ADVOCACY TASMANIA INC.

ANNUAL REPORT 2011 / 2012

2011/12

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ADVOCACY TASMANIA INC.

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FOREWORD

Advocacy Tasmania Inc. (ATI) is an independent, state-wide, non-profit, advocacy service for older people, people with disabilities, people with mental health disorders, people who use alcohol, tobacco and other drug services, 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 services
- 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
- People who use alcohol, tobacco and other drug services
- 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.

As of April 2012, Advocacy Tasmania has been funded to establish the Tasmanian Elder Abuse Helpline. This will commence operation in August 2012.

Our Vision is:

A fair, equitable, just and inclusive society for all.

Our Mission is:

Advocacy Tasmania Inc., acting independently at all times, works to both empower and uphold the rights and interests of our various client groups.

Our Values

We believe:

- in upholding and advancing fundamental human rights
- in advancing the wellbeing of individuals, communities and our society as a whole, and in ending disadvantage
- that all people should be treated with dignity and respect
- in the right of each person to have maximum control over their own lives and to make choices
- that all people are entitled to services and supports to live a dignified quality of life
- in the right of all people to have their voice heard and the right to an independent advocate if necessary, in order to exercise this right
- in working to remove the barriers which exclude some people from participating in the life of the community
- that changing the way the community and the service system respond to our clients is fundamental to a humane, inclusive and just society
- that community engagement is an important element of respect for our clients' capacities and abilities
- that we must model these values by working in a collaborative, open team which shares core values about client rights. Our team is made up of Board, staff and volunteers who act separately and jointly to progress the interests of our clients at an individual and systems level.

Aims

1. To assist clients to understand and exercise their rights and responsibilities by providing information and support to self advocate, and individual advocacy representation
2. To identify and take action on systemic issues affecting our client groups
3. To promote and enhance the rights and interests of our client groups through provision of information, promotion and education
4. To promote best practice in community engagement in relation to our client groups
5. To manage the human and financial resources of the organization 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 state-wide

(i) Advocacy is on the side of the disadvantaged party. It exists to assist clients. Advocates are not “neutral umpires” or mediators

(j) Advocates are non-judgemental.

Advocacy Tasmania acknowledges the funding received to run our various advocacy programs.

Our funding bodies are:

Tasmanian Department of Health & Human Services

- Disability and Community Services
- Mental Health Services
- Home and Community Care Program
- Alcohol and Drug Services

Commonwealth Department of Health & Ageing

- National Aged Care Advocacy Program
- Commonwealth Home & Community Care Program

Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs

- National Disability Advocacy Program

We would also like to thank the University of Tasmania Law School for their financial support of the MHTRS.

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PRESIDENT'S REPORT

Traditionally the President's Report has provided an opportunity to reflect upon the year that was, both in terms of the work of Advocacy Tasmania, but also more broadly on issues and trends impacting on our client groups. Last year the particular focus was on the effect of the State Government's budget cuts. In prior years regular themes were lack of basic services for people living with disabilities and their families, and the ongoing failure to address the insidious problem of elder abuse in our community. It is therefore, with some pleasure, that I start my report with good news on both these fronts.

As most people will be aware, the Commonwealth Government has announced that there will be a National Disability Insurance Scheme (NDIS), as recommended by the Productivity Commission Inquiry into services for people living with disabilities. At the time of writing last year's report, the Productivity Commission's report and recommendations were out in the public, but there had been no definite response from the Government. We now know that the NDIS will be a reality, and that Tasmania will be a launch site. Starting 1 July 2013, 1000 18-24 year old Tasmanians will be some of the first people in the country to access the new scheme. As someone who personally campaigned long and hard to see the NDIS become a reality, it gives me great satisfaction to know that the efforts of many people to make this happen will be successful.

However, two caveats I would add. Firstly, the current situation for hundreds of Tasmanians on waiting lists for services is dire. Waiting lists continue to lengthen, and people with disabilities and families continue to bear the burden of an inadequate service system. It is not good enough to say that the NDIS will fix it all. It won't. We need to address urgent, unmet need now; not in several years time when the NDIS is fully functioning. This needs government funding.

Secondly, the important potential role that advocacy will need to play in the new NDIS based system is not yet clearly articulated in the design of the system. By its nature, the NDIS will provide people living with disabilities with more choice and control; and it will therefore be a more complex system to navigate. Independent advocacy will have a vital role to play in supporting people to navigate the system, and to have problems and concerns addressed when things go wrong.

The other good news story I want to acknowledge is the funding of Advocacy Tasmania by the State Government to operate an Elder Abuse Helpline (the Helpline), which was announced in April 2012. We are currently working to have all in place for an August 2012 commencement.

The Helpline will provide a single point of contact for older people experiencing elder abuse, or wanting information about prevention strategies. The Helpline will provide information, advice and referral; and will link people experiencing abuse with a range of existing services and supports. Unfortunately, the proposed dedicated advocacy and counselling positions, which were originally part of the State Government Strategy "Protecting Older Tasmanians from Abuse", were cut in the 2011/12 State Budget. While the funding of the Helpline is a positive move, and we

applaud Minister Cassy O'Connor and her Department for making this happen, we want to see the full Elder Abuse Strategy budget restored in next June's budget. If we are truly serious, as a community, in tackling elder abuse; we will allocate the necessary resources to do the job properly. As the soon to be launched Elder Abuse Community Awareness Campaign slogan says "There is no excuse for abuse". This is an issue that effects an estimated 3000-4000 Tasmanians over the age of 65, and it needs the whole community to get behind a range of actions to deal with it.

Before finishing this report I should comment specifically on the work of Advocacy Tasmania over the last year. As you'll read in CEO Ken Hardaker's report, ATI again had an extremely busy year providing assistance to 1,475 people across our various individual advocacy programs, with several thousand others assisted through the Mental Health Tribunal Representation Scheme and our education and information provision work.

In a climate of tight government finances and cuts to health and community services, many vulnerable and disadvantaged Tasmanians are finding life difficult and are turning to ATI for assistance. The specifics of the issues people are struggling with can be found in the various program reports that follow.

Looking forward, ATI has a challenging year ahead. Challenges include:

- Bedding down the new Elder Abuse Helpline in an environment of unknown demand

- Preparation for the commencement of a new Mental Health Act on 1 January 2014. This will have a major effect on our Mental Health Tribunal Representation Scheme, which will need to totally review and rework its extensive training program; and on our already under-resourced Mental Health Advocacy program

- Our ATOD Consumer Engagement project has a demanding program planned, including working with consumers and providers to establish an ATOD Consumer Organisation over the period of the new funding agreement

- Our Disability Advocacy program will undergo an external certification audit against the National Disability Advocacy Standards, in November 2012. Disability Advocacy agencies across Australia are required to meet the Standards. Failure to comply will mean that they will no longer receive Commonwealth funding.

These are just some of the demands we will need to respond to over the coming twelve months.

In conclusion, I'd like to thank the extremely hardworking Advocacy Tasmania staff for their tremendous efforts throughout 2011/12. I'd also like to thank my fellow Board members for their time, expertise and commitment to ATI. Finally, for the first time in 2012, ATI is awarding Life Membership to a number of recently retired and current Board members. We altered our constitution earlier this year to make this possible. We decided that after over 20 years of operating, it was time we acknowledged some of the people who have helped to get us to where we are today. Our first ever life members, who will be formally presented with their life membership at our AGM in October are; Marion Florence, Robin Wilkinson AM, Priscilla Berkery and Daryl McCarthy.

David Pearce OAM
President

CHIEF EXECUTIVE OFFICER'S OVERVIEW

Introduction

The reports which follow discuss the work of Advocacy Tasmania over the last year in each of our six Advocacy Programs: Aged Care, Home and Community Care, Dementia, Disability, Mental Health and ATOD; as well as our volunteer program – the Mental Health Tribunal Representation Scheme. This section provides a brief statistical overview of the organisation's activities through 2011/12.

Individual Advocacy

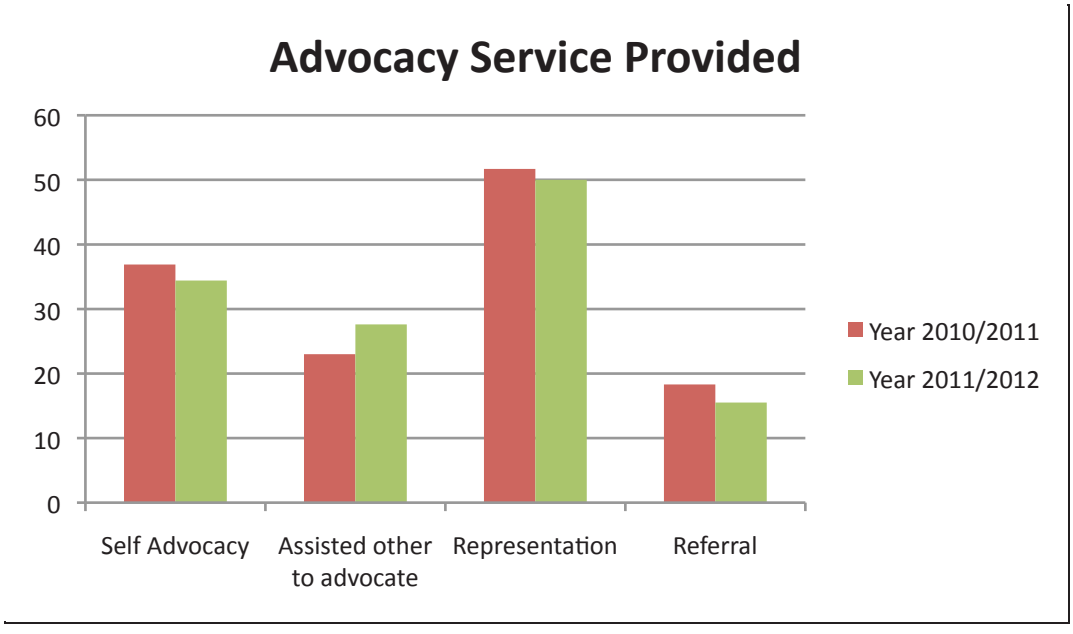
Over the last twelve months Advocacy Tasmania has provided individual advocacy to **1475** older people, people with disabilities, people with mental health disorders, people who use alcohol, tobacco and other drug services; and their families and carers. This can be broken down as follows:

Table 1

Program	2009/10	2010/11	2011/12
Disability	446	517	483
Mental Health	216	301	339
Aged Care	182	243	302
Community Care	256	205	226
ATOD	17	75	125
TOTAL	**1117**	**1341**	**1475**

This was an increase of 10% in the total number of individual advocacy cases this year.

Table 2



In terms of the type of advocacy assistance provided, there was an increase in the proportion of cases where advocates provided assistance to a third party to advocate on behalf of somebody in a client group. This was particularly noticeable in working with family members advocating on behalf of an elderly relative with dementia in residential aged care (see Aged Care Advocacy report).

As indicated in table 2, there was correspondingly a slight decrease in the proportion of people assisted to self-advocate, and those provided with direct representational advocacy.

Chart 1

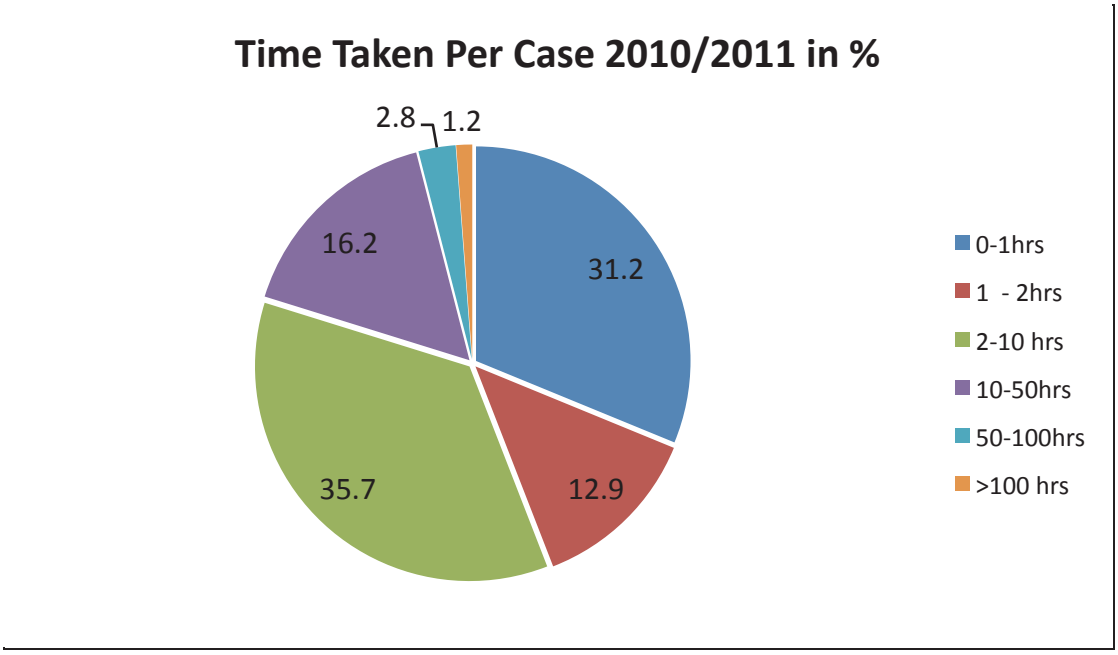
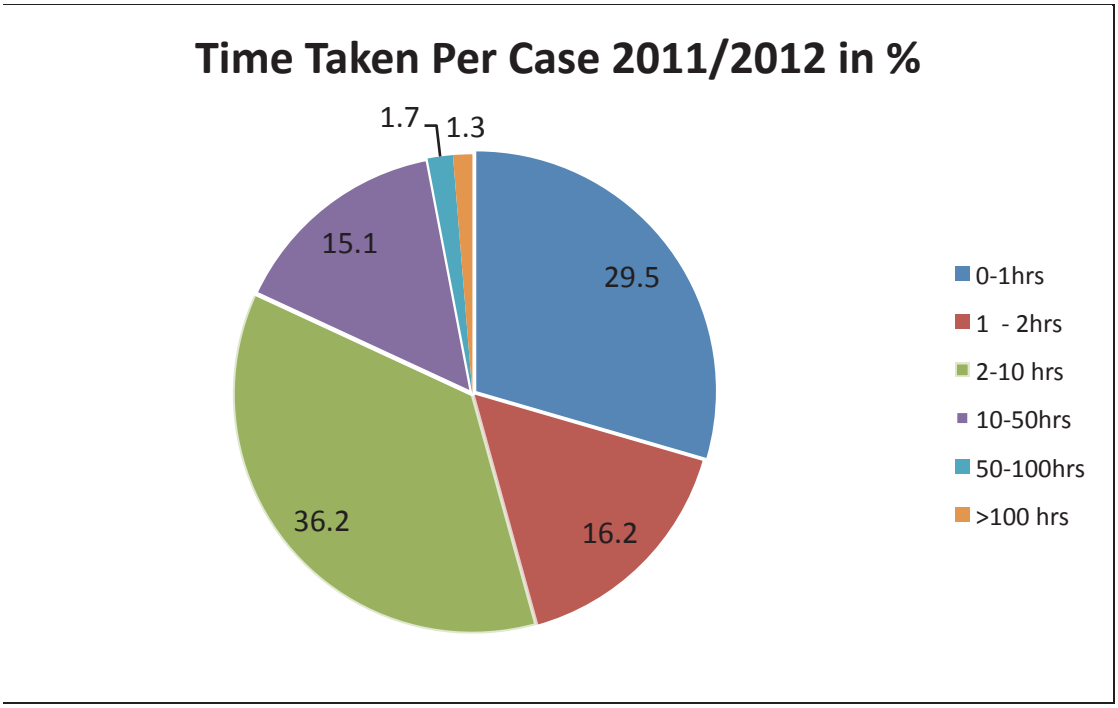


Chart 2



Analysis of time taken per case (Graphs 1 and 2) shows an increase in both the 1-2 hour and 2-10 hour categories. This suggests that cases requiring more than a few phone calls, emails or other contacts from an advocate to resolve (i.e. 0-1 hour category) are on the increase. In particular, service cuts across the health and community sector means that it can often be harder to identify the person responsible within the relevant non-government organisation or government department for dealing with a client's issue, or increased workloads means that people take longer to get back to advocates and clients.

In 2011/12, advocates across all programs redoubled efforts to resolve longstanding, complex client cases, which is reflected in the improvement in 10-50 and 50-100 hour categories.

Mental Health Tribunal Representation Scheme

This year was the eighth full year of operation of the Scheme. In 2011/12, **277** people were represented by one of our trained volunteers. In terms of the Scheme's training and education activities, 236 people participated in the training program and 589 people participated in education and promotion sessions for the Scheme or, as current volunteers, attended a professional development session. The combined figure is **825.**

Information, Promotion and Education

Information

In 2011/2012 Advocacy Tasmania responded to **435** information enquiries. Whilst this is a small (8%) decrease on 2010/11, it is still a very high figure, and one which we suspect we under-report as busy staff sometimes don't record all of these enquiries. Many information enquiries were people seeking advocacy assistance. With little ability to accept other than the most urgent of referrals, many callers were provided with information about their rights, advice on how to self advocate and/or referral to other agencies that may be able to assist.

Education & Promotion

In the year 2011/2012 a total of **4687** people participated in information, promotion, education and other group work sessions facilitated by Advocacy Tasmania staff, a decrease of 16% on last year's total participant numbers. This decrease was brought about by a combination of decreased resources (i.e. cuts to disability advocacy) and increased demand for individual advocacy. The break-up is as follows:

Table 3

Program	2009/10	2010/11	2011/12
Disability	1023	1269	909
Mental Health	256	300	402
Aged Care	1285	1301	1056
Community Care*	1314	866	860
MHTRS	1079	813	825
ATOD	566	1040	635
TOTAL	**5523**	**5589**	**4687**

** Figure combines HACC and Dementia service as both funded by DHHS HACC Program.*

Client Satisfaction

The advocacy we provide is issues-based. Once an issue has been resolved for a client, their file is closed and the person is sent a Client Satisfaction Survey. Exceptions to this are where issues are opened and closed over a very short period (e.g. one or two phone calls or emails has resolved the matter), or where the person lacks the capacity to complete the survey. In these cases, surveys are sometimes sent to another party, such as a family member who was involved.

Each returned survey is reviewed by the relevant Program Manager. Positive surveys are useful for affirming that the advocacy we provide is of a high quality. Suggested improvements are incorporated into our quality improvement process. Surveys also offer respondents the opportunity for a follow-up phone call from an ATI manager, to discuss the service the client received.

In 2011/12 nearly 400 surveys were sent out with 100 returned, a return rate of just over 25%. To the key question 'were you satisfied with the way that Advocacy Tasmania helped you'; the response was 'yes' – 97% and 'partly' – 3%.

The most common comment regarding a suggested improvement was *'I wish I'd known about you sooner'*, pointing to our limited ability to promote the organisation's services. This is a perpetual dilemma, as despite the fact that many people in the community have little knowledge of ATI, enough do know about us to ensure that our programs are constantly working at capacity.

Some examples of feedback received through the surveys are:

'Advocacy Tasmania was able to assist us with our complaint and concerns, and was able to explain things for us.'

'The advocate's knowledge of my entitlements enabled me to achieve what I was requesting, and this would not have happened otherwise.'

'The advocate's support was sensitive and professional.'

'The advocate has been with us on the journey (with our family member) moving into a group home – you have been a great support to us all.'

'The advocate understands everything I say, and I have learned a lot about my rights.'

'The advocate's quick response in meeting with the client, and quick feedback enabled timely resolution of this matter' (of abuse to the client).

'The advocate was straight onto my issue, and got some great and helpful information' (enabling self-advocacy from thereon).

'The advocate made my life much easier.'

'Advocacy Tasmania is a great service and has always been there for us when needed' (for and with our family member with a disability).

In keeping with our Client Services Charter, we will continue to seek client feedback using a range of methods, including Client Satisfaction Surveys; and to use this feedback to improve our service delivery.

Conclusion

The combined totals for individual advocacy (1475), people assisted with representation (277), information enquiries (435) and education and information session participants (4687); meant that **Advocacy Tasmania Inc. directly advocated for, assisted and informed 6874 people in 2011/2012.**

Ken Hardaker
Chief Executive Officer

AGED CARE

Introduction

This report covers the work we undertake through the funding we receive from the Commonwealth Government under the National Aged Care Advocacy Program (NACAP). Historically, this work was largely on behalf of residents of aged care facilities and their families. However, with the increasing trend for older people to remain living in the community for longer periods, an increasing proportion of the work has been with recipients of Commonwealth funded community care services, namely Community Aged Care Packages (CACPs), Extended Aged Care in the Home (EACH packages) and dementia specific EACH packages (EACH –D).

Overall, our case numbers for 2011/2012 have increased by 24% on the previous year, from 243 to 302. Of this total, 57% of cases were residents of aged care facilities and 43% people receiving community care.

Advocacy Tasmania currently has two other older persons' programs funded under HACC; (i) HACC Over 65s Advocacy program and (ii) a community based dementia specific program. This prominent presence in the HACC sector has ensured the Commonwealth funded community care providers (who often also provide HACC services) are aware of ATI and refer accordingly.

The majority of cases involved the advocate working directly with the resident or care recipient (i.e. 75% of cases) as opposed to working with a family member. However, this is slightly down on last year, where we worked with the resident or recipient in just over 80% of cases. This shift towards working more with families is a reflection of the higher proportion of clients receiving high levels of care in an aged care facility, usually with advanced dementia, so working with families becomes the appropriate approach.

Generally, working with people with complex needs (referred to in the statistics as 'special needs' groups) are the most time consuming. This year we experienced an increase of 52% in the number of people with dementia (and their families assisted). The fluctuating capacity of many people living with dementia can require multiple visits from the advocate to clearly establish the client's wishes. This is time consuming but also very important, to enable the person living with dementia to continue to be involved in decisions about their life while they are still able to do so. In other cases, where the person clearly lacks capacity to direct the advocate, family members provide direction.

Over the year we had a number of cases involving people admitted to residential aged care facilities who had received a "diagnosis" of dementia or cognitive impairment while in an acute setting. The older person then improved in their overall health and cognition and it was found that they did not, in fact, have dementia. What seems to have occurred is that the process for establishing the diagnosis failed to take into consideration a range of stress-causing factors impacting on the older person such as; the diagnosis was made when the older person was out

of their normal home environment, they were often under the influence of medication or infection, and the stress caused by being under the pressure from doctors and their family members to accept a residential care place was another factor. Feeling much better, these people generally wished to return to living in the community, and contacted Advocacy Tasmania for assistance. However, this was usually very difficult, if not impossible to achieve, with families having sold the family home and disposed of most of the older person's possessions.

There were also increasing numbers of people referred for advocacy with mental health issues, moving from psycho-geriatric care or long term mental health facilities to residential aged care. Aged care facilities had agreed to take the person into care, partly because they felt an obligation to accommodate this client group, as there was nothing else suitable. Staff tended to not be well trained to work with people with mental illness and this led to the new resident being labelled as having a 'behaviour problem'.

Advocacy Issues in Aged care

Administration / Fair Trading

Fees and Charges

Complaints related to this category of issues were up considerably on last year from 56 to 88. Referrals related to "fees and charges" were particularly high. Considerable effort and time is put into explaining aspects of accommodation fees and daily charges to recipients in care, and to prospective residents and families. Understanding the complexities of the financial arrangements, who sets the fees and charges, and how they are calculated were frequent issues. Generally the lack of adequate and understandable information provision was the underlying problem for most enquiries. Other referrals were primarily of issues surrounding their home, and other assets, such as property. Family members dealing with these matters were often confused and angry, and commonly asked *"who will pay the increased fees and charges"* or *"will the property need to be sold?"*

Personnel/staffing

Complaints in this category increased by 71%, mainly due to inadequate numbers of care workers being available to look after residents in residential care. Residents report that staff will often say to them *"we are short staffed today; we will get to you when we can".* This discourages many residents from speaking up to express their dissatisfaction at poor quality care and services.

Concerned residents and relatives also reported the absence of carers visible on weekends, and some relatives have stated that breakfast and/or meal trays are sometimes left all day in the resident's room. Some residents were left unattended and unwashed, with no water at hand or an accessible call bell. When ATI raised these issues with facility managers, we were told that the correct complement of staff was on weekend duty.

Level of Care

Categories of complaints that increased this year were:

- Lack of Hydration and Nutrition
- Assessment /Care Planning
- Personal Hygiene.

Concerns raised relating to Personal Hygiene included; some clients and family members reporting that the resident received a *'quick wash every now and then'*, that hair washing often consists of *a 'wet face washer run over the top of the scalp'*, and that finger nails are reported as being dirty which then leads to infection when the person scratches impaired skin.

There has also been an increase in the number of complaints brought to us regarding continence management, for example:

- Incidents where catheters had been inserted in residents with no previous problems, including some who have moved from acute care (where they did not require catheterisation) to residential care where they now, supposedly do
- Reports of facility managers insisting upon an older person using a continence aid "just in case"
- Reports that residents were left in "wet and soiled bedding" as there was no carer to assist in a timely manner.

Such complaints again point to a lack of adequate staffing levels. Such practices result in a resident's loss of dignity, their right to self determination and self esteem.

Consumer Rights

Consumer Rights issues have increased by 52% over the previous year. It was hoped that ''rights issues'' would be decreasing, given the Charter of Residents' Rights and Responsibilities, the Charter of Rights for Community Care and Common Community Care Standards. However, we have seen increases in a number of categories including:

- Choice and Decision Making (81% increase)
- Independence (24% increase)
- Information, or lack of (145% increase)
- Privacy and Dignity (27% increase).

This indicates the need for aged care service providers to be aware of the individual needs of their clients and to provide a service which is consumer-directed, both in the community and in the residential setting.

Environment

There was an increase in the number of complaints and concerns received in relation to the environment of facilities, with catering (*don't like the food*) and social (*not enough to do*) being the most common.

One Residents Committee advised an advocate that they all complained about the tasteless and tough food at their meeting. One gentleman stated *"I paid a big bond to come here and the food is disgraceful. They all think that because we are putting on weight our nutrition is adequate, but it's because we can't eat the food and we keep other food e.g. cheese and biscuits and cakes etc in our rooms, and fill up there"*. The cook attended the meeting, took notes and promised changes. Some of the "changes" were; "*rissoles*" were renamed "*Italian meatballs*" and "*beef stew*" to "*beef goulash*". By all accounts the tasteless and tough food has continued, it has just been called something else.

Social (not enough to do) has increased also. The complaints being around the lack of person-centred choices from:

- "*no one really asked me what I like, but I am not into craft"*
- *"I do like the garden, can't I have somewhere to dig and plant something?"*
- *"Why is it always bingo?"*
- *"If I hear the White Cliffs of Dover one more time I will run naked through this place, then they will lock me away, at least it might be quiet."*

Lack of adequate, stimulating activities for residents is a major cause of dissatisfaction for many residents and their relatives. We have received numerous reports that "*residents are wheeled out to sit in front of some noise on television, which is left on all the time in the facility".* There is a need for much better interactive social activities based around the residents' likes and dislikes, in many facilities.

Additional Categories

Alternate Decision Making

Referrals regarding ''alternate decision making'' increased again this year. In line with the last two years, the majority of these cases involved family members of residents assuming that their relative could no longer manage their finances or make decisions about their lives due to diminished capacity. Facility managers contacted Advocacy Tasmania for an independent advocate to assist their resident.

Financial Issues

Financial issues also remained high, with an increase of 38%. Issues in this category included: financial abuse by a relative, matters relating to Centrelink, queries about fees and charges, the use or revocation of a power of attorney, and the inability to access property and money.

Community Care

In recent years we have reported long waiting lists for packages, particularly for available EACH and EACH-D. These long delays in receiving appropriate care continue and lengthen. Unfortunately, there has been no increase in the number of packages this last year, which is surprising considering the Commonwealth Government policy is to support the desire of increasing numbers of older Australians to stay at home for as long as possible. It is hoped that the Living Longer Living Better reform package will lead to a significant increase in availability of community care packages.

Many people currently on CACPs, who are in desperate need of EACH and EACH D packages, are either without extended services or are lucky enough to have an innovative service provider who is managing to provide the extra hours needed.

Some people referred to Advocacy Tasmania have waited so long for a package that the carer and/or the recipient has become frailer, or the care recipient's dementia has become unmanageable, and they have been forced to admit the person with dementia to residential care, when this could have been avoided.

The shortage of qualified and trained staff in the community, especially in rural areas, is an ongoing issue. Some facilities cannot get staff at all, or are required to travel long distances; the travel time is taken from the package, thereby significantly reducing the hours available for care. This same issue was reported last year with no change.

(See our Community Care Report for more details of issues presenting in the community aged care sector).

Education and Information

There was a slight drop in formal education work undertaken during the year, which reflects our need to devote more resources to the increased individual advocacy work. In all, 53 sessions were conducted, with 1056 people participating.

However, it needs to be stated that many residential aged care providers, are non-responsive to our offers to provide education and information sessions for staff and residents. Those that do accept these offers tend to be 'regular users' of advocacy, who advise residents and families of our availability, who invite us to relatives and residents meetings, and who want at least one staff session each year. These organisations generally have a stronger organisational culture that is supportive of clients' rights. We endeavour to be proactive with all service providers; but until it becomes a requirement for facilities to hold staff and residents sessions on Client Rights and Responsibilities and the Role of an Advocate, this trend is likely to continue.

In contrast, in the past six months there has been an influx of community care providers requesting us to hold staff education sessions. We believe this is being driven by the national split in HACC which sees the Commonwealth now responsible for community aged care, and also the associated requirement to meet the Common Community Care Standards and Quality Reporting. These education sessions have resulted in a better understanding about the role of advocacy and the rights of care recipients. It is encouraging to note also, that these same service providers are inviting advocacy to speak at their day centres where care recipients and future recipients meet.

Promotion and Publicity

We have continued to achieve widespread exposure to the wider community through advertising in GP information booklets in both metropolitan and regional areas, advertising and written articles in newsletters/newspapers such as *Prime Times* and *Seniors*, and specific articles for local newspapers which endeavour to promote the importance of independent advocacy.

Over this year we were invited to speak to: The Skills Institute, University of 3rd Age in most regions, Rotary and Lions Clubs, Registered Training Authorities and TAFE students; we also continued our ongoing involvement with Alzheimer's Australia (Tasmania Branch) and the Wicking Institute. The North-West Health Promotion Forum and the Association of Independent Retirees were new on our list of speaking engagements this year. Expos were also prevalent, and we exhibited and attended several, including Agfest.

The Migrant Resource Centre held a state-wide Forum under their Partners in Culturally Appropriate Care (PICAC) program in May. We were invited to present at this Forum, which was attended by over 150 service providers, Department of Health & Ageing personnel and community workers. The session we presented was how Advocacy Tasmania worked with culturally and linguistically diverse clients, and prospective clients.

COMMUNITY AGED CARE

Introduction

Last year we merged our Home and Community Care (HACC) and Dementia Advocacy Service (DAS) programs into one report.

We did this for several reasons:

- HACC and DAS are now funded under the one HACC funding agreement
- The one team of advocates provides both services; the distinction is in the style of service delivered and the wider 'menu' of options provided through the DAS
- As of I July 2011 the Commonwealth took responsibility for the funding of HACC services for older Australians. As of 1 July 2012 they assumed policy responsibility.

In our previous report on our Commonwealth funded Aged Care Advocacy Program, we referred to the growing number of advocacy cases for people who are Commonwealth funded Community Aged Care recipients. In 2011/12, of the 302 people assisted by this advocacy program, 116 or 38% were community care clients. If we combine these 116 with the 142 HACC clients and 84 DAS clients, the final figure for this year is 342 community care clients assisted by our older persons' advocates, out of 528 or 66% of clients.

With increasing numbers of older people wanting to receive care in the home for as long as possible, thereby delaying the move to residential care until it is absolutely necessary, then this trend is likely to continue.

Home and Community Care

The following report describes the most common issues that clients requested advocacy assistance with over the last year.

HACC Service Related Issues

Despite annual growth funding rounds for HACC, the community aged care sector is struggling to meet the demand for services. Advocates often find themselves working with clients with levels of HACC service insufficient to meet their needs. This could be a client needing home help each week who is only receiving a service fortnightly, or a person needing daily personal care who only receives it twice weekly. These may seem like relatively minor problems, but they can have a profound effect on the person. Firstly, such under-servicing means that the person's quality of life is diminished; which in turn, can undermine their health and wellbeing, confidence and sense of dignity. Secondly, the need for service rationing creates an environment where many clients feel that they have no choice in when and how services are delivered, and no right to expect any say in such matters. Clients often say to us that the implied message to them is *"this is all we have – take it or leave it".*

And thirdly, with many clients being made to feel that they have been ''lucky'' to get any service at all, most are reluctant to speak up and complain when services are inadequate or poorly delivered, for fear of losing what little they have.

In recent years there have been some positive initiatives which have increased the potential for strengthening a consumer rights culture within the community care sector. This includes the Charter of Rights & Responsibilities in Community Care, the Common Community Care Standards and the Consumer Directed Care Trials. Unfortunately, the lack of sufficient supply of services, from basic HACC through to high end community care packages, undermines the ability of these initiatives to really cut through.

In practice, some of the complaints we have assisted clients with over the last year have included changes to timetables without notification, changes of worker(s) without notification, and changes to the actual hours provided. Some consumers have agreed to unsatisfactory arrangements in order to continue to receive services. These include limiting the client's choice of times when service can be delivered, and new workers arriving at a client's home ready to provide personal care without having the opportunity to be introduced beforehand. Buddy shifts for new workers used to be the norm, today they seem to be a rare luxury.

We reported last year on difficulties experienced in the community care industry regarding recruitment, retention and remuneration of workers, and the effect this can have on HACC consumers. There is a general shortage of suitable people who are working as support workers, and recruitment has become more difficult, especially in rural and remote areas. For some clients in rural areas who have been assessed as requiring small amounts of support (e.g. one hour per week or a fortnight home help) service providers have been unable to provide staff. Ironically, it can be easier to provide staffing for someone with a higher level of support, who has a care package, as the hours available for a care worker make it a more viable employment option.

In most cases, clients do not have the freedom to choose a different service provider, as their HACC funding is not portable. They also have not had access to robust and timely independent complaint mechanisms. However, as of 1 July 2012 older people receiving HACC services will have access to the Commonwealth funded Aged Care Complaints Scheme (ACCS). It will be interesting to see whether access to the ACCS will result in improved HACC services over time.

Acute Care and Transition Back to Community Living

A number of cases each year involve advocates supporting an older person who has had a health breakdown, which has resulted in their admittance to an acute hospital setting, and who wants to be able to return to their home. Older people in such situations generally benefit from having sufficient time and effort put into rehabilitation, and in having home care services put in place to assist in their transition from hospital back to home. Sometimes these services are only needed for a short period of time (e.g. 6 weeks), but sometimes they need to be permanently in place.

In recent years, the philosophy underpinning the HACC Program has shifted away from seeing its role as providing services to fill deficits that the older person has, to enable them to function in the community, thus delaying entry into residential care; to an increasing emphasis on restoring lost functions and improving wellbeing of the older person. While we fully support this shift in approach, the acute hospital system, in many instances, does not subscribe to this view. All too often we find that the older person who has asked for our assistance, is under immense pressure to take a place in an aged care facility before they have had a chance to reasonably explore their options for returning home. The pressure comes from doctors and family members. There is pressure on the hospital system to free up hospital beds, and many family members see residential care placement as a ''safe'' option for their elderly relative.

We have also received a number of referrals from older people who, having been pressured into moving into residential care, now have improved functioning after a period of ''convalescence'' in the facility and want to return home (and who would be quite capable of coping, with support). However, in most cases this is difficult, if not impossible, as their home and furniture have been sold by the family ''tidying things up''. We believe that there is much scope to improve the prospects of many older people to stay at home for longer, if more emphasis was placed on this as a goal for those admitted to acute care; and for more ready availability of rehabilitation and support services to make this happen.

Proactive Advocacy

On a more positive note, we are experiencing increased referrals in what we refer to as 'proactive' advocacy. Historically, in the community sector advocacy has been viewed largely as a reactive service. In the case of the HACC sector, this means people contact advocacy if they have a complaint or concern regarding a HACC service or some other service that has the potential to severely impact on their ability to remain living in the community (e.g. housing services).

However, increasingly service providers and consumers are viewing advocacy as also having a proactive role; whereby older people living in the community benefit from the assistance of an advocate regarding a matter, which has the potential to prevent problems from occurring, or at least ameliorate them. Such matters commonly relate to the person's ability to 'navigate' the care system. This can be support in assessment or review processes, care planning, or in choosing a provider. It can also involve personal planning for such things as powers of attorney, choosing a trustee for people struggling to manage their finances, enduring guardianship, or advanced care directives. Such assistance has been offered as part of the work of our Dementia Advocacy Service for some years (see following section), but we are finding that some other older people are requesting such assistance. These are commonly older people who live alone and do not have family or close friends to assist them to consider such issues. The role of the advocate is as a tool to support the person to make their own decisions – to provide information, discuss options and consequences, and support to make the necessary changes.

Providing people with information regarding Enduring Power of Attorney (EPOA) and the Guardianship and Administration Board (GAB) is increasingly common. This can be very useful to the person as they are then able to make informed decisions and have a better understanding of their rights. There are times when a person's attorney is not acting in the best interests of the donor - the advocate can discuss the situation and possible options the person has available to them. An advocate is able to discuss the advantages of accessing a solicitor, and is then able to assist the person with the often complex information and involved processes.

Interestingly, in a recent report produced by the Australian Human Rights Commission titled ''A Human Rights Approach to Ageing and Health", the Commission advocates for the establishment of a national scheme for assisted and supported decision making for older people. HACC has long recognized the need for physical and practical support to enable older people to maintain their independence in the community, but the Commission has recognised that support in decision making - in assisting older people to manage their own lives - is also needed. We're pleased to be able to say that Advocacy Tasmania has been providing supported decision-making assistance to older people for some years now, through our HACC and dementia specific advocacy.

Elder Abuse

In April 2012, Advocacy Tasmania was advised that we were the successful applicant to operate Tasmania's first ever elder abuse helpline (the Helpline). The Helpline will provide a single point of contact for older people experiencing abuse or wanting advice on prevention strategies. Family members, friends and service providers are also expected to contact the Helpline for assistance. The Helpline will offer information, advice and referral services. It will aim to provide the older person with information and options to enable them to make informed decisions for dealing with the abuse they are experiencing. It will also link people to existing support services where appropriate. The Helpline will commence operations in August 2012.

As far as the last year has been concerned, we continued to provide advocacy to older people experiencing abuse, despite the fact that we were not formally funded to do so. The number of abuse cases we received this year for community care and aged care combined was 29, similar to last year. Commonly the form of abuse was a combination of financial and psychological, and the perpetrator was usually a close relative, such as a son or daughter. Where the older person has diminished mental capacity due to dementia or other condition, a referral can be made to the Guardianship and Administration Board to investigate and intervene. However, most of the cases handled by ATI involved a frail older person with good intellectual capacity, but fearful about taking action. Commonly, the person experiencing the abuse wanted it to stop but they did not want police involvement or other legal intervention, as they did not want the perpetrator to be punished. A number of older people were also dependent on their abusive relative for care and sustenance, and therefore even more reluctant to speak up.

A few examples of the types of referrals received:

> *A Woman in her late 70's moved into her son's home at his request, as she needed a carer. Her son "looked after" her finances, until it was discovered that he was operating another cheque book. When he was questioned, he became verbally abusive and tried to keep her at home by locking the doors. Friends contacted Advocacy Tasmania for assistance.*
>
> *A man in his early 80's had been invited down to Tasmania from interstate by a relative. Concerns were raised by another relative "back home" that they were denied access to the gentleman; and when he did make contact he was very afraid of causing trouble and told them he was "locked in" throughout the day until the relative returned after work, and told not to call or talk to anyone.*

Housing

Advocacy Tasmania assisted HACC clients with various housing issues in the last financial year. The breakdown of a client's secure housing can cause major psychological and health problems, and the timely involvement of an advocate is often instrumental in avoiding premature admittance to residential aged care. Supporting HACC clients to resolve critical housing related problems is consistent with the HACC policy of promoting independence and supporting health and wellbeing.

As in previous years, many clients were faced with long waiting lists for transfers to a new location or to a more suitable housing option, which was needed due to a significant change in the person's health. 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.

Dementia Advocacy

The Advocacy Model

The 2012 Report by the Australian Human Rights Commission provides the following information:

- Dementia is one of the most common reasons for entering residential care
- In 2008-09 53% of the permanent residents living in Australian Government subsidised aged care facilities have been diagnosed with dementia
- 79% of all residents with dementia were over 80 years old
- 60% of all people with dementia live in the community with many of them receiving no support from funded services.

The majority of people with dementia remain living in the community well into their 80s, and we still have no accurate way of knowing how many of them are living alone and have little or no family or other supports.

The Dementia Advocacy Service (DAS) targets people living alone in the community in the early stages of dementia. The focus of the service is to provide support to the person with decision-making, regarding key matters that affect their ability to remain living in the community. Clients are encouraged to think about, discuss, and plan for the future. People living alone with dementia can be vulnerable and rarely self-refer for any form of assistance if they have no family or other supports, and may remain invisible until a crisis occurs and a service provider such as Alzheimer's Tasmania or ACAT is involved with them.

Once referred, the advocate establishes a relationship with their client, and, while the person still has the capacity to communicate and reason, builds a rapport and an understanding of their priorities and hopes for the future. This can take place over a number of weeks or even months, during which time at successive meetings the client, in dialogue with the advocate, identifies their needs and explores options to meet their future and ongoing goals. These may include putting in place formal mechanisms to assist them to manage their lives as the dementia progresses; including Enduring Powers of Attorney, Enduring Guardianship, Advanced Medical Directives, and Will making.

The model has now been operating for 5 years, and in that time there has never been a need for clients to have a formal diagnosis of dementia. We accept clients who have degrees of cognitive impairment as a consequence of ageing. Over time advocates have recognised the existence of older people in the community who, as a consequence of ageing, may be vulnerable due to disability, frailty and or isolation and also fit other criteria of the DAS model. In particular, living alone and having no family or other supports in their life and wishing to plan for the future and negotiate the aged care system. For this reason a small number of such clients have been referred and assisted under the model.

Over the past year the number of referrals has remained relatively stable, with overall client numbers up slightly from 78 to 84. Clients continue to fit the original target group of having early dementia (72%), living alone (72%) and require assisted decision making to plan for the future and negotiate the aged care system. However there is a 50% increase in the number of clients who are in residential care, and this largely represents a number of the original DAS clients who have now moved into permanent residential settings.

Decision Making

In the process of assisting over 200 clients in 5 years, the advocates working with DAS clients have learned much about the ways in which people living with dementia can be empowered and disempowered by people and situations in their lives. We are now in a position to identify both the positive and negative ways both formal and informal advocates can assist people living with dementia (PLWD), and we are endeavouring to educate others to ensure their right to active decision-making can continue for as long as possible.

During the process of assisting clients, advocates are spending considerable time with both families and service providers, discussing the importance and process of supported decision-making. Too often assumptions are made that PLWD lack decision-making capacity, and fail to understand that capacity is decision specific and not global. Advocates are increasingly assisting clients to undergo formal assessments by geriatricians and psycho-geriatricians, who will establish their capacity for such things as appointing Enduring Guardians and Powers of Attorney. In the last year, 18 current clients have been assisted to access dementia specific medical/capacity assessments. In many instances such assessments have been able to restore client's decision-making credibility. There is still considerable community education needed around this issue.

Formal assessments of 'capacity' are required for many legal and semi-legal matters, and few GPs are confident or aware of the requirements necessary to fulfil the increasing demands. In some instances, GPs may resort to 3rd party assessments by family members in relation to a client's decision-making ability. Such reports may be motivated by self interest or a need to over protect PLWD. This can often be the case where a decision to move to permanent care is required.

Transition to Support/Care

Transitions to care can be the introduction of any service for a person; including those into their home or in the wider community, as well as supported accommodation, including residential care. It should be a process involving ongoing discussions and the provision of information around assessments, costs and client needs, including that of retaining independence and the consequences of decisions.

For some people who live with a carer, a diagnosis of dementia and its consequences can lead to a change in relationships; occasionally rejection, and the need to seek alternative accommodation. In such situations the support of an advocate can be vital if there are no others available. The demands on the advocate can be considerable and time consuming, and clients can be dealing with grief and increased confusion due to their stress. Finding appropriate alternate accommodation can be difficult and there are now long waiting lists for in-home support packages. There have been 4 cases of client/carer relationship breakdown this year, resulting in the need to find alternative accommodation.

For some people the introduction of services into their home can represent loss of independence, and public recognition of a disability. Advocates who have spent time getting to know clients are often best placed to support this transition as they will observe, listen and discuss with clients when they are asking for assistance. In most instances clients will accept assistance if and when they believe it is necessary. Several clients with whom advocates are working have not been ready to accept assistance from services into their home for at least 2 years. One man has recently requested a service to help with shopping because he accepts his difficulty with money recognition. Advocates continue to assist clients' access to such services (33 clients) by making referrals (21) and attending assessments when requested (50).

An admission to hospital can be a dangerous time for many older people. For a variety of reasons, dementia being a major one, people may be told by medical staff that they can no longer go home to live. The decision regarding when and where they go can also be taken from them. In such a situation, a long standing DAS client was told she had to go to residential care and was at risk of having no choice about where she would be placed. The advocate who knew her well arranged for her to visit homes and actively negotiated the move to ensure the client was the one to make the decision. Follow up contact and actions also assisted the client to settle by making sure she and staff got to know each other.

Working with families

Only a handful of current clients have no immediate family. A larger number have some extended family and there are a number with family interstate or overseas. In these instances advocates can be a valuable link between families and PLWD. One client from a CALD background has an only son who was posted overseas just after his father came to live in Tasmania to be close to him. The father has few contacts and was new to the state. He has said he wants to be independent and doesn't want his son to have to care for him or be worried about his day to day needs. In this instance the advocate assists; and when requested, reports all is well.

In many instances, families of people living alone with dementia have the role of absent carers, and assume that of alternate decision-makers at a time when people feel well able to make decisions independently or be supported to do so. It is common for some to take control of finances, and then fail to discuss decisions or include PLWD in monitoring expenses and their spending. Many people do not mind this move, but resent not being consulted about it or asking for it to happen. As a result, older people may become unnecessarily suspicious and mistrusting of a family member and request assistance from an advocate. In some instances this can help to repair mistrust, but positive outcomes are not always possible.

There are also many instances where one family member, such as a daughter or son has an Enduring Guardianship (EG) or Enduring Power of Attorney (EPOA) and siblings are not informed of decisions regarding a parent. They may approach advocacy to assist them get information or control of decision-making. In such cases advocates require the older person to be consulted and request assistance. If this is not possible, family is directed to seek legal advice, make an application to The Guardianship and Administration Board to review the EG or EPOA, or seek a specialist opinion regarding a parent's capacity to make changes to the appointments if they want to.

Statistics reflect high involvement with planning and substitute decision-making (50 cases), with 27 discussions around EPOA and 12 around Wills; but the complexity of these issues and discussions is best captured by case notes and time spent assisting clients.

One of the most problematic issues around working with families is in the need and timing for people to accept, or move into residential care. With the best of intentions and usually with safety as a paramount concern, families can take away a

person's right to decide. They may have a limited experience of the ways people can be safely assisted at home, and unwilling or able to allow services such as CACP and EACH providers to become involved in providing care. Having older people 'safe' in residential care can be seen as an easier option for everyone. However, for the older person it may not yet be their choice. Lengthy discussions of the possible negative consequences of a daughter's move to have her mother kept in a home after her respite, later led to her comment to an advocate that she *'had taken on board their comments about her mother needing to make the decision, as the outcome would be more likely to be positive'*. She is now supporting her mother to remain living at home.

Working with Case Managers

Inevitably, clients who remain linked to the DAS service will require increasing levels of services into their home. This is done with consultation, and usually referrals from clients via their advocate. Case managers are often engaged through care packages such as CACP, EACH, EACHD or Community Options services. Advocates play a vital role to ensure the timing and style of service delivery meets client's needs for control and independence. Once established, it also means the advocate will step back for a time while the client gets to know the case manager and their day to day workers. Advocates may then take on a role of monitoring progress and giving feedback about how clients are feeling about the support, and be consulted when important decisions need to be made regarding service reviews or changes.

Generally our experience of working with case managers has been very positive, particularly with those who have a good understanding of the advocacy role with DAS clients. They mostly recognise the complementary role advocates have to case management. However, it is essential that from the outset this is made clear to them and that good communication is the key to positive outcomes for clients. In a few instances where the role is not well understood or when they are inexperienced at managing issues associated with dementia, case managers can take on the role of surrogate decision makers for clients and seek admission to permanent care. As with families, advocates can spend considerable time educating by example, the process of supported decision making.

Financial Issues and Finance Managers

Database statistics indicate a high proportion of advocacy assistance (30 issues) in relation to finances that does not relate to matters specified, such as setting up EPOA, etc. To fully grasp the complexity of the need for advocacy of PLWD, it is important to analyse the tasks being asked of advocates. Such assistance may mean helping to complete paperwork to set up direct debits for client's utilities accounts, and often assisting clients gain information about their financial situation from those entrusted to manage their affairs. State-wide advocates report these as common requests. In several instances clients have been assisted to meet with financial managers who may be family members or from Trustee organisations, to help them regain some decision-making around their money.

Future Planning

Future planning is an essential aspect of the DAS advocacy model but it is not generally (unless specifically requested) the case that advocates suggest clients "sit down with them for a planning session". Rather, the existence and importance of formal mechanisms such as Enduring Powers of Attorney or Guardianship, Wills or Medical Advanced directives will emerge as part of a general discussion about a client's present circumstances and their wishes for the future. As a consequence of this emphasis, there was a small increase to 50 in clients assisted with various advanced directives.

Lifestyle Options

The social and lifestyle options available to maintain quality of life for those in the early stages of dementia remain limited. There are many excellent day centres for people with more advanced dementia, but are not generally well accepted by those who are recently diagnosed. This is often the time when people who wish to continue with their normal or previous activities can become isolated, and would benefit from a mentor or volunteer to help maintain contacts and assist with access. It is an important issue for clients who are becoming socially isolated, and can be frustrating and time consuming for advocates to achieve positive outcomes.

Information and Education Sessions

Advocacy Tasmania makes a constant effort to reach as many consumers or potential consumers, carers and service providers state-wide 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 860 people participated in information and education sessions, and Advocacy Tasmania delivered 37 sessions state-wide.

During the year, advocates again visited rural and remote communities including King and Flinders Islands, the West and East Coast, Scottsdale, St. Helens, Tasman Peninsula, Huon Valley, Dover and the Derwent Valley. Most Community Health Centres were also visited and provided with brochures. We also spoke to a number of older persons' groups, including School for Seniors and U3A .

Overall session and participant numbers were similar to last year. With the national roll-out of the Common Community Care Standards and associated reporting processes, we experienced an increase in requests from community care providers for information and education sessions on advocacy and consumer rights in the second half of the year. We expect this will continue in 2012/13.

DISABILITY

Introduction

The total number of cases acted upon by disability advocates in the last year was 483, which represented a slight decrease in actual client numbers in comparison to the previous year (517). As has consistently been the case in recent years, we experienced a high volume of referrals around a wide range of complaints and concerns; some of which could be resolved quickly, while others were complex and time consuming. The lack of sufficient funding for state disability services continues to limit our ability to reach early resolution for those clients on waiting lists for services.

The Tasmanian State Government budget for 2011/12 was characterised by significant budget cuts across all portfolios, including Health & Human Services. In Advocacy Tasmania's case, we received a cut in our disability advocacy funding, which resulted in the loss of 0.7 position (three and a half days a week). This created a significant challenge to be able to continue to provide advocacy to all those referred to our service. This was achieved in part by providing self-advocacy support or assistance to another person (e.g. a family member) to advocate, in a higher percentage of cases than previously. We also made a conscious decision at the beginning of the year to limit our education and promotion activities.

With the Program working at capacity, and the demand for advocacy ever increasing, we remain concerned that many people living with disabilities and their families do not have access to sufficient advocacy to meet their needs. With the selection of Tasmania as a National Disability Insurance Scheme (NDIS) launch site in 2013 and an initial rollout to 1,000 15-24 year olds, referrals from individuals and families to our service are expected to increase. This being a national scheme with a State Government contribution, the funding for advocacy services to assist in this transition needs to be considered by both the Commonwealth and State Governments.

Individual Advocacy

Disability Type

- The proportion of clients with **intellectual disability** (60%) increased by 9% from last year and continues to be the largest client group. Many referrals from this group are in relation to a lack of sufficient case coordination. In what appears to be efforts to manage high demand for assistance, Gateway services are referring clients to advocacy services for functions that were either previously done by service coordinators, or for tasks that we believe are part of their role (i.e. locating services for clients and managing transition issues for clients who move into a new service setting, such as a new group home). Other common issues include assistance to communicate with lawyers and trust officers (regarding finances). In the South there have also been a number of cases where advocates have supported parents with intellectual disability in their dealings with Child Protection Services.

- There was a 3% increase in referrals from clients with **acquired brain injury**. A reoccurring theme is the complaint by clients with ABI that their specialist disability service provider, usually a supported accommodation provider, "*treats me like an idiot, like I can't make any decisions for myself".* We believe that for some providers, this is a hangover from when the service system was geared entirely towards people with significant intellectual disability. This attitude is inappropriate for all people, irrespective of their disability type and severity; but some service providers have proven slow to adapt to contemporary thinking and practices.

- There has been a similar 3% increase in referrals from clients with **psychiatric disability.** The most prominent theme being people with a dual intellectual disability or ABI who also have a mental health disorder, finding it difficult to get appropriate services as they are pushed backwards and forwards between the disability and mental health service systems.

- There was a 3% increase in the number of clients with **sensory disability.** Such clients often require specialist interpreters and additional time to ensure that communication of the issue they have raised is fully understood. We have also found that some providers have been slow to accept new modes of communication (e.g. unwilling to accept SMS texts from deaf clients as a valid form of communication).

Trends in Issues

Abuse (10%[1])

There was a slight increase in abuse related referrals in the last year. A number of these came from service providers seeking support in managing an abusive situation, particularly when a client (usually of a supported accommodation service) had been allegedly assaulted by a staff member. This included physical, verbal and emotional abuse. Support included support from an advocate to the person with the disability who had experienced the abuse; and also discussion of options and actions with the provider on the best protocol to follow (i.e. the Department's Abuse Reporting Guidelines).

Other abuse cases included workplace bullying (both disability specialist employment and mainstream), client to client abuse within a specialist disability service, and family violence.

Accommodation (25%)

Complaints and concerns related to finding and retaining suitable accommodation and support accounted for 25% of all client issues.

These included people with disability seeking support:

- In obtaining supported accommodation funded by Disability Services (the waiting list at the end of December 2011 was 68, which is an increase of 15.2% over the same time the previous year[2]). Some clients were successfully placed; however, many more continue to wait for extended periods in difficult circumstances - some for years

- In obtaining accessible accommodation with Housing Tasmania due to their physical disability[3]

- To resolve complaints through Housing Tasmania; which often involve harassment by neighbours who are also Housing Tasmania residents, or problems with getting maintenance issues addressed

- To access funding for support, usually via an Individual Support Package (ISP) through Disability Services. There have been cases where a person has had to forgo an offer of housing from Housing Tasmania because they did not have the required support lined up. Coordination of these elements is fundamental, but often proves to be lacking

- To assist people requiring high levels of accommodation support who are unhappy with their current service provider, to transfer to another provider. While waiting lists exist, most people seem to wait years before a transfer occurs, if ever. The pervasive attitude seems to be – *they are housed, that's all that really matters*. This means that people can spend literally their entire lives living in situations where their quality of life and sense of wellbeing is extremely poor, because they are 'locked in' to an unchangeable situation

- Continued pressure being placed on people with disabilities under 65 to move permanently into residential aged care, if an appropriate accommodation option is not readily available (e.g. if nothing turns up within 3 months); this then gets those people "off the books". See case study below.

Case Study
A woman in her early 50's, high functioning, with an intellectual disability, and living in a Disability Services funded supported accommodation facility was informed that she was required to seek alternative accommodation, as the service reported they were unable meet her needs.

The local Gateway assisted her to search for alternative supported accommodation. However, after a relatively short period of searching (two months), and unable to locate a suitable permanent vacancy, she was admitted to emergency respite for housing.

She was then referred for an aged care assessment, and has now been permanently placed in an aged care facility. She no longer remains on the waiting list for Disability Services funded accommodation or able to access Disability funded day programs.

Service Provider Policy and Practice (17%)
Service provider policy and practice represents the majority of complaints from people with disability against their service providers in supported accommodation, community access, tenancy support, and Gateway Services.
Examples include:

- Service quality issues, such as staff treating clients poorly or rudely
- Staff not respecting that the supported accommodation facility that is their workplace, is also the clients' home

- Lack of choice in service providers and how services are delivered
- Staff or services not adhering to expected service standards
- Service providers cutting shifts in tenancy support without prior consultation.

There was a slight increase in the number of issues in this category this year.

It needs to be recognised that speaking up is difficult and stressful for many people with disability, who fear the repercussions for doing so.

Service Gaps and Access to Services (16%)
There was also a slight increase in referrals where there were service gaps or clients were unable to access services. There continues to be a high number of clients who are on the waiting list for supported accommodation, individual support packages, community access programs, respite, Housing Tasmania accommodation[4], or who are having difficulty in getting accepted for service by the Gateway services.

Legal Issues (16%)
The number of referrals in this area remains fairly constant, including:

- Clients with intellectual disability needing support to communicate with their lawyers and, in turn, for their lawyers to communicate with them
- Clients with disability to communicate with Child Protection Services, in relation to their children being taken into care or seeking re-unification with their children
- Clients with intellectual disability or acquired brain injury seeking support to obtain legal advice and/or representation, in relation to criminal charges or when being interviewed by police
- Clients with intellectual disability or acquired brain injury who are in prison or on remand, seeking support or representation to make complaints (primarily regarding their treatment while in custody, lack of access to medical services and transition back to the community)
- Clients needing support and/or representation at Guardianship and Administration Board hearings, and Anti-Discrimination Commission or Tribunal conciliations and hearings.

Most instances where an advocate is assisting a person with a disability to communicate with a lawyer is very time consuming. There is usually a need to meet with the client before the meeting with their lawyer, to help them to understand what is going to happen, and to assist them to prepare what they want to say. There is also then a need to attend meetings between clients, lawyers and other parties, to ensure that the client (and their advocate) is fully conversant with the issues. Finally, there is usually a need to meet with the client afterwards to check that they have understood what was discussed and decided, answer any further questions they have, and debrief them due to the stress and confusion, which is often part and parcel of the problem.

Finances (16%)
There was an increase in the number of referrals in relation to financial matters. These referrals are most often regarding clients with intellectual disability or acquired brain injury not being able to manage their finances, who want assistance to seek financial support from their service provider, financial counselling from a registered provider, or support with the Guardianship and Administration Board processes in relation to financial administration. In some instances, we support clients to discuss their financial issues with their administrator/ trust officer, or to have their Administration Order reviewed towards managing their own finances.

Discrimination (7%)
There was a slight decrease in the number of discrimination referrals. This is due in most part, to referring clients directly to the Anti-Discrimination Commission or the Disability and Discrimination Solicitor in the first instance. We support clients who require an advocate to make those applications, understand the process and support them at hearings. These are often complex issues which have a long resolution timeframe.

Navigating the System
With low literacy levels among people with disability, it is often necessary for disability advocates to support clients who have no case manager, local area co-ordinator or other service provider, to assist them to complete applications (of many and varying types) and arrange meetings in pursuit of specialist disability services and generic services.

Systemic Advocacy and Policy Work

While individual advocacy represents most of our work, Advocacy Tasmania undertakes systemic advocacy in order to address issues affecting many people living with disability. This includes contributions to policy development, written submissions, and participation on various working groups. In 2011/12 some of our systemic work included:

Disability and Community Services, Self-Directed Funding Reference Group and the NDIS
The Self-Directed Funding project has been established by State Disability Services to maximise the capacity for people with disability to exercise greater control over the services they receive, and therefore providing them with greater control over their daily lives. As a member of the Reference Group, we provide guidance and advice with regards to the implementation of the project in order to achieve the project outcomes.

Advocacy Tasmania has for many years played an active role in the promotion of, what we believe is the right of people with disability to have more control over the services they receive. As far back as 2001, we produced a paper on Individualised Funding and the scope for its development in Tasmania. Most recently we continued to promote this view via our submission to the Productivity Commission Enquiry, which was the catalyst for the Commonwealth Government's decision to establish an NDIS; and we have supported the Every Australian Counts campaign from its

inception. We are pleased that Tasmania has been chosen as one of the launch sites for the NDIS, though we would have preferred to see that the trial be open to people living with disabilities of all ages, not just the younger 14 – 25 cohort.

State Disability Services Reform- Area Advisory Groups (AAGs)
Advocacy Tasmania continued to participate in the AAGs in all four regions. However, with the loss of the funding referred to at the beginning of this report, we were no longer able to work to facilitate the involvement of people with disabilities in the AAGs.

Quarterly Liaison Meetings with Tasmanian Brain Injury Association (BIAT)
We have an ongoing relationship with BIAT, which involves sharing of general information and identification of systemic issues for people with acquired brain injury. We also work together to resolve systemic issues for people with acquired brain injury.

Tasmanian Dept of Justice Disability Working Party
Advocacy Tasmania serves on the Working Party, in order to provide advice to ensure that all disability access issues are brought to the attention of the Working Party and addressed wherever possible.

Tasmanian Guardianship & Administration Board Regular Users Group
Advocacy Tasmania, as a member of the Users Group, has provided feedback on processes, functions and procedural matters regarding how the Board engages with relevant members of community.

FaHCSIA Emergency Relief Advisory Board
Advocacy Tasmania is a member of the Board and provides disability specific advice, relating to the appropriate distribution of emergency relief funds to NGOs within Tasmania.

Disability Advocacy Network Australia Board (DANA)
Advocacy Tasmania was an inaugural member of the Disability Advocacy Network Australia; and has continued, as a member of the Board, to provide national leadership and promote the development of the national disability advocacy sector.

National Disability Standards Consultation Workshop
We participated in a workshop on the six draft National Standards for Disability Services: Rights, Participation, Individual Outcomes, Feedback and Complaints, Service Access, Service Management. ATI also facilitated and supported the attendance of two clients with disability to attend a Focus Group on the Standards.

Education and Promotion

Education and Information Sessions

As reported earlier, the loss of a 0.7FTE disability advocacy position lead to a reduction in the amount of education that could be offered to the sector this year.

However, despite this constraint, a total of 230 people participated in 17 sessions; including visits to King and Flinders Islands and the West Coast, an International Day of Disability presentation to Hobart based FaHCSIA staff, a presentation by our CEO at the AGM of our Quality Improvement Partner (QIP) agency Regional Information and Advocacy Council (RIAC) in Shepparton (Victoria), and sessions with Certificate 3 and 4 Polytechnic students.

The Role of Advocacy Services in the Tasmanian Disability Sector: An Information Booklet Compiled by Advocacy Services in partnership with Gateway Services and Disability and Community Services

The Disability Advocacy Program contributed to the updating of this booklet, which was first published in 2007. The update incorporates recent changes in the service system, which include: the new Gateway Services, the role of Local Area Coordinators with the Gateway Services, and updated information on all advocacy services in Tasmania.

Consumer Engagement

In 2011/12 Advocacy Tasmania worked with a number of non-government Disability Service providers to assist them to improve their consumer engagement practices. These organisations were Optia, Veranto, Langford, Oak Tasmania (Community Access services), NOSS, and Life Without Barriers. Assistance included regular facilitation of client meetings and forums, a visiting advocate program to seek client views on service satisfaction, and support for client representatives on boards. This was a fee-for-service function, and Advocacy Tasmania was greatly assisted by consultant Jenny Dixon, to carry out this work.

Total numbers of client contacts through this work was 679. This work will continue in 2012/13 in a scaled back form, due to staffing constraints.

References:

1. Denotes percentage of total number of referrals in the year in all instances.
2. Our Performance. Your Health and Human Services Progress Chart. What are the waiting lists for people requiring supported accommodation: March 2012. Page 24. Department of Health and Human Services. http://www.dhhs.tas.gov.au/about_the_department/performance
3. Our Performance. Your Health and Human Services Progress Chart. How many people have been houses? What are the waiting lists for Public Housing? What is the usual wait for people with priority housing needs? March 2012. Pages 20 & 21. Department of Health and Human Services. http://www.dhhs.tas.gov.au/about_the_department/performance
4. Our Performance. Your Health and Human Services Progress Chart. What are the waiting lists for people requiring supported accommodation? What is the waiting list for community access clients? March 2012. Pages 24 & 25. Department of Health and Human Services. http://www.dhhs.tas.gov.au/about_the_department/performance

MENTAL HEALTH

Introduction

The second year of a combined team approach for the Mental Health (MH) and Alcohol Tobacco and Other Drugs (ATOD) individual advocacy programs has seen a gradual slowing in growth of new MH matters, while new ATOD matters have continued to grow strongly.

This was expected, given the growth potential of the relatively new ATOD program (instituted 2010) and the stringent prioritisation measures that have had to be employed when assessing new matters for the MH program, due to resource constraints.

Nonetheless, there was a 13% increase in new MH matters compared to the previous twelve-month period, and our intake personnel report that the demand for our services continues to grow state-wide.

With MH/ATOD program staff working at full capacity, and demand likely to strengthen due to the economic climate, there are concerns that the significant number of potential clients with real issues who cannot be now serviced by ATI will continue to grow. There is also evidence that resourcing constraints have slowed the delivery of service to those clients we have been able to reach.

Individual Advocacy

Many trends have continued largely as reported last year. These include:

- Community-based clients remain our strongest growing sector group, while inpatient/residential sector based client numbers have reduced to 2009/10 levels

- Accommodation issues continue to grow, both in terms of numbers and complexity. A lack of appropriate accommodation and required accommodation supports, together with recent unfriendly consumer practices by Housing Tasmania, have meant this issue category has remained amongst the most time intensive for our program

- Child protection and child and family services issues have grown incrementally, and continue to be emotionally-loaded, complex and stressful for our clients as well as the advocates

- Health care and treatment issues in outpatient and private settings have remained at similar levels to last year, with much of the advocacy work being devoted to improving communications between health care providers and

their patients, clarifying treatment options or helping consumers to access services that have been reduced or denied

- Our involvement in financial matters remains strong; particularly our dealings with the Public Trustee on behalf of clients under Administration Orders and our representation work in hearings before the Guardianship and Administration Board itself.

The most significant trend change in the past 12 months has been the 54% increase in legal issues. The reasons for this large increase are not completely clear, although there has been a significant number of Legal Aid application rejections reported in connection with child protection, family violence and family law matters; with associated requests for help in appealing those decisions. There have also been a large number of requests for assistance in understanding legal advice, changing legal representation or obtaining legal assistance with civil law matters (which are not normally Legal Aid funded). There has also been a concerning trend change, in terms of a 105% increase in the number of stigma/labelling issues.

Trend Tables and Commentary

The following tables provide a comparison of this, and the previous reporting period for trend evaluation purposes. The percentage figures are the percentage of the total issues for the relevant year.

Table 1 – Where Do Our Clients Reside?

	2010-11		2011-12	
Community	207	69%	247	73%
Inpatient	69	23%	43	13%
Residential	46	15%	49	14%
TOTAL	**301**		**339**	

As previously indicated, our number of community based clients continues to grow strongly, both in percentage terms and absolute numbers, while the number of inpatient clients has declined sharply. The reduction in inpatient numbers has possibly been brought about by noted improvements with internal hospital complaints processes and a greater use of the Mental Health Official Visitors Scheme. Residential client numbers have remained fairly static, although advocates report that the general nature of the matters for these clients have tended to become more serious and involved.

Table 2 – What Are the Issues?

	2010-11		2011-12	
Health care/treatment	69	23%	70	21%
Employment	15	5%	16	5%
Child and Family Services	23	8%	28	8%
Legal issues	82	27%	126	37%
Accommodation	64	21%	76	22%
Financial	54	18%	55	16%
GAB & MHT orders	70	23%	62	18%
Community Supports	11	4%	13	4%
Stigma & Discrimination	19	6%	39	12%
Discrimination	22	7%	40	12%
Service issues	36	12%	39	12%
TOTAL	**301**		**339**	

The above table demonstrates the wide range of issues that our advocates deal with. As discussed under 'General Trends', the previous work load drivers such as health care and treatment, accommodation, child protection (child and family services) and financial matters have remained a constant feature of our work.

Accommodation/housing issues continue to track around 25% of our clients, and a slightly lower percentage of all issues. This large number of accommodation/housing matters is a cause of major concern, given that stable and/or supported accommodation is necessary to underpin appropriate health care and treatment. These matters also included a number of complex issues involving Housing Tasmania's practice of non-renewal of consumer leases without giving a reason. This issue is now before the Supreme Court of Tasmania as a direct result of advocacy on behalf of our clients.

Demand for assistance with legal issues across a wide range of problems has spiked as earlier discussed, as has the reporting of discrimination issues; although the latter have often lacked sufficient evidence for successful referral to the Anti-Discrimination Commission.

Referrals to social workers and charitable organizations have also been noted to be on the rise as a considerable number of clients report financial difficulties.

Table 3 – Client Diagnostic Information/Profiles

	2010-11		2011-12	
Anxiety	49	16%	68	20%
Depression	50	17%	74	22%
Bipolar	37	12%	38	11%
Schizophrenia	87	29%	92	27%
Personality Disorder	30	10%	17	5%
Other	21	7%	26	8%
Intellectual Disability	18	6%	14	4%
Dual Diagnosis	32	11%	33	10%
Co-Morbidity	30	10%	60	18%
Unknown	77	26%	91	27%
TOTAL	**301**		**339**	

At first glance, there appears to have been little change in the reported conditions of our clients. However, closer scrutiny reveals that depression and anxiety based illnesses have overtaken the major psychotic illnesses, where the illness has been disclosed.

There has also almost been a halving of clients with personality disorder, which may be attributable to that client group having become discouraged about its prospects of being able to access or maintain the intensive psychotherapy services required for that condition. The number of clients reporting co-morbid conditions has also doubled, possibly a result of the combined MH/ATOD team approach.

More than a quarter of our clients have preferred not to disclose the nature of their condition for various reasons, including the not uncommon situation of where the client disputes their diagnosis.

Further Observations

Advocates state-wide are reporting that they are increasingly being called upon by clients to help them navigate through what clients understandably perceive to be a complex, near impenetrable maze of bureaucratic systems in health, finance, the law and social supports.

Often the clients complain that they are unable to understand the advice that they are given by lawyers, doctors, allied health workers, counsellors, government officials and even some community support workers. Clients say that when they express their lack of understanding, they are frequently given no further assistance to aid their comprehension.

In many cases, these problems are compounded by the high levels of illiteracy in our client base, and how access to service and redress for grievance is often based on systems which presume literacy or average communication skills.

Clients also make it clear that stigma and discrimination are still a regularly deflating experience for them, even when dealing with services that have been highly trained to deal with those issues.

Participation in the health care system can also still be degrading experience, they say. They claim that their own opinions about the effect of treatment, and in particular medication side-effects, is usually given scant weight; and clients say that a change of treating doctor can often produce a change of diagnosis or treatment, with unsettling effects.

The feeling amongst our advocacy team is that while there has been significant progress in tackling some of the many issues affecting those with a mental health condition, there is still a long way to go before there is a "user friendly" system for our clients.

Systemic Advocacy

Our major systemic advocacy effort this year was our submission to the State Government on the proposed new Mental Health Act. A consultation draft bill of well over 300 pages was released in the latter half of 2011, and ATI devoted many hours to analysing the bill and contributing a detailed submission. The draft bill had a significant number of weaknesses, so it was pleasing to see that the consultation process resulted in many organisations and individuals putting in submissions, which highlighted many of the same issues identified by ATI. At the time of writing this report a revised bill has just been tabled in State Parliament. While there still appears to be further amendments required to improve the bill, it is a considerable improvement on the consultation bill.

Education Sessions

With advocates carrying peak file loads to meet the rising demand, it has not been possible to undertake an extensive education program. Despite these constraints, overall participant numbers increased from 300 to 402.

Advocates in each of the three regions have continued regular liaison meetings with the staff and management at Mental Health Services and the NGOs, as well as allied stakeholders. There have also been bi-monthly Mental Health staff education sessions, in conjunction with the Mental Health Representation Scheme Co-ordinator at the major public hospitals, to make sure that the role of advocacy is understood. Further sessions are being planned with organizations such as ARAFMI and the Women's Health Centre, to broaden the understanding of the role of advocacy in the wider sector.

ALCOHOL TOBACCO AND OTHER DRUGS

Introduction

The number of ATOD clients and issues has risen significantly since the last 12 month report. Our client base rose by 32% (98 for 2011/12 as opposed to 74 for 2010/11), whereas our issues rose by 67% (125 for 2011/12 versus 75 for 2010/11). This is an obvious consequence of the ATOD individual advocacy program now having had sufficient time to raise its profile with both consumers and sector workers since its inception in early 2010.

Who Are We Working With?

As Table 1 below shows, opioid users continue to be a large component of our client base; although there has been a small, but statistically significant drop in percentage terms (although not the actual total). Advocates report that there is anecdotal evidence that demand may have slightly decreased after ATI interaction with Department of Health and Human Services, Alcohol and Drug Services (ADS) led to a client perception that the ADS pharmacotherapy statewide had adopted better internal dispute resolution processes.

There has also been a surprising drop in the percentage of clients professing to have issues with benzodiazepines, given the increased prescribing restrictions that have been placed on that class of drug. Advocates have been told by clients that there has been an increase in black market trade in these drugs, especially Xanax, which has led to a tragic increase in a number of injection related deaths and limb amputations.

The number of alcohol, cannabis and amphetamine users has remained static in percentage terms, although the actual numbers have increased markedly. North-West clients continue to figure strongly amongst those who use alcohol and cannabis, while the southern bias towards opioid use remains predictably high.

The “unknown” category of users has recorded an unexpected jump in both percentage terms and actual numbers. Advocates have indicated that this may because a larger number of clients have disclosed poly drug use without specifying the nature of the drugs used, other than those which have had a direct bearing on the issue they have brought to ATI.

Table 1 - Client Usage

	2010/11		2011/12	
	Total 74	% clients	**Total 98**	% clients
Amphetamines	7	(10%)	12	(12%)
Benzodiazepines	15	(20%)	12	(12%)
Opioids	32	(43%)	35	(36%)
Tobacco	3	(4%)	6	(6%)
Cannabis	15	(20%)	22	(22%)
Alcohol	30	(41%)	37	(38%)
Unknown	5	(6%)	21	(21%)
Medicinals	8	(10%)	11	(11%)
Other	8	(11%)	7	(7%)
TOTAL	**123**		**163**	

What Are We Doing For Our ATOD Clients?

Client issues have increased by two-thirds in the last 12-month period, as indicated by Table 2 below.

Health care and treatment issues have grown, both in actual number and percentage terms; while service related issues have fallen slightly in percentage terms, but have grown in actual numbers. Advocates have suggested that the outright growth in health care and treatment issues has come partly at the expense of the service related category, as clients have increasingly recognised that their right to appropriate health services is better characterised as a 'health' rather than a 'service' related issue. The types of health care issues recorded have included; a lack of holistic approaches to medical care by opioid prescribers, problems with prescribing conditions emplaced by the Pharmaceutical Services Board under section 59 of the Poisons Act, and a lack of GP's willing to take on clients with a history of prolonged opioid use.

There has also been a sustained increase in Child Protection Service (CPS), legal and accommodation issues in both actual numbers and percentage terms. This increase in all three categories was anticipated, given the economic circumstances and the present 'risk averse' CPS policy setting in child care matters.

Table 2 - Client Issues

	2010/11	2011/12
Key issues		
Health care and treatment	22 (20%)	34 (27%)
Inpatient care and treatment	0	1 (<1%)
Police	3 (4%)	3 (2%)
Child and Family services	11 (15%)	24 (19%)
Financial	3 (4%)	7 (6%)
Legal	8 (11%)	23 (18%)
Orders	2 (3%)	3 (2%)
Accommodation	13 (17%)	26 (21%)
Abuse	2 (3%)	2 (1%)
Service related	44 (59%)	54 (43%)
Interpersonal/family	0	1 (<1%)
Smoking	1 (1%)	1 (<1%)
Community Supports	2 (%3)	1 (<1%)
Other service provider	0	2 (1%)
Other	1 (1%)	4 (3%)
TOTAL	**75**	**125**

A Focus on Service

At 54% of all matters, service related issues continue to be the main area of concern for our clients. Table 3 below gives a breakdown of the different types of drug and alcohol service issues, for which clients have sought assistance from an advocate.

The obvious area of growth in numbers has been the inability to access service, with advocates reporting that in the south, this has largely related to the difficulty that many clients have claimed in accessing the ADS pharmacotherapy program or a GP who will prescribe opioids. Several matters have related to clients who have been terminated from the pharmacotherapy program because they have been deemed to be engaging in unsafe practices. There have also been a number of matters where clients have been left without a prescriber after their existing prescriber has moved or retired, and no other prescriber could be found until ADS intervened. In the north there has been a reported widespread lack of GP opioid prescribers; while in the north-west, an overall lack of relevant and responsive medical services within practical proximity has been noted to be a standard complaint.

There have also been significant increases in client complaints concerning service quality and refusal of service. Advocates understand that many of these are related to dosing practices and procedures, as implemented pursuant to the soon to be released new Tasmanian Opioid Pharmacotherapy Program (TOPP) policy; with the issue of dose “takeaways” limits figuring large amongst those matters. There have also been client complaints that staff in the government sector continue to display a “one size fits all” policy in their dealings with clients, which results in some clients claiming they are receiving a standard of treatment which is demeaning and unsatisfactory given their own personal history.

Table 3 - Service Related Issues

	2010/11	2011/12
Service quality	9 (18%)	17 (22%)
Reduction of service	9 (18%)	5 (7%)
Refusal of service	7 (14%)	14 (18%)
Inability to access service	19 (37%)	32 (42%)
Other	7 (14%)	8 (11%)
Total	51	76

Other Matters

- This report has not dwelt on the co-morbid features of our client base. Nonetheless, while our statistics show that only 25% acknowledge a co-occurring mental health condition to be relevant to their situation; the anecdotal evidence is that this figure is in fact much higher, perhaps as high as between 60% to 70%. These features often impact on a client's ability to access and maintain both government and community services. Advocates report a continuing need to educate all sector workers to improve their understanding and skill set in dealing with these complex clients.

- Our statistics show that the major compounding factor in our clients' issues is stigma and discrimination (55%). We have had many cases where clients have failed to obtain necessary and timely medical intervention at major hospitals because of the way they feel they will be treated because of their drug use history. We have also had a number of matters where clients have been refused treatment by a GP because of their past drug use. These experiences have been observed to have a crippling effect on the confidence of our clients, as well as affecting their ability to access appropriate treatment.

- Accommodation (or rather the lack of it) remains a major issue impacting on the ability of some of our clients to obtain appropriate sector services. Eight per cent report being homeless; these people are usually the most vulnerable and frequently have serious drinking issues, which renders them unable to maintain any decent level of self-care. Other clients endure sub-standard accommodation which makes it difficult to access appropriate support services.

- There are some encouraging signs that the ATOD advocacy program has had some impact in increasing sector awareness of the need to listen to and engage with clients as individuals who are 'experts by experience'. In particular, we acknowledge that the ADS pharmacotherapy program has embraced advocate involvement in internal reviews of its decisions affecting clients. We remain hopeful that this trend will continue.

Systemic Issues and Policy

In 2011/12 ATI continued to play a significant role in a range of reviews and policy development processes relating to the ATOD sector. This work included (a) Coordination of consumer input into the consultation around the Tasmanian Opioid Pharmacotherapy Program policy and practice guidelines; (b) Participation in the parallel Opioid Prescribing Review, being conducted by consultants from the University of NSW for DHHS; (c) Participation in the review of the Alcohol and Drug Dependency Act; (d) Participation in the Tobacco Coalition; and (e) Participation in the ADS Prevention, Promotion and Early Intervention (PPEI) reference group.

ATOD Consumer and Carer Participation Project

We are delighted to report that this path-breaking project has been refunded for a further year, with Alcohol and Drug Services (ADS) indicating their wish to offer a longer-term funding agreement, if current Treasury restrictions are eased.

The history of consumer engagement work in the ATOD sector – nationally and internationally – tells us that significant progress is typically the result of persistent effort over a substantial period of time. So too in Tasmania, where the first two years of the project have seen small but gratifying gains in the consumer engagement practices of funded service providers. More service providers are now routinely looking for ways to involve their consumers in service improvement processes, staff selection and the development of information/promotion materials. Most funded service providers have developed formal policy positions that stipulate greater involvement of consumers, and which hold managers accountable for this involvement.

Considerable work has been done in establishing the key policy settings for ATOD consumer engagement efforts, culminating in the publication late in 2011 of the *Guide to Consumer Engagement in the Tasmanian ATOD Sector*, written by ATI and endorsed by ADS as the over-arching strategic framework for the funded sector.

In April 2012, ATI convened a state-wide forum of ATOD service providers to review work completed to date, and to offer priorities for coming years. Among the priorities nominated – and now built into the current funding agreement – were (a) the continuation of work to assist service providers to meet emerging accreditation requirements; (b) development of a Tasmanian ATOD consumer organisation; (c) exploration of funding opportunities to assist consumers with the costs of engagement; (d) collaboration with service providers in boosting training opportunities for consumers and practitioners; and (e) improved communication flows across the sector, including a greater emphasis on social media.

Advocacy Tasmania reserves the right, indeed responsibility, to criticise government agencies when we feel they have failed to perform as they should. The other side of that coin, of course, is our responsibility to offer congratulations where appropriate. We are pleased to be able to congratulate and thank Alcohol and Drug Services for their support to ATI's consumer engagement work. In particular, we wish to acknowledge the terrific support provided by Adela Ristovski as our main

departmental contact for this project. We wish Adela well in her new role within ADS, confident that she will continue to strengthen ADS's consumer engagement commitment.

This report sees a changing of the guard in ATI's management of the project. Work stated in 2010 by Bert Dorgelo and continued in 2011-12 by David Owen and Kate Fish, will now be headed up by Tanya Zollner. We are very confident that this important project will continue to have a significant impact on the capacity of Tasmanian ATOD consumers to influence the services they receive.

Education and Promotion

Total numbers of participants in information and education sessions for 2011/12 were 635. While this was down on last year's figure of 1040, the previous year had included several major conference presentations which tended to skew figures. Pleasingly, the numbers of consumers involved in information sessions increased by 57%; a trend we expect will continue in future years, as more consumers come to know about our ATOD advocacy program. The increase in demands for ATOD Advocacy also reduced our ability to devote time to promoting the service.

ATI contributed to the Alcohol Tobacco and Other Drugs Council (ATDC) Conference in May 2012, through facilitating a consumer panel which discussed issues impacting on consumers in their ability to receive effective ATOD services. ATI was also represented on an industry panel discussion on Community Pharmacy, providing a perspective of issues consumers bring to ATI for advocacy assistance.

SYSTEMIC POLICY ADVOCACY

Introduction

In last year's Annual Report, we noted that ATI's policy advocacy work was increasingly fashioned by two important trends. The first of these was the very tight budget environment at State level, something we suggested would continue for at least a couple more years. The second was the shift toward Australian Government dominance – relative to the states – in a very wide range of policy areas.
Both trends continue unabated.

The 2012/13 Tasmanian Budget confirmed our expectation that few new initiatives would be funded, and if they were it would be at the expense of other important programs. While the non-government community services were largely quarantined from the significant cuts experienced across government agencies, the plight of so many of ATI's clients will continue to deteriorate because of cuts to core services. With the further contraction of the Tasmanian economy and the shedding of even more jobs, 2012/13 looms as a challenging year for service providing organisations. Challenging and confusing, because there is still a distinct lack of clarity about the future roles of the Tasmanian Government, with respect to major program areas in the health and human services arena. Just as 2010/11 saw a major Commonwealth push towards total control of acute and primary health care, so too 2011/12 was marked by a similar preparedness to assume full control of disability service provision, as well as a further expansion in the mental health sector. With the Tasmanian Department of Health and Human Services moving to abandon all direct service provision, non-government organisations like Advocacy Tasmania will need to forge new operational relationships with the Commonwealth and with the new Tasmanian Health Organisations. Our policy advocacy work will accordingly become more complex than ever before.

Productivity Commission Inquiries

In our last Report, we highlighted the ways in which ATI's submissions had influenced the reports of the Productivity Commission inquiries into Long Term Disability Care and Support and Caring for Older Australians. We are this year, able to report that important progress has been made in implementing (some of) the recommendations arising from those two important inquiries.

It is now apparent that we will, from mid-2013, see the commencement of a National Disability Insurance Scheme (NDIS), with five launch sites piloting the approaches to be adopted (and adapted) by the eventual national roll-out of the Scheme. We are delighted that Tasmania has been included as one of the launch sites, though it is disappointing that only a relatively small number of Tasmanians with disability will be assisted in this initial phase. While both major political parties have expressed support for the NDIS, it is clear that we are still a long way from having an agreed funding model for the national implementation of the Scheme.

ATI has continued its local and national systemic advocacy roles. We are participating in a Tasmanian Government working party on individualised funding and, through our role on the Board of the Disability Advocacy Network of Australia (DANA), we have attempted to influence important system design decisions. The role of independent advocacy organisations such as ATI will be crucially important in giving expression to the goals of the NDIS, and much work needs to be done to clarify the ways that consumers will be supported to fully participate in the new processes.

In aged care, the Australian Government rejected many of the key recommendations of the Productivity Commission (especially those involving the leveraging of family-home assets to enable co-contributions to the costs of care), but did announce a welcome increase in funding for a number of components of the aged care sector. Included in these announcements was a 20% increase in funding for aged care advocacy services, with these increases scheduled to flow from mid-2013.

Elder Abuse

ATI's success in obtaining funding to manage the Tasmanian Elder Abuse Helpline has been mentioned elsewhere in this Annual Report. Also deserving of mention is the role played by ATI in shaping the overall Tasmanian Government response to elder abuse. ATI has, for far too many years, been part of the collaborative NGO effort to highlight the prevalence of elder abuse, and to agitate for a funded government response. In this past year, ATI has actively participated in the Ministerial Advisory Committee on Elder Abuse, where we have had significant influence in the framing of the Helpline project, the development of practice guidelines and the framing of the public education and promotion campaign. There is much more to be done, of course: restoration of the original budget allocation for this response is a major priority for the coming year.

Public Trustee

ATI has this past year, increased its advocacy work in relation to the cost structures applying to low-income clients of Public Trustee. Our advocates have consistently reported that clients who are subject to Guardianship and Administration Board orders are obliged to pay fees to Public Trustee that significantly reduce their capacity to live on low, fixed incomes. Even more worrying, we are aware that one response to this fee impost is that some NGOs are electing to take on informal administration roles with respect to clients' finances. These informal arrangements are inherently risky for clients and NGOs alike.

In response, we have highlighted the issue in our last Budget Priority Statement and recently addressed members of the House of Assembly Select Committee on the Cost of Living, arguing for an increased community service obligation payment to the Public Trustee so that it can waive or reduce fees to low-income clients. ATI will step up this advocacy work during 2012/13.

Supported and Substitute Decision Making

This has been a particularly frustrating year for ATI in respect to long-overdue changes to the legislative frameworks that govern substitute decision-making processes impacting on our clients. The review of the Mental Health Act has now finally led to the tabling of a new Mental Health Bill that could have a substantial impact on the operation of the Mental Health Tribunal. A review of the Alcohol and Drug Addition Act is also progressing very slowly.

Advocacy Tasmania has consistently argued that Tasmania needs a single, unified structure for determining capacity and for overseeing substitute and supported decision-making processes – across all sectors (i.e. disability, mental health, drug and alcohol, etc.). In this context, recommendations from the recent Victorian Law Reform Commission inquiry into guardianship must be given urgent consideration by the Tasmanian Government. These recommendations – based around the concept of a single, unified structure – include a greater emphasis on shared and supported decision making.

Policy Advocacy in the Alcohol, Tobacco and Other Drug (ATOD) Sector

While the preparation of the *Guide to Consumer Engagement in Tasmania's ATOD Sector* is mentioned in the section on ATOD Consumer Engagement, it is important to recognise this work in the context of ATI's systemic advocacy work. It is very rare for any non-government organisation to be given the opportunity to develop the policy settings for an important state-wide initiative – especially one that embraces government-run services (i.e. ADS) as well as NGO services. ATI was responsible for writing the *Guide*, since endorsed and published by ADS. The *Guide* will provide a strategic framework for Tasmania's ATOD consumer engagement work for years to come – an excellent example of work that impacts at system level, not just client or service level.

ATI continued to play a significant role in a range of reviews and policy development processes relating to the ATOD sector. This work included (a) Coordination of consumer input into the consultation around the Tasmanian Opioid Pharmacotherapy Program policy and practice guidelines; (b) Participation in the parallel Opioid Prescribing Review being conducted by consultants from the University of NSW for DHHS; (c) Participation in the review of the Alcohol and Drug Dependency Act; (d) Participation in the Tobacco Coalition; and (e) Participation in the ADS Prevention, Promotion and Early Intervention (PPEI) reference group.

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 8½ years that the Scheme has been operating, approximately 3000 people have been offered representation.

The last 12 months have been very busy for the Scheme. The jump in hearing numbers from 2 years ago has been maintained, whilst the number of people requesting representation continues to increase, with 20 more clients being represented at their hearings. The training sessions have again been fully booked in Launceston, Burnie and Hobart (2), and a number of additional education sessions have been provided to service providers, students and community groups in all regions.

***TABLE A: Breakdown of listed hearings conveyed to MHTRS**

	2009/2010	2010/2011	2011/2012
Notification to MHTRS of persons listed for Tribunal hearing	599	675	671
Offer of representation made to persons listed for hearing	599	675	671
• No response from person/no contact	- 22	- 18	- 11
• Person declined representational service	- 57	- 87	- 90
• Person discharged before hearing	- 230	- 275	- 258
• A representational service provided to person	- 290	- 295	- 277
• Information and advice/self advocacy support	- 101	- 102	- 64
• Representation at hearing	- 189	- 193	- 213

TABLE B: Outcomes of hearings with MHTRS Represented clients

	2009/2010	2010/2011	2011/2012
Represented at hearing	187	193	213*
• Adjourned	2	7	2
• Order confirmed	108	115	127
• Order revoked	26	23	21
• Order varied	53	47	62
• Length of order extended	0	1	3
• Length or order reduced	53	46	59

- Further figures and statistics of individual facilities are available if required.
- *One hearing the representative was discharged before the conclusion of the hearing and therefore no result is included.

Regarding Table A:
The above tables are designed to provide some detail of the Scheme's performance. The figures for the previous two financial years have been included for comparison. An offer of representation, either as a brochure attached to Notice of Hearing or as a follow-up phone offer by the representation, is classified as an offer. There was 100% offer to all people who were notified of their hearing.

When a representative makes contact with a person listed for hearing, they may provide information as to the service the representative can undertake or may make available other information so that the person may self-advocate. The figure which is listed as 'person declined representational service', is when the representative's offer of representation is declined outright without any information provided.

A person listed for hearing may be discharged by the doctors at any time right up until the hearing commences. Quite often a representative has already contacted a person prior to their discharge, whereby the person has either accepted the information for self advocacy and/or accepted the offer for a full representational service. The item 'person discharged before the hearing' is the number of people who are discharged before a representative can make initial contact. For those numbers of people who are discharged after the contact by the representative, this comes under 'information and advice/self advocacy support'.

Where a representative has accompanied a client into the hearing it is listed as 'representation at hearing'.

Occasionally other results arise and these include; patients being listed on one hearing list and having contact with a representative only to be transferred to another facility before their hearing and re-listed with the new facility, hearings are adjourned prior to the actual hearing, and very occasionally others are cancelled due to invalid orders.

Analysis

Overall, most categories have remained relatively constant, with minimal variation either way. Although 4 less people were listed for 2011/12 than 2010/11, this is still significantly more than 2009/10, with a 12% increase between 2009/10 – 2011/12. This is indicative that there were still high numbers of people over the past 12 months being involuntarily admitted to hospital with symptoms of a mental illness (s24).

One trend this year was an increase in the number of people being represented at hearings, from 193 to 213, an increase of 10%. While it is hard to pinpoint why this has occurred, we believe it is because many patients are now familiar with the Scheme and using representatives. We increasingly note that patients are contacting us, requesting a representative before we can contact them to offer the service.

Correspondingly, the number of people requiring information and advice/self advocacy has dropped. We believe that this is partly because of the increase in the take-up of a representative but also it appears that there is an increase in patients being more confident in representing themselves.

Several years ago, Legal Aid (LA) started providing representation for MHT hearings. Patients have a choice between a Scheme representative and a LA solicitor. However, despite the availability of the solicitors, the numbers of hearings at which a representative attends are still increasing.

Whilst over 50% of the orders are confirmed as requested at represented hearings, quite a significant number are reduced. In approximately 35% of the hearings where a representative is present, the requested length for the order is not accepted by the Tribunal and a lesser period is imposed, or the order is revoked. A representative will run through the requirements of the hearing beforehand, and this leads to people giving more relevant information to the Tribunal which in turn enables the Tribunal to make orders which better reflect the needs of individual patients.

It has been reported by the President of the Mental Health Tribunal that the information the Tribunal now receives from a patient, and the additional information offered by the representative, gives a much more accurate picture of the patient's issues; and thus the Tribunal is in a better position to make decisions that reflects the patient's situation.

Partnerships

Mental Health Tribunal

The Mental Health Tribunal (MHT) has continued to be involved in the training of all representatives. The President, Ms Debra Rigby, gives a key lecture on appearing before the MHT, based on the legal requirements for involuntary detention under the *Mental Health Act 1996.* She has given this lecture (3 – 4 times each year) to every training group in every region since 2003.

The Tribunal also provides independent evaluations for a proportion of the hearings where a representative is in attendance, especially for new representatives. These evaluations are important for quality assurance. The volunteers are informed of their individual evaluations and this is a useful tool for them to gauge how the Tribunal views their performance. This also has been found to be beneficial to new volunteers, as it helps increase their confidence and assures them that they are fulfilling their role.

The MHT also provides the coordinator with the hearing lists for upcoming hearings. This is a vital role of the Tribunal, without which the Scheme would not be able to function effectively and be in a position to offer representation to all people appearing at hearings.

University of Tasmania

The University of Tasmania (UTas) Law School has continued its relationship with Advocacy Tasmania and with the Scheme, and guarantees an annual grant and the use of its lecture theatres for the training. This is a much valued and appreciated resource, which ensures that the Scheme continues to run smoothly. Students are reimbursed for their out-of-pocket expenses that are associated with attending hearings.

The Dean of the Law School, Professor Margaret Otlowski, has continued her strong support of the Scheme, and ensures that the annual training is provided in the Law School. She delivers an introductory talk to the students stating that she welcomes the opportunity for the undergraduate law students to gain practical experience and to expand upon the skills offered through their degrees. Over 98% of representatives that attend hearings in the South are undergraduate students.

Centre for Legal Studies

The Centre for Legal Studies (CLS) is supportive, and the Certificate stage (see below 'Training of Volunteers') of the Scheme's training continues to be a compulsory unit within their "Tribunal Practice" Module. The Intensive Training is an optional session, and each year a small group of trainees go on to do this stage.

Mental Health Services

The Scheme is mostly funded through Mental Health Services (MHS), and we gratefully acknowledge their ongoing funding, without which there would be no Scheme. We provide a twice-yearly report to MHS and liaise with them during the year.

Training of Volunteers

The training is a two-stage process, designed to increase the awareness of mental health issues and to provide participants with additional skills in working in this area. The first stage is the Certificate stage. The participants undertake 5 one hour lectures, and receive their Certificate of Skills and Awareness in Mental Health. They are then eligible to undertake the second stage, the Intensive Training. This session comprises the more practical aspects of providing representation for a client appearing before the MHT.

The first training session for this financial year was held at the University of Tasmania Law School in July 2011. There was a strong interest in the training, with a record number of students registering for the Certificate stage of the training, with 114 students receiving their Certificates of Skills and Awareness in Mental Health. Of these, 69 students continued on to complete their training and prepare for becoming a volunteer with the Scheme.

Early in 2012 the Legal Practice training saw 57 trainees complete the Certificate stage of the training with 20 continuing on to do the Intensive Training (see above 'Centre for Legal Studies'). It is to be noted that a further 11 trainees were at that

time current representatives with the Scheme. This indicates that approximately half of the newly admitted barristers and solicitors have actual experience as mental health representatives. It is also noted that all newly admitted barristers and solicitors in Tasmania have undertaken the Certificate stage and therefore have a basic understanding of mental health issues. This in turn increases the level of services that professionals provide for those with a mental illness, and thus decreases the stigma and discrimination experienced by this client group.

The final training sessions for this financial year took place in May/June in Burnie and Launceston. After holding only one combined training session last year in the North, which included the North West; it was decided to hold separate sessions in order to increase the pool of representatives available in both regions (32 participants in the North West and 28 in the North completing both days of the training).

Regardless of the site or region, there is a high level of interest, and all sessions were fully booked. This ensured that we were able to maintain a strong pool of volunteers in both the North and North West, and therefore be able to meet the needs of those patients appearing at hearings before the Tribunal.

Provision of In-Service Sessions at Psychiatric Facilities

The Scheme Coordinator and the ATI's Mental Health Advocates have provided In-Service education sessions to staff at a number of facilities across Tasmania. This included holding regular sessions at Northside, the Department of Psychiatry (DoP), Spencer Clinic and the Adult Community Mental Health Services (ACHMS) in Launceston. The sessions discuss the roles of both the Scheme representatives and the ATI advocates – when to call the advocate and when to call the Scheme. The Coordinator provides the staff with general information regarding what they can expect when a representative visits the ward to meet with a patient, and information that staff can give a patient should questions be raised about the Scheme. This ensures a positive on-going relationship between staff and representatives which overall benefits the patients.

Promotional and Professional Development Sessions

A number of sessions are run during the year that either promote the training of the Scheme, or provide ongoing educational sessions to the representatives. The Coordinator delivers information sessions to various faculties and study units in the regional UTas Campuses, as well as at the Polytechnics. These include Introduction to Law classes, Nursing, Community Service, Social Work and Psychology. The purpose of these sessions is to interest people in attending upcoming training, and thus ensure a continual number of people available to provide representations.

The professional development sessions are held for current volunteers and those people who have recently completed their training, with a view to becoming a representative. The sessions further develop the skills and knowledge gained in the initial training. The sessions are also an opportunity for the representatives to meet face-to-face with the Coordinator, and have some contact with each other to discuss current issues and trends in the hearing process.

Table of Education

	South Combined	North	North West	Combined N-N/W	UTas	Legal Practice	National	TOTAL
Certificate		33	34	N/A	114	55		**236**
Intensive Training*		28	32	N/A	28	69		**157**
Other Educational Sessions**	125	247	217	N/A	N/A	N/A		**589**
TOTAL	**125**	**308**	**283**		**38**	**142**		**825**

**This is the number of participants who complete both the Certificate and the Intensive Training.*
***This figure includes In-service Sessions, Promotional Presentations and Professional Development Evening Sessions for Representatives*

Queensland Scheme

During the reporting period, contact had been made with Advocacy Tasmania by Ann Herriot, Coordinator of Student Programs at the Queensland Public Interest Law Clearing House (QPILCH); who had been investigating the potential for establishing a Scheme in Brisbane. Ms Herriot participated in the North West training in May (TAS) and early in August 2012. The first training session was held in QLD, with 29 volunteers completing their training and being available for representational work in Brisbane. We are very pleased that the model used in Tasmania has been picked up and trialled in another State/Territory.

Mental Health Bill

At the time of writing, a new Mental Health Bill is before Parliament. It is anticipated that, once passed, it will come into effect early 2014. The new Mental Health Act will necessitate many changes to the Scheme, and to the provision of the training of both current and new volunteers. In order to continue to provide representations under the new legislation, the training program will need to change, and current volunteers will need to undertake further training in order to up-skill. Planning is already underway to meet this need, and ATI anticipates that the transition will proceed smoothly.

STATISTICAL REPORTS 11/12

INDIVIDUAL ADVOCACY

MENTAL HEALTH	10/11	11/12
Client Numbers		
Finalised	232	244
Not Finalised	69	95
Total	**301**	**339**
Groups		
Mental Illness	278	328
Personality Disorder	30	17
Dual Diagnosis	32	33
Co-morbidity	30	60
Sector		
Community	207	247
Inpatient/Residential	98	74
Adolescent	1	2
Forensic	14	8
Psycho geriatric	2	3
Issues		
Accommodation	64	76
Child & Family Services	23	28
Police	17	14
Discrimination	22	40
Community Supports	11	13
Health Care & Treatment	69	70
Legal Issues	82	126
Stigma/labelling	19	39
Financial	54	55
Interpersonal/family	12	19
Inability to Access Service	15	21
Refusal of Service	15	12
Reducation of Service	6	6
Mental Health Facility Issues		
Inpatient Care & Treatment	35	21
Choice	15	26
Confidentiality & Privacy	5	4
Smoking	1	0

AGED CARE	10/11	11/12
Client numbers		
Not finalised	48	39
Finalised	195	263
Total	**243**	**302**
Type of Aged Care Serivce		
Residential Care	152	171
Community Care	87	116
Flexible Care	2	6
Unknown	2	9
Level		
High Care	128	91
Low Care	104	61
Respite Care	11	19
Client Category		
Recipient, potential recipient,former recipient of aged care	198	222
Person representing care recipient eg carers, family, legal standing'	45	80
Issues		
Administration/Fair Trading		
Administration Procedures	4	10
Agreements	9	9
Bonds	4	5
Concessional Access	4	6
Fees/Charges	13	23
Management	7	11
Security of Tenure	8	12
Personnel/Staffing	**7**	12
Level of Care		
Access to specialised services	4	5
Assessment/Care Planning	3	17
Behaviour Management	7	5
Clothing	0	0
Continence	2	9
Dental	0	0
Emotional	5	9

DEMENTIA	10/11	11/12
Living arrangements at referral		
Other	3	3
Residential care	1	7
Transition care	1	1
Hospital/Acute care	1	4
Lives with carer/s in community	11	12
Lives alone in communit	61	57
Special needs		
Rural and remove	19	27
CALD	11	10
Stage		
Unclear	2	8
Late	0	4
Mid	16	21
Early	58	51
Care and Services		
Residential care	5	4
Allied health	1	2
Respite residential	8	5
Respite community	4	4
EACH dementia	8	8
EACH dementia	7	5
CACPs	12	7
HACC	5	6
Hospital	2	2
Dementia specific medical	9	7
General medical	6	8
Carer support	7	2
Support and counselling	8	4
Assistance Accessing Services		
Representational Advocacy	14	12
Active support (eg attend appointments)	23	21
Referral	23	21
Research	11	12
Information provide/self advocacy - career	8	2
Information provide/self advocacy - client	28	18

Abuse Issues	14	16
Physical	8	7
Emotional	4	6
Financial	2	2
Sexual	7	3
Abuse by staff	3	5
Abuse by family	3	4
Abuse by other	5	5
Consultation and Participation	35	35
Administration Order	26	26
CAB	22	20
CCO	15	10
CTO	7	6
Supervision	3	2

DISABILITY	10/11	11/12
Client Numbers		
Finalised	430	401
Not Finalised	87	82
Total	**517**	**483**

Primary Disability Type*

Intellectual	265	291
Physical	155	128
Sensory	36	50
Psychiatric	67	78
ABI	78	82
Neurological	44	25
Autism	43	26
Specific Learning/ADD	9	5
Other	18	8

Other Issues

Abuse	42	50
Aids/Equipment	12	18
Accommodation	133	118
Discrimination	41	33
Education	8	6
Employment	27	28
Financial	66	81
Health	45	48
Independent Living	53	45
Legal Issues	92	80
Service provider/policy & practice/gaps/access	161	170
Falls	3	3
Hydration/Nutrition	2	6
Medication	7	4
Mobility	3	6
Pain Management	4	4
Palliative Care	0	0
Personal Hygiene (Bathing/Grooming)	5	15
Rehabilitation	1	1
Sensory Loss/Aids	0	1
Skin Care	1	5
Specialised Care & Services	7	7
Sleep	7	0
Restraints	1	1

Consumer Rights

Abuse	14	15
Activities	5	12
Choice/Decision Making	26	47
Complaints Proces	4	10
Consent to Care/Treatment	6	8
Confidentiality	2	2
Cultural	1	0
Independence	25	31
Information	11	27
Medical Records	2	0
Personal Property	4	3
Privacy/Dignity	11	14

Environment

Cleaning	2	2
Catering	8	14
Equipment	0	2
Fire	0	0
Infestation Control	0	1
Laundry	0	0
Physical	0	2
Repairs & Maintenance	3	4
Security	0	3
Social	11	17
Theft	3	2

Additional

Alternative Decision Making	49	51
Care Options - Access to Apporpriate Care	15	17
Financial Issues	60	83

Assessment

Other	12	12
HACC	7	6
ACAT	23	22
Dementia specific medical/capacity	14	11
General medical	6	11

Planning and substitute decision making

Financial	48	50
Other	15	16
Informal assistance	20	15
Administration	8	7
Enduring power of attorney	24	27
Power of attorney	6	4
Will	7	12

Medical

Other	2	2
Advanced care directives	4	4

HACC	10/11	11/12
Service Consumers		
Finalised	23	21
Not Finalised	104	121
Total	**127**	**142**

HACC Service Related Issues

Assessment	3	1
HACC fees	4	3
Carer Support	9	4
Case Co-ordination	3	2
Case Management	0	0
Access to Service	18	14
Service hours insuffient/unsuitable	5	5
Service unavailabe	3	5
Service refused	1	1
Service reduced/fear of reduction	3	4
Service withdrawn/fear of withdrawal	4	3
Information and Support	10	3
Privacy/confidentiality	3	1
Staff issues	2	4
Complaints handling	3	3
Cultural inappropriate	0	0
Other service related matter	4	8
Access to Support Packages	4	6

Vulnerable and/or isolated	9	16

New Fields		
Fear of Retribution	13	10
Transfer Facilities	5	9
Waiting for Placement	15	19

Other Issues		
Family/personal relationships	9	12
Abuse	16	14
Guardianship	9	9
Trusteeship/enduring power of attorney	14	12
Equipment	1	3
Income security	4	2
Health	9	7
Housing	15	27

NB ATOD and Mental Health Tribunal Representation Scheme statistics are contained within the body of their reports.

Advocacy Tasmania Inc

Financial Report

For the Year Ended 30 June 2012

Advocacy Tasmania Inc

For the Year Ended 30 June 2012

CONTENTS

Advocacy Tasmania Inc

Board of Management Report

30 June 2012

Your Board of Management members submit the financial report of the Association for the financial year ended 30 June 2012.

1. General information

Board of Management Members

The names of Board of Management members throughout the year and at the date of these statements are:

David Pearce (OAM)	
Marion Florence	
Nick Baily	
Daryl McCarthy	
Sue Hodgson (OAM)	
Amanda Ripper	Leave of absence from April 2012
Meg Webb	Appointed August 2011
Kris McCracken	Appointed August 2011
Priscilla Berkery	Resigned September 2011
Pam Sutton	Resigned August 2011

Principal Activities

The principal activities of Association during the financial year were:

- providing an independent, state-wide, non-profit advocacy service for older people, people with disabilities, people with mental health disorders, people who use alcohol, tobacco and other drugs, and their families and carers; and
- operating a scheme which provides free, trained volunteers to represent people with mental illness in hearings before the Mental Health Tribunal across the state.

Significant Changes

No significant change in the nature of these activities occurred during the year.

2. Operating Results and Review of Operations for the Year

Operating result

The surplus of the Association for the financial year amounted to $ 5,198 (2011: $ 27,872).

Signed in accordance with a resolution of the Members of the Board of Management:

Board of Management Member:.....

Dated this ..... day of 2012

Advocacy Tasmania Inc

Statement by the Board of Management

The Board of Management has determined that the Association is not a reporting entity and that this special purpose financial report should be prepared in accordance with the accounting policies outlined in Note 1 to the financial statements.

In the opinion of the Board of Management the financial report:

1. Presents a true and fair view of the financial position of Advocacy Tasmania Inc as at 30 June 2012 and its performance for the year ended on that date.

2. At the date of this statement, there are reasonable grounds to believe that Advocacy Tasmania Inc will be able to pay its debts as and when they fall due.

This statement is made in accordance with a resolution of the Board of Management and is signed for and on behalf of the Board of Management by:

Board of Management Member .....D. J. McCarthy, Treasurer.....

Dated this ....2nd..... day of.....October..... 2012

Advocacy Tasmania Inc

Statement of Comprehensive Income

For the Year Ended 30 June 2012

	2012 $	2011 $
Income		
Grants income	1,596,776	1,580,532
Interest income	26,402	24,039
Other income	42,781	35,674
Profit/(loss) on disposal of assets	3,775	2,176
Total income	1,669,734	1,642,421
Less: Expenses		
Accountancy & audit	21,150	30,689
Advertising & promotions	8,461	6,421
Equipment & supplies	5,700	2,263
Bank charges	707	34
Cleaning & pest control	5,287	4,803
Committee expenses	12,122	14,157
Consultancy fees	15,084	8,111
Depreciation	63,733	62,954
Fees & permits	486	-
Insurance	19,678	20,458
IT capacity	49,770	20,401
Lease rentals on operating lease	-	6,449
Legal fees	27	-
Light & power	5,936	7,316
Meeting expenses	-	13,653
Motor vehicle expenses	51,921	62,384
Postage, freight & courier	2,146	1,963
Printing & stationery	15,996	10,349
Provision for annual leave	11,653	(15,674)
Provision for long service leave	(12,016)	-
Provision for time off in lieu	100	(6,101)
Rent	131,381	112,068
Repairs & maintenance	(69)	8,216
Salaries & wages	1,063,738	1,048,237
Superannuation	94,994	94,268
Security costs	2,689	3,041
Staff amenities	3,236	3,186
Staff training & development	28,809	15,142
Subscriptions	3,523	1,976
Sundry expenses	874	842
Telephone & internet	22,998	29,894
Travel & accommodation	18,760	24,975

The accompanying notes form part of these financial statements.

Advocacy Tasmania Inc

Statement of Comprehensive Income

For the Year Ended 30 June 2012

	2012	2011
	$	$
Volunteer costs	15,662	19,515
Write off expenses	-	2,559
Total Expenses	1,664,536	1,614,549
Surplus/(Deficit) for the year	5,198	27,872
Total comprehensive income	5,198	27,872

The accompanying notes form part of these financial statements.

Advocacy Tasmania Inc

Statement of Financial Position

As At 30 June 2012

	Note	2012 $	2011 $
ASSETS			
CURRENT ASSETS			
Cash and cash equivalents	2	372,898	250,905
Trade and other receivables	3	30,147	7,100
TOTAL CURRENT ASSETS		403,045	258,005
NON-CURRENT ASSETS			
Property, plant and equipment	4	220,657	225,379
Other non-current assets	5	4,917	-
TOTAL NON-CURRENT ASSETS		225,574	225,379
TOTAL ASSETS		628,619	483,384
LIABILITIES			
CURRENT LIABILITIES			
Trade and other payables	6	120,190	116,781
Borrowings	8	-	2,533
Provisions	9	130,033	111,188
Deferred income	7	152,160	12,738
TOTAL CURRENT LIABILITIES		402,383	243,240
NON-CURRENT LIABILITIES			
Provisions	9	8,101	27,207
TOTAL NON-CURRENT LIABILITIES		8,101	27,207
TOTAL LIABILITIES		410,484	270,447
NET ASSETS		218,135	212,937
EQUITY			
Accumulated surpluses		218,135	212,937
TOTAL EQUITY		218,135	212,937

The accompanying notes form part of these financial statements.

Advocacy Tasmania Inc

Statement of Changes in Equity

For the Year Ended 30 June 2012

2012

	Accumulated Surpluses	Total
	$	$
Balance at 1 July 2011	212,937	212,937
Surplus/(deficit) for the year	5,198	5,198
Balance at 30 June 2012	218,135	218,135

2011

	Accumulated Surpluses	Total
	$	$
Balance at 1 July 2010	185,065	185,065
Surplus/(deficit) for the year	27,872	27,872
Balance at 30 June 2011	212,937	212,937

The accompanying notes form part of these financial statements.

Advocacy Tasmania Inc

Notes to the Financial Statements

For the Year Ended 30 June 2012

1 Summary of Significant Accounting Policies

(a) Basis of Preparation

This financial report is a special purpose financial report prepared in order to satisfy the financial reporting requirements of the Associations Incorporations Act Tasmania. The Board of Management has determined that the Association is not a reporting entity.

The financial report has been prepared on an accruals basis, is based on historic costs and does not take into account changing money values or, except where specifically stated, current valuations of non-current assets.

The following significant accounting policies, which are consistent with the previous period unless otherwise stated, have been adopted in the preparation of this financial report.

(b) Comparative Figures

Where appropriate, comparative figures have been adjusted to conform to changes in presentation for the current financial year.

(c) Cash and Cash Equivalents

Cash and cash equivalents include cash on hand, deposits held at call with banks, other short-term highly liquid investments, and bank overdrafts. Bank overdrafts are shown within short-term borrowings in current liabilities in the statement of financial position.

(d) Trade and other receivables

The Association considers accounts receivable to be fully collectible, accordingly no allowance for doubtful debts is required.

(e) Property, Plant and Equipment

The depreciable amount of all property, plant and equipment is measured at cost and is depreciated over the useful lives of the assets to the Association commencing from the time the asset is held ready for use.

The depreciation rates used for each class of depreciable assets are:

Class of Fixed Asset	Depreciation Rate
Motor vehicles	25%
Plant & equipment	10%
Computer equipment	25%
Leasehold improvements	20%

1 Summary of Significant Accounting Policies continued

(f) Trade and other payables

Trade and other payables are stated at cost, which approximates fair value due to the short-term nature of these liabilities.

(g) Employee Benefits

Provision is made for the Association's liability for employee benefits arising from services rendered by employees to the end of the reporting period. Employee benefits have been measured at the amounts expected to be paid when the liability is settled.

Contributions made by the Association to an employee superannuation fund are charged as expenses when incurred.

(h) Provisions

Provisions are recognised when the Association has a legal or constructive obligation, as a result of past events, for which it is probable that an outflow of economic benefits will result and that outflow can be reliably measured.

(i) Change in accounting policy

The Association changed its accounting policy relating to providing for long service leave.

The Association previously calculated long service leave for all staff using probability factors and discount rates. In 2012 the Association commenced providing for staff with more than 7 years service at a nominal rate. This has resulted in a decrease in the provision of $13,453 attributable to prior years.

(j) Income Tax

No provision for income tax has been raised as the Association is exempt from income tax under Division 50 of the *Income Tax Assessment Act 1997.*

(k) Goods and Services Tax (GST)

Revenue, expenses and assets are recognised net of the amount of GST, except where the amount of GST incurred is not recoverable from the Tax Office. In these circumstances the GST is recognised as part of the cost of acquisition of the asset or as part of an item of the expense. Receivables and payables in the statement of financial position are shown inclusive of GST.

(l) Revenue and Other Income

The Association recognises grant revenue when there is reasonable assurance that the grant will be received and all grant conditions will be met.

Revenue from the provision of services is recognised upon delivery of the service to customers.

Advocacy Tasmania Inc

Notes to the Financial Statements

For the Year Ended 30 June 2012

1 Summary of Significant Accounting Policies continued

(l) Revenue and Other Income continued

Membership income is recognised over the period to which the memberships relate.

Interest revenue is recognised over the period for which the funds are invested.

Donation income is recognised when the Association obtains control over the funds which is generally at the time of receipt.

All revenue is stated net of the amount of goods and services tax (GST).

2 Cash and Cash Equivalents

	2012	2011
	$	$
Cash on hand	800	370
Cash at bank	202,252	100,112
Short-term bank deposits	169,846	150,423
	372,898	250,905

3 Trade and Other Receivables

	2012	2011
	$	$
Trade receivables	24,376	940
Prepayments	3,111	6,160
Accrued income	2,660	-
	30,147	7,100

4 Plant and Equipment

	2012	2011
	$	$
PLANT AND EQUIPMENT		
Plant and equipment		
At cost	58,249	50,299
Accumulated depreciation	(32,906)	(29,956)
Total plant and equipment	25,343	20,343
Motor vehicles		
At cost	191,024	197,742
Accumulated depreciation	(56,727)	(47,031)
Total motor vehicles	134,297	150,711

4 Plant and Equipment continued

	2012	2011
	$	$
Computer equipment		
At cost	93,604	78,857
Accumulated depreciation	(64,883)	(47,589)
Total computer equipment	28,721	31,268
Leasehold improvements		
At cost	68,641	54,047
Accumulated depreciation	(36,345)	(30,990)
Total leasehold improvements	32,296	23,057
Total property, plant and equipment	220,657	225,379

5 Other Non-current Assets

	2012	2011
	$	$
Bond held in trust	4,917	-
	4,917	-

6 Trade and Other Payables

	2012	2011
	$	$
Trade payables	27,821	50,601
Accrued wages	46,572	35,582
Superannuation payable	-	3,202
PAYG tax payable	13,228	8,778
GST payable	32,569	18,618
	120,190	116,781

7 Other Liabilities

	2012	2011
	$	$
CURRENT		
Grant liabilities	152,160	12,738
	152,160	12,738

8 Borrowings

	2012 $	2011 $
CURRENT		
Bank overdraft	-	2,533
	-	2,533

9 Provisions

	2012 $	2011 $
CURRENT		
Annual leave	78,278	66,625
Time off in lieu	7,765	7,665
Long service leave	43,990	36,898
	130,033	111,188
NON-CURRENT		
Long service leave	8,101	27,207
	8,101	27,207

10 Capital and Leasing Commitments

Operating Lease Commitments

	2012 $
- not later than 12 months	161,297
- between 12 months and 5 years	366,574
	527,871

There are no capital or financial lease commitments as at reporting date to be disclosed.

11 Contingent Liabilities and Contingent Assets

There are no contingent liabilities or contingent assets as at reporting date to be disclosed.

12 Events After the End of the Reporting Period

There are no events after reporting date affecting this financial report to be disclosed.

Advocacy Tasmania Inc

Notes to the Financial Statements

For the Year Ended 30 June 2012

13 Association Details

The registered office of the Association is:
Advocacy Tasmania Inc
PO Box 426
SANDY BAY TAS 7006

WHK

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Level 1, 142-146 Elizabeth Street
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hobart@whk.com.au
www.whk.com.au

Advocacy Tasmania Inc

Auditors Independence Declaration

I declare that, to the best of my knowledge and belief, during the year ended 30 June 2012 there have been:

(i) no contraventions of the auditor independence requirements as set out in the Australian Professional Ethical Standards in relation to the audit; and

(ii) no contraventions of any applicable code of professional conduct in relation to the audit.

WHK

WHK

Alison Flakemore
Audit Partner

Dated this 2nd day of October, 2012.

WHK

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Advocacy Tasmania Inc

Independent Audit Report to the members of Advocacy Tasmania Inc

Report on the Financial Report

We have audited the accompanying financial report, being a special purpose financial report, of Advocacy Tasmania Inc (the Association), which comprises the statement of financial position at 30 June 2012 for the year ended, statement of comprehensive income, statement of changes in equity, and a summary of significant accounting policies, other explanatory notes and the statement by members of the Board of Management.

Board of Management's Responsibility for the Financial Report

The Board of Management of the Association is responsible for the preparation and fair presentation of the financial report and has determined that the accounting policies described in Note 1 to the financial statements, which form part of the financial statements, are consistent with the financial reporting requirements of the *Associations Incorporation Act Tasmania 1964* and are appropriate to meet the needs of the members. The Board of Management's responsibility also includes designing, implementing and maintaining internal control relevant to the preparation and fair presentation of the financial report that is free from material misstatement, whether due to fraud or error; selecting and applying appropriate accounting policies; and making accounting estimates that are reasonable in the circumstances.

Auditor's Responsibility

Our responsibility is to express an opinion on the financial report based on our audit. No opinion is expressed as to whether the accounting policies used, as described in Note 1, are appropriate to meet the needs of the members. We conducted our audit in accordance with Australian Auditing Standards. These Auditing Standards require that we comply with relevant ethical requirements relating to audit engagements and plan and perform the audit to obtain reasonable assurance whether the financial report is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial report. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Association's preparation and fair presentation of the financial report in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Association's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the Board of Management, as well as evaluating the overall presentation of the financial report.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

WHK

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Advocacy Tasmania Inc

Independent Audit Report to the members of Advocacy Tasmania Inc

Independence

In conducting our audit, we have complied with the independence requirements of the Australian professional ethical pronouncements.

Auditor's Opinion

In our opinion, the financial report of Advocacy Tasmania Inc presents fairly in all material respects of the financial position of Advocacy Tasmania Inc as at 30 June 2012 and of its financial performance for the year then ended in accordance with the accounting policies described in Note 1 to the financial statements, and the *Associations Incorporation Act Tasmania 1964*.

Basis of Accounting and Restriction on Distribution

Without modifying our opinion, we draw attention to Note 1 to the financial statements, which describes the basis of accounting. The financial report has been prepared to assist Advocacy Tasmania Inc to meet the requirements of the *Associations Incorporation Act Tasmania 1964*. As a result, this financial report may not be suitable for another purpose.

WHK

WHK

Alison Flakemore
Audit Partner

Dated this 3rd day of October 2012.