clients' needs or where the levels of support are seriously inadequate. In these situations, one of the consequences can be that clients with high support needs who also have behavioural problems can begin abusing other clients with whom they live or attend day support.

Advocacy Tasmania draws attention to what we see as necessary in the area of abuse, that is the need to develop a statewide collaborative Abuse Prevention Strategy within the Disability sector.

Employment

The percentage of employment referrals has remained constant compared to the previous year but the issues presenting have changed considerably. This year 25% of employment referrals were from clients in Business Services on a wide range of issues, a considerable increase on 2005/06.

A dominant Business Services issue for the advocate was the follow up to the closure of Tahune Pottery Business Service which resulted in 6 clients wishing to find alternative employment. Unfortunately, half of those clients had to accept placement in a local day support option instead of supported employment mainly due to their inability to travel from the Huon to Hobart for work. One very positive outcome has been that one of the workers has found work in open employment.

Referrals from people with disabilities working in open employment with such issues as wages, entitlements, discrimination and workplace harassment, represented a high percentage (17.5%) of the employment workload. These cases were often complex and time-consuming and required a greater level of support to the client. The number of such referrals increased with the loss of the position of the Employment Advocate at the Launceston Community Legal Centre.

The remainder of employment issues were distributed thus:

Seeking Employment 15% in Business Services and open employment.

Unfair Dismissal 7.5% in Business Services and open employment.

Complaints Against Specialist Disability Employment Services 7.5% including unacceptable delays in following up or responding to clients who had contacted a service seeking assistance to find employment; or not explaining work conditions and entitlements.

Living Independently Project

Following the announcement by the Government to transfer government run group homes to the non-government sector Advocacy Tasmania was funded for one full time position to cover the LIP project. Three advocates share responsibilities for the LIP, two in the South and one in the North. The primary function of the Advocates in this project is to protect the rights and interests of residents who live in Disability Services Group Homes as the homes transfer to the non-government sector.

Advocacy support for all clients involved with the LIP is a critical element for involving the clients in the process, giving them a voice, which will hopefully bring about positive changes to their quality of life.

The role of the advocates has been to:

- identify, from speaking with the clients, individual issues impacting on their quality of life, looking at options, actions and resolution to those issues e.g. one client identified that he would like to ride a bike and go for a walk, as part of his exercise program. The issue was brought to the attention of the service provider. A bike was purchased by the organisation so support workers could accompany the client
- group issues, that are being experienced by many clients, and address the matter systemically with key people within Disability Services and the LIP project e.g. up to date equipment needs, relevant life plans, community nursing support
- facilitate fortnightly client meetings, at the residential sites when identified to changeover from Disability to NGO management. These client meetings are documented and are a good tool for raising and addressing issues from the client perspective about current support issues or fears about the imminent changes e.g. at one site there have been many physical changes to the setting. Through the meeting process they were able to discuss the problem, identify that they wanted to happen and instruct advocates to pursue the matter with management
- attend monthly LIP Reference meetings on behalf of clients, supporting client representatives to attend, and raising issues heard from clients or seen at sites
- meet regularly with LIP and Disability Services management to progress client issues
- have regular contact with the Disability Ethics Committee over any restrictive practices e.g. locked doors, removal of stove and the number of cigarettes residents are allocated for a day.

Most of the clients living within these currently Disability Services managed group homes, have multiple disabilities, are extremely vulnerable, with the majority unable to ring and ask us for help. With this enhanced model of practice, with a dedicated advocate regularly visiting all clients, seeing and hearing first hand their issues, has meant their voice is finally being heard.

Without this regular contact from an independent person, they are at risk of neglect, abuse or restrictive practices and certainly not a quality of life dictated by their desires.

Education and Promotion

Overall participant numbers (1624) were up by 110% from last year and the number of sessions held increased by 54% from 83 to 128. The main driver for this considerable increase has been the LIP and the education and promotion activities associated with it which has been valuable in ensuring that residents and families are aware of the advocacy role and our availability. Advocate facilitated monthly resident meetings have been held at all sites where residents were able to participate in such meetings. Once a site was announced as commencing the transition process to NGO, management meetings were increased to fortnightly, e.g. Pottery Road and Tolosa Street. At locations where residents were unable to participate in such discussions, primarily due to limitations in ability to communicate, advocates have undertaken regular site visits to see clients, communicate as best as possible with each resident individually and to keep a watching brief on their circumstances.

The LIP has also included involvement in a number of family information sessions in both the North and South.

Another major source of education activity this year as been requests by registered training organisations for sessions on advocacy as part of their certificate 3 and 4 training for people working or intending to work in the disability services sector.

MENTAL HEALTH

Advocacy

Introduction

It was reported in last year's Annual Report that:

The 2005/06 year realised a 15% increase in the number of Mental Health Program cases handled, which was part of a 49% increase over the last 3 years. The program can not continue to sustain the yearly increases and provide an equitable state-wide service.

This prediction proved to be the case this year which has resulted in an 11% decrease in the number of cases. The decrease however does not reflect an overall reduction in the numbers of consumers or their carers/relatives and professional support persons contacting Advocacy Tasmania seeking service. Rather, it was due to the fact that our Mental Health Program closed its books to all but urgent/crisis cases for an eight week period in late 2006; a more stringent application of the eligibility criteria at intake being applied; and a more generic approach taken by the organisation in attempting to meet the service needs of mentally ill persons in the north and north-west.

For many years Advocacy Tasmania has identified gaps in service. It has regularly reported on areas of unmet need and the manifestly inadequate funding and resourcing of mental health services in both the government and non-government sectors, and particularly in mental health advocacy. In the past for example, Advocacy Tasmania has accepted referrals from Legal Aid and community legal services on behalf of mentally ill persons unable to access basic non-criminal legal support and services. By necessity, this provision of service has had to be reduced.

The mental health program no longer has the capacity to provide the breadth of services it has provided in the past. The organisation is concerned that in having continued to provide these services, it may have succeeded in masking the seriousness of the unmet need for increased advocacy services for people with mental health disorders.

If Advocacy Tasmania is to continue to provide an equitable services to all Tasmanians with mental health issues, it is essential that, as a minimum, a second position of mental health advocate be funded for the north/northwest regions.

Accommodation

Accommodation is always a major issue and once again there has been a significant increase in referrals (30%). In past years, the mental health program focused more on accessing services for the client; i.e. helping the client to move into category 1 on the public housing waiting list or to transfer from inappropriate housing. It was reported last period that the recent trend for advocacy had been to try to prevent a client from becoming homeless due to eviction and this trend continues.

Continuing to rise in reporting numbers is the problem of mentally ill persons accommodated in private boarding houses. Often the residents have been unable to apply to Housing Tasmania because of past issues such as damage to previously rented Housing property, or rental arrears. Many are vulnerable to the discriminations and at times, criminal actions experienced within the private sector boarding environment. Residents report issues such as physical and sexual assaults by other residents, psychological abuse by untrained staff including denying residents access to vital medication such as insulin being kept in facility refrigerators, inappropriate and unprofessional treatment such as swearing and shoving, and financial manipulation and abuse of residents. Many of the allegations go unreported because of the fear of retribution. The residents do not wish to make trouble because they know to do so may result in them becoming homeless. There are often no immediate options available to these persons other than homelessness.

Maximising Recovery Panel

A new trend emerging is the problems associated with the requirement that only the clinical Maximising Recovery Panel (MRP) can select residents for supported accommodation in Tasmania. Increasingly, consumers and NGOs complain to ATI that the Panel appears to have little to do with maximising recovery and everything to do with controlling beds. This can be to the client's detriment.

Breakdowns in placement do occur because of a person's lack of suitability for the provider's service model. Clients become confused and distressed when their accommodation breaks down and they are returned to an inpatient facility or become homeless and the recovery of other residents is negatively affected.

Limited work is done around discharge planning and at the time of discharge there is no available accommodation despite the fact that there are vacancies in NGO supported accommodation facilities. This is frustrating for clinical staff and NGO staff. As a consequence, some inpatients are being detained longer than their clinical status requires as they await a decision of the MRP and subsequent

placement, some are discharged into boarding house accommodation, while others are discharged homeless.

Residents have lost their accommodation because of the intervention of the Panel when the person has been hospitalised. Persons whose applications are rejected most commonly are advised by letter and given no reasons for the rejection even though their case manager/support professionals have helped them complete the application, expecting that the person would be a successful candidate. Often it is these persons who would benefit most from the supported accommodation recovery model program but increasingly, the MRP is being viewed by consumers and industry staff as an administrative mechanism to move patients within the MHS system and free up hospital beds.

Review of the Mental Health Act (1996)

The Advocate participated in the Mental Health Act Review Project Group until the group's demise in March 2007.

The Advocate continued her involvement in the review with the researching and writing of a 33,000 word submission in response to the publication of the Government's Issues Paper; the provision of written and oral analysis and advice for the successful lobbying of a time extended framework for the review; the lobbying and support of individuals and NGOs in their submission responses to the Issues Paper.

Education and Promotion

Education Sessions

The Advocate undertook 34 educational sessions with a total of 1043 participants during the reporting year. Ten of the education sessions represented training sessions across the state for the Mental Health Tribunal Representation Scheme and 336 of the 1043 participants were students, primarily law students. Since 2003, over 1000 Tasmanian lawyers and young professionals have undertaken the Scheme training, satisfying the two equal goals of the Scheme.

1. Provision of free, competent representation for persons appearing before the MHT
2. Promoting awareness of mental health issues, and the provision of improved skills, amongst professionals working with mental health clients to enable better outcomes for clients.

The Advocate has continued in her role as a consultant for the Scheme and participates in the development of necessary policies and strategic planning. She also continues to assist in the promotion of the Scheme through written submissions, information sessions and writing and creating promotional materials.

Website

The Advocate built and maintains the Advocacy Tasmania Inc. website and in this period, reviewed and updated the site including the Mental Health Fact Sheets as well as other publications linked to the site. The site maybe accessed at www.advocacytasmania.com.au

MENTAL HEALTH TRIBUNAL REPRESENTATION SCHEME

Introduction

The Mental Health Tribunal Representation Scheme (the Scheme) trains volunteers to provide competent representations to people appearing before the Mental Health Tribunal (MHT). Until the Scheme commenced in 2003, people with a mental illness were unrepresented at MHT hearings despite the fact that they could be involuntarily detained for a period of up to six months. In the 3 ½ years that the Scheme has been operating over 600 people have been offered representation.

The last 12 months have seen a positive year for the Mental Health Tribunal Representation Scheme. Training has been held in each of the regions with great success. The Scheme has also continued to receive the full support of the President of the Mental Health Tribunal and the Tribunal members.

Representations

TABLE A: TOTAL NUMBER OF CLIENTS

| | North | North West | South | TOTAL |
|--------------------|-------|------------|-------|--------------|
| List from Tribunal | 78 | 73 | 116 | 267 |
| Represented | 47 | 33 | 76 | 156 |
| Unrepresented | 31 | 40 | 40 | 111 |

TABLE B: MHTRS REPRESENTED

| | North | North West | South | TOTAL |
|------------------------|-----------|------------|-----------|--------------|
| Partial Representation | 16 | 14 | 26 | 56 |
| Full Representation | 31 | 19 | 50 | 100 |
| TOTAL | 47 | 33 | 76 | 156 |

TABLE C: UNREPRESENTED CLIENTS

| | North | North West | South | TOTAL |
|----------------------------------|-----------|------------|-----------|--------------|
| Client discharged before Contact | 13 | 31 | 25 | 69 |
| Client declined offer | 7 | 1 | 13 | 21 |
| No Contact | 11 | 8 | 2 | 21 |
| TOTAL | 31 | 40 | 40 | 111 |

Analysis

The presentation of the statistics has changed this year so as to give the most concise and informative analysis of the numbers.

Table A is the total number of clients that have been on the lists sent by the MHT and whether or not they were represented by the MHTRS. Statistics show that of the 267 hearings listed, 69 were discharged before the hearing date leaving 198 which went ahead with 156 (78%) of these clients being represented. Those that were not represented either declined (11%) or were not contacted (11%) mostly because the client was not contactable. A key goal for 2007/08 will be to increase the total percentage of people who are represented.

Overall numbers of hearings listed were down by 11% from 2005/06, but may be due to the addition of the Wilfred Lopes Centre which now holds separate forensic hearings. The Scheme does not extend to these hearings.

Table B is the breakdown of the type of representation provided by MHTRS. To count as 'represented' there must have been some work done by the representative, from the provision of information and answering of questions through to attendance at the hearing. Full representation is when the MHTRS representative attends the hearing with their client. Partial representation is when the representative provides information or assistance to the client without necessarily attending the hearing. This additional information includes informing clients of the legal requirements of their particular orders, discussing the evidence that the Tribunal is going to be considering in ascertaining the legality of the order, and providing explanation as to why the orders are to be reviewed.

Table C illustrates the breakdown of clients who were unrepresented. These include those clients with whom contact could not be made, or who had agreed to be represented but failed to arrive at their hearing. Also, some clients are content to remain on orders and do not wish to attend their hearings.

Out of 267 people who were listed for hearings, more than 90% of people were offered representation.

Partnerships

Mental Health Tribunal

Over the last 12 months the evaluations received from the Mental Health Tribunal continued to demonstrate that the representatives are maintaining a very high standard of professionalism. The Tribunal members from each region consistently

support and positively comment upon the work done by the volunteer representatives.

The volunteers are informed of their individual evaluations and this has been deemed a useful tool for the volunteers to gauge how the Tribunal views their performance. This has also been found to be beneficial to the new volunteers in increasing their confidence and assures them that they are fulfilling their role.

University of Tasmania Law School

The University of Tasmania Law School (UTas) has continued to support the training and the opportunity for the law students to gain some practical experiences whilst still at the undergraduate level. The UTas Law School has continued to assist with costs associated with training students and the reimbursements paid to the students for their out-of-pocket expenses.

Centre for Legal Studies

It was the 3rd year that the Legal Practice Centre has run the training as a compulsory unit within its study course. This has been a mutually beneficial partnership as not only does the Scheme have an influx of representatives from which to draw upon, but also the Legal Practice trainees are gaining useful experience with mental health issues. Over 175 newly admitted legal practitioners have completed the training over the past 3 years.

Promotion And Education

In August 2006 the Coordinator presented a paper to the National Mental Health Conference (TheMHS) in Townsville and this was subsequently accepted by the committee for inclusion in the Book of Proceedings. The paper was received with much interest from both consumers and service providers from other States and overseas.

In April 2007, a major promotional exercise was undertaken by the Coordinator of the MHTRS and the Mental Health Advocate in order to promote the Scheme and ATI's Mental Health Advocacy Program to a wider audience as well as with a view to gaining interested participants for the training, which was to be held later that month. Presentations were made across the north and north west of the state and included the TAFE colleges, the university campuses, Red Cross, Family Based Care and Richmond Fellowship, to name a few. Interviews were given for the Examiner newspaper and for WayFM radio station. The success of this exercise

was evident in the numbers attending the training sessions in both Burnie and Launceston.

Training And Mentoring Of Volunteers

During the reporting period there has been three major training sessions. One was held at the University of Tasmania Law School, one at the Centre for Legal Practice and another one in Devonport, which combined both the Northern and North Western regions.

In August and September 2006, 21 undergraduate law students took part in the lecture series and attained their Certificate of Skills and Awareness in Mental Health, with 15 proceeding to the intensive training stage to become volunteer representatives.

In February the Centre for Legal Studies continued its policy of compulsory participation in the training as part of the Course. The training for the Legal Practice trainees was held in two sessions. A total of 45 trainees completed the Representation Training.

In April the Lecture series and Training were held over the weekend 28th-29th. In the morning of the 28th the 3 lectures were presented to 22 interested participants in Launceston. That afternoon, a further 22 participants in Burnie also attended the lecture series. On the following day, 30 people attended a combined training session in Devonport, with many of those people who did not attend stating they would like to be kept in touch for future training sessions. This substantial increase in the pool of volunteers gave a much needed boost to the regions.

| | North | North West | Combined N/NW | University of Tasmania | Legal Practice | State | National | TOTAL |
|-----------------------------------|-------|------------|---------------|------------------------|----------------|-------|----------|--------------|
| Lecture 1 | 22 | 22 | N/A | 21 | 45 | | | 110 |
| Lecture 2 | 22 | 22 | N/A | 21 | 45 | | | 110 |
| Lecture 3 | 22 | 22 | N/A | 21 | 45 | | | 110 |
| Intensive Representation Training | N/A | N/A | 30 | 15 | 45 | | | 90 |
| Other Education Sessions | | | | | | 60 | 45 | 105 |

STATISTICAL REPORTS 2006/07

INDIVIDUAL ADVOCACY

Disability

Total

| | <u>05/06</u> | <u>06/07</u> |
|--------------------------------|--------------|--------------|
| Client Numbers | | |
| Finalised | 366 | 371 |
| Not Finalised | 114 | 142 |
| Total | 480 | 513 |
| Primary Disability Type | | |
| Intellectual | 250 | 276 |
| Physical | 83 | 87 |
| Sensory | 15 | 12 |
| Psychiatric | 37 | 30 |
| ABI | 45 | 52 |
| Neurological | 8 | 10 |
| Autism | 6 | 19 |
| Specific Learning/ADD | 16 | 2 |
| Other | 17 | 25 |
| Abuse Issues | | |
| Financial | 14 | 18 |
| Emotional | 24 | 14 |
| Physical | 38 | 29 |
| Sexual | 7 | 6 |
| Neglect | 6 | 4 |
| Total | 68 | 58 |
| Other Issues | | |
| Aids/Equipment | 14 | 11 |
| Accommodation | 118 | 140 |
| Child & Family Services | 14 | 13 |
| Choice | 25 | 20 |
| Criminal Justice | 28 | 19 |
| Crisis Situation | 12 | 13 |
| Day Service | 36 | 29 |
| Discrimination | 13 | 14 |
| Education | 8 | 10 |
| Employment | 54 | 46 |
| Family & Social Supports | 44 | 38 |
| Financial | 39 | 35 |
| Guardianship & Administration | 33 | 31 |

05/06**06/07**

| | | |
|----------------------------------|-----|----|
| Health | 53 | 65 |
| Housing Tasmania | 24 | 31 |
| Independent Living | 20 | 19 |
| Individual Planning | 39 | 45 |
| Lack of Information | 14 | 13 |
| Legal Issues | 47 | 53 |
| Respite | 9 | 13 |
| Safety | 25 | 26 |
| Service Access | 27 | 19 |
| Service provider/policy/practice | 76 | 81 |
| Other | 124 | |

Mental Health**Total****05/06****06/07**

| | | |
|-----------------------|------------|------------|
| Client Numbers | | |
| Finalised | 273 | 250 |
| Not Finalised | 34 | 21 |
| Total | 307 | 271 |
| | | |
| Access/Equity | | |
| ATSI | 5 | 3 |
| CALD | 23 | 38 |
| | | |
| Groups | | |
| Mental Illness | 290 | 254 |
| Personality Disorder | 19 | 17 |
| Dual Diagnosis | 25 | 10 |
| Co-morbidity | 8 | 5 |
| | | |
| Sector | | |
| Community | 166 | 147 |
| Inpatient/Residential | 131 | 104 |
| Adolescent | 8 | 7 |
| Forensic | 10 | 4 |

| | 05/06 | 06/07 |
|--------------------------------------|--------------|--------------|
| Community Issues | | |
| Accommodation | 39 | 51 |
| Child & Family Services | 9 | 17 |
| Police | 24 | 13 |
| Discrimination | 41 | 31 |
| Community Supports | 39 | 38 |
| Health Care & Treatment | 41 | 49 |
| Legal Issues | 87 | 57 |
| Stigma/labelling | 27 | 22 |
| Financial | 46 | 40 |
| Rights | 104 | 99 |
| Interpersonal/family | 38 | 51 |
| Inability to Access Service | 19 | 13 |
| Refusal of Service | 12 | 14 |
| Reduction of Service | 3 | 6 |
| | | |
| Mental Health Facility Issues | | |
| Inpatient Care & Treatment | 64 | 59 |
| Choice | 74 | 80 |
| Confidentiality & Privacy | 15 | 4 |
| Smoking | 3 | 2 |
| | | |
| Abuse Issues | 33 | 30 |
| Physical | 10 | 8 |
| Psychological/Emotional | 8 | 2 |
| Financial | 5 | 12 |
| Sexual | 9 | 11 |
| Abuse by staff | 11 | 7 |
| Abuse by family | 11 | 5 |
| Abuse by other | 5 | 11 |
| | | |

HACC**Total**

| | <u>05/06</u> | <u>06/07</u> |
|--|---------------------|---------------------|
| Service Consumers | | |
| Not finalised | 60 | 44 |
| Finalised | 193 | 171 |
| Total | 253 | 215 |
| | | |
| HACC Service Related Issues | | |
| Assessment | 2 | 2 |
| HACC fees | 7 | 4 |
| Carer Support | 18 | 12 |
| Case Co-ordination | 7 | 5 |
| Case Management | 5 | 5 |
| Service hours insufficient/unsuitable | 33 | 23 |
| Service unavailable | 5 | 6 |
| Service refused | 4 | 1 |
| Service reduced/fear of reduction | 3 | 4 |
| Service withdrawn/fear of withdrawal | 11 | 12 |
| Privacy/confidentiality | 3 | 2 |
| Staff issues | 11 | 6 |
| Complaints handling | 4 | 7 |
| Lack of consultation | 2 | 5 |
| Culturally inappropriate | 0 | 0 |
| Other service related matter | 3 | 4 |
| Access to Support Packages | 11 | 5 |
| | | |
| Other Issues | | |
| Family/personal relationships | 28 | 13 |
| Abuse | 35 | 20 |
| Guardianship | 11 | 10 |
| Trusteeship/enduring power of attorney | 10 | 10 |
| ACAT/RAC issues | 4 | 6 |
| Equipment | 9 | 4 |
| Income security | 8 | 11 |
| Legal | 32 | 19 |
| Health | 38 | 22 |
| Housing | 48 | 36 |

Aged Care**Total**

| | <u>05/06</u> | <u>06/07</u> |
|--------------------------------------|---------------------|---------------------|
| Client Numbers | | |
| Not finalised | 173 | 175 |
| Finalised | 37 | 27 |
| Total | 210 | 198 |
| | | |
| Remote | 100 | 92 |
| Rural/Regional | 48 | 52 |
| Metro/City Hobart only | 60 | 51 |
| Unknown | 2 | 3 |
| | | |
| Issues | | |
| Administration/Fair Trading | | |
| Administration Procedures | 14 | 21 |
| Agreements | 13 | 8 |
| Bonds | 8 | 2 |
| Concessional Access | 4 | 1 |
| Fees/Charges | 24 | 12 |
| Management | 26 | 29 |
| Security of Tenure | 16 | 16 |
| Personnel/Staffing | 25 | 25 |
| | | |
| Level of Care | | |
| Access to specialised services | 27 | 14 |
| Assessment/Care Planning | 17 | 15 |
| Behaviour Management | 26 | 20 |
| Clothing | 0 | 0 |
| Continence | 6 | 8 |
| Dental | 4 | 2 |
| Emotional | 24 | 13 |
| Falls | 10 | 11 |
| Hydration/Nutrition | 7 | 4 |
| Medication | 17 | 17 |
| Mobility | 9 | 9 |
| Pain Management | 4 | 9 |
| Palliative Care | 4 | 3 |
| Personal Hygiene (Bathing, Grooming) | 12 | 11 |
| Rehabilitation | 4 | 2 |
| Sensory Loss/Aids | 1 | 1 |
| Skin Care | 6 | 11 |
| Specialised Care & Services | 5 | 4 |
| Sleep | 1 | 1 |
| Restraints | 0 | 2 |

| | 05/06 | 06/07 |
|---|--------------|--------------|
| Consumer Rights | | |
| Abuse | 25 | 19 |
| Activities | 9 | 14 |
| Choice/Decision Making | 49 | 32 |
| Complaints Process | 51 | 46 |
| Consent to Care/Treatment | 6 | 2 |
| Confidentiality | 4 | 2 |
| Cultural | 4 | 3 |
| Independence | 18 | 15 |
| Information | 39 | 29 |
| Medical Records | 2 | 0 |
| Personal Property | 4 | 1 |
| Prescribed Services | 0 | 0 |
| Privacy/Dignity | 9 | 6 |
| Spiritual | 2 | 3 |
| | | |
| Environment | | |
| Cleaning | 1 | 1 |
| Catering | 11 | 11 |
| Equipment | 9 | 8 |
| Fire | 0 | 1 |
| Laundry | 4 | 0 |
| Physical | 1 | 2 |
| Repairs & Maintenance | 1 | 1 |
| Security | 2 | 3 |
| Social | 4 | 9 |
| Theft | 0 | 1 |
| | | |
| Additional | | |
| Alternative Decision Making | 14 | 11 |
| Care Options – Access to appropriate Care | 72 | 51 |
| Financial Issues | 35 | 40 |
| Significant Others – Family Disputes | 11 | 10 |
| | | |
| New Fields | | |
| Fear of Retribution | 13 | 9 |
| Transfer Facilities | 15 | 8 |
| Waiting for Placement | 19 | 11 |

EDUCATION & PROMOTION

| | <u>Disability</u> | |
|--|-------------------|-------------|
| | 05/06 | 06/07 |
| Total Sessions | 83 | 128 |
| Participants | | |
| Consumers & Carers | 566 | 902 |
| Staff | 123 | 581 |
| Others* | 88 | 141 |
| TOTAL | 777 | 1624 |
| * Includes students and general public | | |

| | <u>Mental Health</u> | |
|--|----------------------|-------------|
| | 05/06 | 06/07 |
| Total Sessions | 30 | 34 |
| Participants | | |
| Consumers | 55 | 180 |
| Carers | 10 | 79 |
| Allied Health Professionals | 35 | 32 |
| Industry Staff | 196 | 206 |
| Volunteer reps | 281 | 336 |
| Other community, govt organisations & general public | 391 | 210 |
| TOTAL | 968 | 1043 |

| | <u>MHTRS</u> | |
|---------------------|---------------------|--------------|
| | 05/06 | 06/07 |
| Students/volunteers | 117 | 110 |
| Industry Staff | 228 | 105 |
| TOTAL | 345 | 215 |

| | <u>HACC</u> | |
|-----------------------|--------------------|--------------|
| | 05/06 | 06/07 |
| Total Sessions | 45 | 67 |
| Participants | | |
| HACC Clients | 590 | 480 |
| Carers | 27 | 65 |
| HACC Staff & Others | 497 | 473 |
| TOTAL | 1114 | 1018 |

| | <u>Aged Care</u> | |
|---------------------------------|-------------------------|--------------|
| | 05/06 | 06/07 |
| Total Sessions | 53 | 50 |
| Participants | | |
| Residents | 532 | 449 |
| Carers | 45 | 45 |
| Allied Health Staff | 63 | 0 |
| Staff/Industry | 420 | 304 |
| Other Community Organisations | 26 | 33 |
| Other Individuals incl students | 320 | 354 |
| TOTAL | 1406 | 1185 |