Annual Report

2018-19

The
Public Advocate
Influencing change to empower lives

Acknowledgement of Country

The Public Advocate and staff acknowledge the traditional custodians of the lands across the State of Queensland, and pay our respects to the Elders past, present, and emerging. We value the culture, traditions and contributions that Aboriginal and Torres Strait Islander people have made to our communities, and recognise our collective responsibility as government, communities and individuals to ensure equality, recognition and advancement of Aboriginal and Torres Strait Islander Queenslanders in every aspect of our society.

Public availability

This report is available online at http://www.justice.qld.gov.au/public-advocate/about-us/performance or you may contact our office to access a hard copy.

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Feedback on this report

Feedback on this report is welcomed. A feedback survey is available at https://www.getinvolved.qld.gov.au/gi/consultation/6500/view.html. Alternatively, a hard copy of the survey may be requested from our office.

Disclaimer

The views or opinions in this report do not necessarily reflect the views of the Department of Justice and Attorney-General or the Queensland Government.

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Interpreter service

The Queensland Government is committed to providing accessible services to Queenslanders from all culturally and linguistically diverse backgrounds. If you have difficulty in understanding the Annual Report, you can contact our office and we will arrange an interpreter to effectively communicate the report to you.

The Honourable Yvette D'Ath MP
Attorney-General and Minister for Justice
Leader of the House
1 William Street
BRISBANE QLD 4000

15 October 2019

Dear Attorney-General,

I am pleased to present the Public Advocate's Annual Report for the financial year ended 30 June 2019.

The report is made in accordance with the requirements of section 220 of the *Guardianship and Administration Act 2000*.

The Annual Report provides information on the key activities of the Public Advocate and staff of the office for 2018-19 and a statement of the office's financial and operational functions for the year.

I certify that this Annual Report complies with the detailed requirements set out in the *Annual report requirements for Queensland Government agencies* as outlined in the compliance checklist (Appendix 1). The Public Advocate is not considered to be a statutory body for the purposes of the *Statutory Bodies Financial Arrangements Act 1982* or the *Financial Accountability Act 2009*.

Yours sincerely,

Mary Burgess
Public Advocate

The year in review

To be an effective advocate for system change requires planning, patience and resilience. Change comes slowly. When you decide to take on an issue that requires system change, you need to plan for 'the long game'. So it is with the issues affecting the rights and interests of Queenslanders with impaired decision-making capacity for whom I, and the hard-working members of my office, advocate.

Consequently, many of the issues that my staff and I focused our advocacy efforts on over the past year, are the same as those we were working on in 2017-18. Only I like to think that our work over the past year has built on our previous efforts and we have seen some progress with some of those issues, which I hope will ultimately deliver positive outcomes for people with impaired decision-making capacity.

The key issues my office focused our endeavours on in 2018-19 were:

- the residential aged care sector, particularly the unregulated use of restrictive practices, and preparing a detailed submission to the Royal Commission into Aged Care Quality and Safety;
- continuing to engage with government in relation to its response to the Public Advocate's 2016 report *Upholding the right to life and health*;
- monitoring the final year of the rollout of the National Disability Insurance Scheme (NDIS) in Queensland;
- engagement with government about the future of the forensic disability service system, the operations of the Forensic Disability Service and its treatment of clients; and
- monitoring aspects of the operation of the mental health system and the Mental Health Review Tribunal, and the treatment of involuntary patients.

Building on our advocacy efforts last year in relation to the issue of unregulated restrictive practices in residential aged care, we continued to raise concerns about the unlawful treatment of older people in residential aged care. Our advocacy over the year included continuing to correspond with the then Minister for Aged Care the Honourable Ken Wyatt AM and writing to the Commonwealth Attorney-General, the Honourable Christian Porter, requesting the government implement the recommendations of the Australian Law Reform Commission report *Elder Abuse: A national legal response,* relating to the regulation of restrictive practices in residential aged care.

Despite our efforts, it was a series of disturbing reports by the ABC on *Four Corners* and *7:30* about the physical abuse and neglect of people in residential aged care, and in particular the use of physical restraint and anti-psychotic medication as a form of chemical restraint, that moved the Australian Government to action. This culminated in the announcement of the Royal Commission into Aged Care Quality and Safety in September 2018.

While I welcome the Royal Commission and the possibilities for change it foreshadows, I am aware of a level of frustration in the aged care sector and among older persons' advocates that the sector has seen many reviews and inquires in recent years that have made significant recommendations (including the Australian Law Reform Commission's Elder Abuse Report), which, had they been implemented by government, may have avoided the need for a Royal Commission.

Despite these reservations, I have been encouraged by the approach taken by the Royal Commission and its Counsel Assisting during its hearings. I also made a detailed submission to the Commission which is on the Public Advocate website at: https://www.justice.qld.gov.au/public-advocate/submissions.

I look forward to the Royal Commission's reports and to the Australian Government committing to swift action to implement its recommendations to protect the rights and interests of older people in residential aged care.

Before I leave this issue, I also want to acknowledge the important work of those committed journalists at the ABC who brought these stories of abuse and neglect of people in residential aged care to public attention. Their work helps put a human face on these concerning issues that connects with their viewers in ways that our advocacy efforts often can't, which ultimately assists us to achieve systemic change.

This year, I continued to engage with the Queensland Government in relation to its response to the 2016 Public Advocate report *The Right to Life and Health: A review of the deaths in care of people with disability in Queensland*. In March 2019, the Queensland Government finalised its response, *An Action Plan: Meeting the health needs of people in care with a disability*.

The Action Plan lists a large number of initiatives relating to the provision of health and disability services by Queensland Government agencies, many of which were being delivered at the time of the deaths that were reviewed (and therefore could not reasonably be expected to make any difference to the health outcomes for this group of people going forward). The Action Plan focuses on only two 'new' initiatives:

- a trial of the Julian's Key Health Passport, which allows a person with disability to share their care and support information with health workers to improve their health care quality and safety; and
- a commitment to encourage each Hospital and Health Service in Queensland (16 in total) to develop a Disability Service Plan.

Considering the complexity of health and service coordination issues identified in the *Upholding the Right to Life and Health* report, these two initiatives are disappointingly inadequate to make any measureable difference to the health outcomes for people with disability in care in Queensland.

I will continue to advocate with Queensland Government agencies and the National Disability Insurance Agency to seek:

- improved service coordination between the NDIS and mainstream health services;
- annual health plans for people with disability with complex health needs;
- more responsive health services; and
- better training for health professionals and disability support workers in the health needs of people with disability.

Information about the Public Advocate's report, a summary of the report and its recommendations, the Queensland Government Action Plan and a position statement about upholding the right to life and health of people with disability can be found on the Public Advocate website: https://www.justice.qld.gov.au/public-advocate/activities/current/deaths-of-people-with-disability-in-care.

This year was meant to be the final year for the transition to the NDIS in Queensland. As noted later in this report, as at 30 June 2019, 52,249 people were being supported by the NDIS in Queensland, with 14,925 of these receiving government-funded disability support for the first time.[1] While this is a very positive outcome, the June 2019 participation figures for Queensland represent only 57 per cent of the anticipated 91,217 participants at full scheme.[2] As a consequence, the NDIS Transition

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[1] National Disability Insurance Scheme, COAG *Disability Reform Council Quarterly Performance Report – Queensland 30 June 2019* (2019), National Disability Insurance Scheme, 5 <https://www.ndis.gov.au/media/1610/download>.

[2] Ibid.

Bilateral Agreement between the Queensland and Australian Governments was extended for 12 months.

I continue to be concerned about the lower than expected rates of participation of people with psychosocial disability in the NDIS. Reports from peak mental health bodies suggest that more than one-third of people with severe mental health problems are being rejected by the NDIS.[3] In Queensland, in late 2016, the Queensland Alliance for Mental Health reported that more than half of the participants in the Day to Day Living program who were receiving support from a mental health service provider were assessed as ineligible for the NDIS.[4] A January 2018, University of Sydney and Community Mental Health Australia report found that at that time less than half of the expected number of NDIS participants with a primary psychosocial disability had become registered.[5] I noted in last year's Annual Report, that Queensland's figures were a little better but still well short of the almost 14 per cent of people with psychosocial disability expected to be participants.[6]

What this means is that at full rollout, even in a 'best case scenario' there will potentially be a significant service gap for this cohort, with many having to rely on non-NDIS community mental health services to meet their needs or fall through the gaps. We will continue to monitor this issue over the next year.

I have continued to engage with the Queensland Government in relation to the review of the Forensic Disability Service System and its future. This included participating on a confidential working group reviewing Queensland's forensic disability service system and the *Forensic Disability Act 2011*.

As noted in this report, I have had ongoing and serious concerns about the treatment of some clients of the Forensic Disability Service. The service is a purpose-built, medium security, residential and treatment facility with the capacity to accommodate and provide care for up to 10 people who are subject to a Forensic Order (Disability) under the *Mental Health Act 2016*.

The Queensland Ombudsman also initiated an investigation into the operation of the Forensic Disability Service during the reporting period.

I look forward to the Queensland Government taking genuine steps to address the problems with the operation of the forensic service system and the Forensic Disability Service and to protect the clients of the service from systemic mistreatment.

My office has continued to engage with key stakeholders in the Queensland mental health system to advance the rights and interests of people with impaired decision-making capacity. Following the work done by my office last year around the issue of electroconvulsive therapy, the Chief Psychiatrist and I have commenced regular meetings where we discuss issues impacting the rights and interests of involuntary mental health patients. From my perspective, these meetings have proved to be very productive and I appreciate Dr Reilly making the time for them and responding to my concerns.

A particularly positive development over the past year was the announcement by the Mental Health Review Tribunal of its Electronic Audio Recording Project. The project involved a consultation process with Mental Health Review Tribunal stakeholders and statutory bodies, via an online survey

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[3] Chistopher Knaus, *NDIS: People with severe mental health problems being denied access on a daily basis* (18 September 2017) The Guardian <https://www.theguardian.com/australia-news/2017/sep/18/ndis-people-with-severe-mental-health-problems-being-denied-access-on-a-daily-basis>.

[4] Queensland Alliance for Mental Health, *Queensland transition to NDIS for mental health (QTN Forum) communique* (October 2016), Queensland Alliance for Mental Health, 2 <https://qamh.org.au/wp-content/uploads/COMMUNIQUE-4-QTN-MH_31-OCT-2016_RS-2.pdf>.

[5] The University of Sydney and Community Mental Health Australia, *Mind the gap: The National Disability Insurance Scheme and psychosocial disability. Final report: Stakeholder Idenfitied gaps and solutions*, The University of Sydney, 4 < http://sydney.edu.au/health-sciences/documents/mind-the-gap.pdf >.

[6] The Public Advocate, *Annual Report 2017-18* (25 July 2019) Public Advocate, 5 <https://www.justice.qld.gov.au/public-advocate/about-us/performance>.

and written submissions. In my Annual Report last year I expressed concerns about the Tribunal's non-recording of its proceedings.[7] The initiation of the project was a very positive development, as was the Tribunal's recent announcement that, based on the findings of the project, it had agreed in principle to proceed with audio recording of hearings. I look forward to continuing to engage with the President and Deputy of the Tribunal to provide whatever support or assistance I can to progress this initiative.

I cannot end this 'Year in review' without addressing two new developments that have generated discussion, debate, and hope for further positive change for people with impaired decision-making capacity.

The first of these is the announcement of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. While we are only in the early stages of this enquiry, I have had some engagement with the Royal Commission and am buoyed by the very positive energy and enthusiasm demonstrated by all those I have met who are connected with it. I expect a significant amount of our office resources in the coming year will be dedicated to preparing submissions for the Royal Commission about some of our key issues of concern for people with disability.

The second major development was a landmark decision by the Queensland Parliament to pass the *Human Rights Act 2019*. This is an historical piece of legislation for Queensland, which should have a profound and significant impact on the State and the lives of Queenslanders. It will provide a key reference point for the values and rules that should be applied by government and public sector agencies in the way they develop legislation, policy and services for members of our community. It will also offer an appropriate frame of reference for community expectations and behaviour in relation to some of our most vulnerable community members.

I also welcome the establishment of the Queensland Human Rights Commission, which creates the necessary avenue of complaint and review that will be required to enforce the Act. It is through this Commission that very real and practical change can happen in peoples' lives.

While a positive first step, I would like to see human rights legislation extended in the future to include publicly-funded aged care providers in addition to registered NDIS providers. There are undeniable similarities between the issues and risks for people receiving aged care services and those receiving disability services, making the need for the necessary protections and safeguards provided under this Act to be extended to aged care services as a priority.

Ultimately, equality before the law, in combination with effective protection against discrimination, is essential in promoting and protecting the rights of all Queenslanders, regardless of where they live or what types of services they receive.

In conclusion, I want to thank the Attorney-General for giving me the opportunity to perform the role of Public Advocate. The longer I do this work, the more I feel privileged to be here. I also want to express my heartfelt thanks to the dedicated team in the Office of the Public Advocate who work with such commitment and passion and whose combined efforts help to produce the high quality papers and submissions that go out under my name and who support all of my advocacy work.

MC Burgess

Mary Burgess
Public Advocate

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[7] Ibid 15.

Contents

People with impaired decision-making capacity

The Public Advocate undertakes systemic advocacy to benefit all Queensland adults who may experience impaired decision-making capacity. 'Having capacity' means a person is capable of understanding the nature and effect of decisions about a matter, can freely and voluntarily make decisions about it, and can communicate their decisions in some way.[8]

There are a range of conditions that may impact a person's decision-making capacity. These include intellectual disability, acquired brain injury, mental illness, neurological disorders (such as dementia) or problematic alcohol and drug use. While not all people with these conditions will experience impaired decision-making capacity, it is likely that many may, at some point in their lives. For some, impaired decision-making capacity may be episodic or temporary, requiring intensive supports at specific times in their lives, while others may require lifelong support with decision-making and communicating choices and decisions.

A person's ability to make decisions may also vary in response to external factors. These factors include the type and complexity of the decision to be made, the context in which the decision is to be made (e.g. the degree of urgency, availability of alternatives), and the level of assistance available from the person's support networks. Over time, some people with impaired decision-making capacity can develop their ability to make decisions with support and through experience.

Experiencing impaired decision-making capacity can happen to any one of us at any time. In the space of a moment our lives can be transformed, through accident or a health event, from ones where we consider ourselves to be in control, employed in responsible jobs, with others who depend upon us, to lives where we may need help and support ourselves.

People with impaired decision-making capacity are a broad and diverse group. They can be found in all age groups, cultures and demographics, and participate socially and economically in society to varying degrees. While some people with impaired capacity receive services that are provided or funded by government, or are involved in the guardianship and administration system, many have little involvement with formal systems.

Given the particular vulnerabilities of people with impaired decision-making capacity, it is critical that their rights and interests are promoted and protected.

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[8] *Guardianship and Administration Act 2000* (Qld) sch 4.

About the Public Advocate

The Public Advocate, and the staff that support the Public Advocate, share the following vision, purpose and values.

Vision

To realise a just and inclusive society where the rights of all Queenslanders are upheld and their autonomy respected.

Purpose

To undertake systemic advocacy to promote the rights and interests of people with impaired decision-making capacity and protect them from neglect, exploitation and abuse.

Values

Relationships and influence: We engage collaboratively with our stakeholders by building goodwill, sharing knowledge and expertise, and fostering confidence in our work.

Knowledge and leadership: We are committed to research and analysis that contributes to informed legal and social policy debate to progress sustainable supports and services for Queenslanders with impaired decision-making capacity.

Courage and integrity: We champion the rights and views of people with impaired decision-making capacity through our systemic advocacy. We work with clear purpose and commitment, and encourage a culture where accountability and respect are paramount.

Legislative functions

The Public Advocate is established under chapter 9 of the *Guardianship and Administration Act 2000* (Qld) to promote and protect the rights and interests of Queensland adults with impaired decision-making capacity through systemic advocacy.

Under section 209 of the *Guardianship and Administration Act,* the Public Advocate has the following functions:

- Promoting and protecting the rights of adults with impaired capacity (the adults) for a matter;
- Promoting the protection of the adults from neglect, exploitation or abuse;
- Encouraging the development of programs to help the adults to reach the greatest practicable degree of autonomy;
- Promoting the provision of services and facilities for the adults; and
- Monitoring and reviewing the delivery of services and facilities to the adults.

In exercising functions under the *Guardianship and Administration* Act, the Public Advocate is required to apply the general principles outlined in Schedule 1 of the Act.

Under section 210 of the *Guardianship and Administration Act*, the Public Advocate has power to:

- do all things necessary or convenient to be done to perform the Public Advocate's functions; and
- intervene in a proceeding before a court or tribunal, or in an official inquiry, involving protection of the rights or interests of adults with impaired decision-making capacity for a matter.[9]

Section 210A of the Act outlines the Public Advocate's information powers, including the right to all information:

- necessary to monitor and review the delivery of services and facilities to adults with impaired capacity for a matter;
- about the arrangements for the provision of services and facilities to a class of the adults; and
- about the policies and procedures of a service or facility that relate to the provision of services and facilities to the adults.

Under section 209A of the Act, the Public Advocate may prepare a report about a matter arising from the performance of the Public Advocate's functions and provide a copy of the report to the Attorney-General, who must table the report in the Queensland Parliament.

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[9] With leave of the court, tribunal or person in charge of the inquiry and subject to any terms imposed.

The Office of the Public Advocate

Approach to systemic advocacy

The systemic advocacy undertaken by the Public Advocate is focussed on influencing and changing systems, including the legislative, policy and practice aspects of systems to promote rights and improve opportunities and outcomes for people with impaired decision-making capacity.

The Public Advocate works to address issues that can make a real difference in the lives of people with impaired decision-making capacity. The Public Advocate's priorities are:

- the promotion and protection of the autonomy, rights and interests of people with impaired decision-making capacity;
- the inclusion and participation of all people equally in society;
- equal access to the goods and services available to all citizens; and
- sustainable service systems that improve opportunities and outcomes for individuals.

Systemic advocacy differs from individual advocacy. Individual advocacy aims to support people to exercise their rights by providing personal support to voice their concerns, obtain access to information, solve issues of concern and identify and access available options.

People who contact the Public Advocate for help may actually require assistance to resolve an individual complaint or need, rather than reporting a systemic issue. In those cases, people are referred to more appropriate agencies for direct assistance with their individual issue. While the Public Advocate undertakes systemic advocacy, not advocacy for individuals, the issues and experiences of individuals can inform our work, and can be used as case studies to demonstrate issues of concern and serious problems with systems that can be addressed through systemic advocacy.

A key challenge for the Public Advocate is how to most effectively enable people with impaired decision-making capacity to contribute to the development of legislation, government policy and services that impact them. Wherever possible, our activities are underpinned by knowledge gained through research and consultation that includes understanding the lived experience of people with impaired decision-making capacity.

Our Stakeholder Engagement Strategy, among other things, helps direct our engagement with community organisations, advocacy groups and individuals with impaired decision-making capacity to seek their input on our work and listen to their concerns and aspirations, so that this knowledge can inform our advocacy activities.

Operating environment

The Public Advocate thanks the Attorney-General, the Department of Justice and Attorney-General (DJAG) and the Queensland Government, for their continued support of the role and functions of the Public Advocate. The Public Advocate often raises issues that can be challenging for Queensland Government agencies, however at the heart of this work is always the objective of protecting the rights and interests of people with impaired decision-making capacity. The Public Advocate seeks to approach issues in an open and transparent way with a clear purpose and respectfully challenge systems while advocating to advance the opportunities and interests of people with impaired decision-making capacity.

The Office of the Public Advocate has a Business Plan that helps guide the work of the office. The business plan is reviewed annually in order to define and prioritise our work program. This review also enables the identification of strategic and operational risks, for which strategies to mitigate impacts are formulated.

As outlined above, people with impaired decision-making capacity can be affected by a range of conditions, and can come into contact with a variety of major government systems that impact their rights and interests, including:

- the disability service system, including the National Disability Insurance Scheme (NDIS);
- systems accessed by older people, including aged care;
- the health and mental health systems; and
- the guardianship and administration system.

There are a range of issues of concern in each of these systems that the Public Advocate engaged with during the past year. While there are some similarities and overlap between issues, many of the more significant matters were exclusive to a specific sector. Accordingly, the Public Advocate's operations and activities for the last financial year are presented in this report on the basis of the particular system impacting people with impaired decision-making capacity.

A key challenge for the Public Advocate in 2018-19 was progressing the office's projects amidst an environment of significant change and fundamental reform. Key features of the external environment in 2019-20 included the:

- commencement of the Royal Commission into Aged Care Quality and Safety;
- Australian Government's aged care reforms, especially in relation to the use of restrictive practices in residential aged care;
- release of the first National plan to respond to the abuse of older Australians;
- announcement of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability;
- final stage of the rollout of the NDIS in Queensland;
- passing of amendments to Queensland's guardianship legislation;
- passing of the *Human Rights Act 2019*; and the
- Queensland Parliamentary Inquiry into aged care, end-of-life and palliative care and voluntary assisted dying.

Maximising the opportunity to advocate for people with impaired decision-making capacity via these significant inquiries and consultations around sector reform, resulted in some of the resources and focus of the Public Advocate being diverted from some internally-driven projects, leading to delays to their progress or completion. Despite these impacts, it was considered important to focus our efforts in these areas to seek to shape important reforms to some of the key systems that affect the lives of people with impaired decision-making capacity.

The full impact of these inquiries and consultations is not yet known, however the Public Advocate will continue to contribute to these important initiatives at every opportunity to advance the rights and interests of people with impaired decision-making capacity, and monitor the outcomes of any changes to legislation, policy, practice and services. Future business plans of the Office of the Public Advocate will take into account the conduct and implementation of these significant initiatives and reviews.

Human rights

As from 1 January 2020, Queensland Government agencies must comply with the *Human Rights Act*. The Act protects 23 human rights drawn from international human rights conventions and requires all government agencies to act compatibly with those rights in the exercise of their functions. The Act provides that the rights can be limited but only when it is justifiable and reasonable.

The purposes of the Act are to:
- protect and promote human rights;
- help build a culture in the Queensland public sector that respects and promotes human rights; and
- promote a dialogue about the nature, meaning and scope of human rights.

Queensland public sector agencies are preparing for the Act's commencement, including the Office of the Public Advocate. The Public Advocate will closely monitor the implementation of the *Human Rights Act* and hopes that it will help improve protections of the rights and interests of people with impaired decision-making capacity.

Guardianship and administration system reforms

The operation of Queensland's guardianship system is expected to change in 2020 when the *Guardianship and Administration and Other Legislation Amendment Act 2019* comes into force. The amendments to the *Guardianship and Administration Act 2000* focussed on contemporary practice and human rights for people with impaired decision-making capacity. They also provide greater safeguards for individuals and include mechanisms to improve the efficiency of Queensland's guardianship system.

The changes to the current guardianship system include:
- improved alignment of the general principles with the *Convention on the Rights of Persons with Disabilities* (CRPD);
- greater recognition of informal decision-making support;
- the creation of *Guidelines for the Assessment of Capacity*;
- strengthening the eligibility requirements for an attorney under an enduring power of attorney;
- clarifying the level of capacity that is needed for a person to execute an enduring power of attorney and/or advanced health directive;
- strengthening the restrictions associated with attorneys and administrators entering conflict transactions;
- greater power for the Queensland Civil and Administrative Tribunal (QCAT) to order an attorney to pay compensation when they fail to comply with their obligations; and
- broadening whistle-blower protections for people who disclose confidential information about the potential abuse, neglect or exploitation of an adult with impaired decision-making capacity.

The Public Advocate will monitor the introduction and implementation of the reforms.

Delivering Guardianship Services audit

The Queensland Audit Office has announced it will be conducting a performance audit on the guardianship and administration system, with the report scheduled to be tabled in the Queensland Parliament in 2020-21. The Public Advocate welcomes the conduct of the *Delivering Guardianship Services* audit, and its focus on the relevant social, legal, health and financial outcomes for people who interact with the public agencies involved in delivering guardianship and administration services. The Auditor-General often makes recommendations as part of its performance audit process. Consequently, it is likely that the *Delivering Guardianship Services* audit report will impact the future operations of Queensland guardianship and administration agencies, including the Office of the Public Advocate.

People and processes

The Public Advocate is an independent statutory position under the *Guardianship and Administration Act* and appointed by the Governor in Council on the recommendation of the Attorney-General. The current Public Advocate, Mary Burgess, was appointed in October 2016 for a four year term.

An acting Public Advocate may be appointed when the office is vacant or the Public Advocate is absent from duty or unable to perform the duties of the role. This provision was called upon to enable the Public Advocate to take two periods of leave in 2018-19. Ms Anne Edwards, Director of the Queensland Sentencing Advisory Council was the acting Public Advocate from 3 September to 12 October 2018, and Ms Kath Dornbusch, Manager from our office acted as Public Advocate from 21 January 2019 to 5 February 2019.

Our team

The *Guardianship and Administration Act* provides that staff may be appointed to assist the Public Advocate in performing their statutory functions. Staff that support the Public Advocate are appointed under the *Public Service Act 2008*, and the office relies on DJAG for core business supports, such as information technology and human resources.

The office that supports the Public Advocate is based in Brisbane.

The staffing establishment provides for five officers (5.0 FTE) to support the Public Advocate. The permanent separation rate of the office in 2018-19 was 0 percent as no permanent employees resigned from the office.

The current composition of staff have experience in the areas of law and justice, research, public and social policy, community engagement, corruption prevention and supporting vulnerable members of the community. Having a multidisciplinary team ensures that issues are explored from a number of perspectives and the final position of the Public Advocate is balanced and well-informed.

Our team is wholeheartedly committed to the functions of the Public Advocate and supporting the Public Advocate to improve the lives of people who experience impaired decision-making capacity through systems advocacy. Our staff support the Public Advocate by exploring systems issues, preparing submissions and papers, working with stakeholders to address systems issues, and representing the Public Advocate at various forums and meetings.

Over the past year the office has made 16 submissions on a wide range of issues to various government and parliamentary reviews and inquiries, including the Royal Commission into Aged Care Quality and Safety. Many of those submissions are discussed under their subject areas in the relevant parts of this report. A list of the submissions that are publicly available have been listed in Appendix 2.

Code of Conduct and public sector values

Our office upholds the Queensland Public Service values, which are: customers first; ideas into action; unleash potential; be courageous; and empower people.

As DJAG employees, our staff also abide by the Code of Conduct for the Queensland Public Service and the DJAG Workplace Policy. The Code of Conduct reflects ethical values contained in the *Public Sector Ethics Act 1994* and is based on principles and values including integrity and impartiality, promoting the public good, commitment to the system of government, and accountability and transparency.

Staff are introduced to the Code of Conduct and related department policy and expectations upon commencement with the office, and can readily access the Code of Conduct and supporting resources at any time through DJAG's intranet. Staff are periodically reminded about the Code of Conduct and complete workplace ethics training annually. Any breaches of the Code of Conduct are managed in line with the Public Service Commission's Discipline Guide.

We ensure the administrative procedures and management practices of our office have proper regard to the ethics principles and values, the Code and other standards of practice.

Learning and development

The Public Advocate is committed to providing staff with professional development opportunities to help advance their knowledge and skills and to help the office protect and advance the interests of people with impaired decision-making capacity. Staff attended a range of learning and development opportunities including conferences, events and training sessions in 2018-19.

Each year, staff observe a series of QCAT hearings for guardianship and administration matters. The hearings provide invaluable experience for staff to gain first-hand knowledge and understanding of guardianship and administration matters, contributing an informed perspective to our systemic advocacy work. The Public Advocate would like to express appreciation to the QCAT President, members and registry staff for facilitating staff observation at these hearings.

Workforce planning and performance

Our workforce planning processes aim to align the business needs of the office with the skills and abilities of staff. The Public Advocate supports staff to achieve an appropriate work-life balance and effectively manage their emotional and physical wellbeing and mental health. The Public Advocate continued to provide flexible working options to staff, which included accessing accrued time, working part time and telecommuting. Where appropriate, staff were provided with information about self-care strategies and access to the confidential employee assistance service offered to DJAG employees.

Performance management is integrated into the day-to-day running of the office where all staff are provided with regular feedback and recognition, and participate in performance and career development planning. As part of this planning, discussions focus on expectations, performance, behaviour, work direction and professional development.

Governance

The Public Advocate is required to fulfil the statutory functions under Chapter 9 of the *Guardianship and Administration Act*. Under the Act, the Public Advocate is appointed for a fixed term, but for no longer than five years. Under section 215(3) of the Act, the Public Advocate may be removed from office by the Governor in Council for physical or mental incapacity, neglect of duty, dishonourable conduct or being found guilty of an offence the Attorney-General considers makes the person inappropriate to perform official duties.

The Public Advocate continued to fulfil DJAG's corporate governance requirements in 2018-19. The office that supports the Public Advocate was not subject to any departmental or external reviews during the period.

The Public Advocate is a member of the Justice Services Division Board of Management and participates in the monthly meetings and quarterly leadership meetings. The Board of Management is a key leadership, decision-making and accountability mechanism for the Justice Services Division of DJAG.

The Public Advocate is represented at Public Interest Disclosures Agency Network meetings by the office's Public Interest Disclosure Coordinator. The Public Interest Disclosures Agency Network meetings are convened by the Queensland Ombudsman each quarter. Meetings are attended by Public Interest Disclosure Coordinators and practitioners in human resources, corporate governance ethical standards and complaints who may be required to assess and manage public interest disclosures. The network meetings provide an opportunity to discuss current issues, developments in case law, and for group discussion on applying the *Public interest Disclosure Act 2010*.

Information systems and recordkeeping

Our office uses DJAG's records management system to manage electronic and physical documents and follows DJAG policies and processes for record keeping. Staff are trained in how to use the records management system.

In 2018-19, the office continued to improve record keeping processes to enhance compliance with the *Public Records Act 2002* and Queensland State Archives Records Governance Policy, and to improve office effectiveness and efficiency. Our office abides by the general retention and disposal schedule developed by Queensland State Archives.

Staff are introduced to our record keeping systems, their record keeping responsibilities and related department policy and expectations upon commencement with the office. Issues relating to record keeping are periodically discussed within our office.

Engagement and consultation

To fulfil the Public Advocate's statutory function to advocate for the protection of the rights and interests of people with impaired decision-making capacity, our office continually seeks to understand the lived experience of people with impaired capacity and ensure that issues impacting them are considered in public policy discussing and debates.

Stakeholder engagement is one strategy for gaining knowledge and understanding of the lived experience of people with impaired decision-making capacity, however it is also a means by which we exert influence and effect positive change in their lives.

Our office is committed to building relationships and working collaboratively with government, non-government and community stakeholders in the disability, aged, health and mental health and justice sectors.

These relationships allow us to gain knowledge and understanding of the key issues impacting people with impaired decision-making capacity, and to generate discussion, cultivate effective collaborations, and develop strategies and solutions that are responsive to the views and needs of people with impaired decision-making capacity.

Stakeholder engagement strategy

Our stakeholder engagement strategy identifies our key stakeholders and aims to ensure that we effectively engage with key players across all sectors impacting people with impaired decision-making capacity. The strategy outlines our principles for engagement, a methodology and engagement activities with specific stakeholders to develop and foster the relationships we need to inform our work and achieve our strategic goals and purpose.

Stakeholder survey

In May 2019, a stakeholder survey was conducted to inform our Stakeholder Engagement Strategy and guide future engagement and collaboration. The survey was administered online and directly distributed to over 120 Queensland-based stakeholders and many more via a shareable link. A total of 61 stakeholders responded to the survey, representing a range of sectors, government, and non-government entities.[10]

The Public Advocate is using the results from the survey to inform its business planning processes for 2019-20 and to conduct further meaningful engagement with stakeholders to work collaboratively for systems change.

The values of the Public Advocate

The survey revealed that the Public Advocate was perceived to be approachable, accessible and responsive to stakeholders.

Around 3 in 4 stakeholders believed that the Public Advocate:
- champions the rights and interests of adults with impaired decision-making capacity; and
- contributes to informed policy and debate.

Around 2 in 3 stakeholders:
- trust the Public Advocate to do the right thing;
- feel comfortable approaching the Public Advocate with issues;
- feel that the Public Advocate takes the time to understand needs; and
- feel that the Public Advocate works collaboratively with stakeholders.

Advocating for change

The Public Advocate was seen to be actively advocating for change to the disability, aged and mental health systems.

During 2018-19, more than 3 in 4 stakeholders felt that the Public Advocate effectively advocated for change on issues associated with the:
- deaths of people with disability in care;
- health and care needs of people with disability and complex conditions; and
- rights of mental health patients.

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[10] The sample of responses featured a slight skew towards mental health sector stakeholders (41%). This did not significantly affect overall results or the ability of results to be benchmarked in the future. Additional work will be undertaken prior to the 2020 Stakeholder Survey to broaden the representative nature of the lists used for survey distribution.

Future priorities

Stakeholders identified the following issues as priorities for advocacy:

- The transition of Queenslanders to the NDIS.
- The abuse of older Australians.
- The rights of mental health patients.
- Advance care planning.
- Restrictive practices in aged care.

Other insights

The survey revealed that mental health sector stakeholders held somewhat less positive perceptions than those of other stakeholders. This is unsurprising considering the continued focus of the Public Advocate on the operation of the mental health system, which has encouraged significant public discussion and debate about the treatment of involuntary patients.

The reasons for the slightly less positive perceptions of mental health system stakeholders are not entirely clear. They may be due to some stakeholders not welcoming the discussion and potential criticism of aspects of the mental health system, or it may be that some want more rapid change in the system and were expressing some frustration about the pace of change.[11]

Stakeholders from not-for-profit organisations expressed more positive views about the operations of the Public Advocate compared with respondents from government agencies. Again, this result is not surprising given the strong focus of the Public Advocate on improving the performance of various government-operated systems that interact with people with impaired capacity.

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[11] Consideration will be given to including an additional question to future surveys to clarify and derive further detail regarding these issues.

Special interest groups

Australian Guardianship and Administration Council

The Australian Guardianship and Administration Council (AGAC) is the national forum of Public Advocates, Public Guardians, Guardianship Boards and Tribunals, and Public Trustees or their equivalents across Australia. The Queensland members of AGAC are the Public Guardian, Public Trustee, the Senior Member of the Humans Rights Division of QCAT and the Public Advocate.

AGAC members meet biannually over two days, except in years when an AGAC conference is held. AGAC meetings provide an opportunity for members to discuss matters of mutual concern and/or national significance, and to formulate an Australia-wide approach to issues relating to guardianship, administration and associated systems.

In 2018-19, only one AGAC meeting was held due to the AGAC national conference being held in March 2019. The well-attended conference focused on *Upholding rights, preventing abuse and promoting autonomy*. The Public Advocate presented twice and chaired a panel discussion at the conference and was part of the conference organising committee. The Public Advocate's presentations were about:

- safeguarding the health of NDIS participants; and
- the unregulated use of restrictive practices in residential aged care.

The Public Advocate also contributed to the work of the AGAC by providing input into the projects that AGAC is undertaking as part of the National Plan to respond to the abuse of older Australians.

Queensland Guardianship and Administration Council

The Queensland Guardianship and Administration Council members are the Public Guardian, Public Trustee, the Senior Member of the Human Rights Division of QCAT and the Public Advocate. The Public Advocate coordinates the quarterly meetings of the Council, which provide an important opportunity for the Queensland members of AGAC to come together informally to discuss current and emerging issues in the guardianship and administration system.

Elder Abuse Prevention Unit Reference Group

The quarterly meetings of the Elder Abuse Prevention Unit Reference Group are attended by a broad range of stakeholder representatives, including the Public Advocate, Office of the Public Guardian (OPG), QCAT, the Public Trustee, the Department of Communities, Disability Services and Seniors (DCDSS), Queensland universities, Aged and Disability Advocacy Australia, Seniors' Legal and Support Service at Caxton Legal Centre, Older People Speak Out, Alzheimer's Australia and other non-government organisations.

The Uniting Care Community's Elder Abuse Prevention Unit chairs the Reference Group meetings which discuss emerging and current issues about elder abuse, the current work and initiatives of member agencies, and strategies and actions that may be required to address issues. The Public Advocate has been a long-term member of the Reference Group.

Queensland: An Age-Friendly Community Senior Officers Group

The Queensland Age-Friendly Community Strategy Senior Officers Group is convened by the Office for Seniors within DCDSS. The group was developed for members to discuss, develop and advance the delivery of the age friendly community strategy in Queensland. The Public Advocate participated in meetings and continued to contribute to the *Queensland: An age-friendly community strategy*, action plan and implementation schedule in 2018-19.

Metro South Hospital and Health Service and Health Service Disability Action Committee

This year the Public Advocate was invited to be a member of the Metro South Hospital and Health Service Disability Action Committee. The committee meets quarterly to oversee the development and implementation of the second Metro South Health Disability Plan. Participation on this committee is another means by which the Public Advocate can continue to advocate for the implementation of the recommendations from the *Upholding the Right to Life and Health* report.

Brisbane North Primary Health Network Health Alliance Group

Metro North Hospital and Health Service and Brisbane North Primary Health Network established the Health Alliance Core Group to create a ‘neutral ground’ for stakeholders across the health sector to come together and generate integrated solutions for responding to people with complex health and social needs who frequently attend emergency departments. Many of the people whose cases were reviewed in the *Upholding the Right to Life and Health* report would have fallen within the cohort of people who the project is targeting.

The members of Health Alliance Core Group include representatives from Metro North Hospital and Health Service, the Brisbane North Primary Health Network, non-government organisations that support vulnerable people and the Public Advocate. Recent work of the group has focused on the creation of sustainable funding pathways for activities responding to the target group of patients.

Queensland Law Society Committees

The Public Advocate has been granted permission to observe the Health and Disability Law, and Elder Law Committees of the Queensland Law Society. The Health and Disability Law Committee was established to monitor, improve, and develop legal services, legislation and practice in areas affecting people with health and disability issues or who are mentally vulnerable including involuntary patients under the *Mental Health Act 2016*.

The Elder Law Committee was established to develop policies and review proposed legislative amendments in the area of elder law, focusing on the rights and responsibilities of aged persons, including in relation to aged care facilities, retirement, estate planning and pensions.

The Public Advocate greatly appreciates the Queensland Law Society’s generosity for enabling her continued attendance at these meetings in 2018-19. This engagement with members of the legal profession has provided invaluable opportunities to learn more about the intersection of law and medicine and emerging issues for vulnerable members of the Queensland community.

DJAG NDIS Transition Working Group

In 2018-19, the Public Advocate continued as a member of the DJAG NDIS transition Working Group, which provides whole-of-department oversight in relation to the NDIS transition. The Working Group is led by the Strategic Policy and Legal Services branch of DJAG.

All represented agencies and/or business units submit progress reports on issues associated with the roll out of the NDIS in Queensland. The DJAG reports are combined with those from other Queensland Government departments to inform the decision-making of the NDIS Reform Leaders Group.

DJAG Guardianship Implementation Reference Group

The *Guardianship and Administration and Other Legislation Amendment Act* was passed on 11 April 2019. This amendment Act represents the first tranche of amendments to the *Guardianship and Administration Act* arising from the Queensland Law Reform review of the guardianship and administration system in 2010.

Complementary to these amendments, the department is conducting a review of the Enduring Power of Attorney and Advance Health Directive forms, including the introduction of explanatory guides, and the development of capacity assessment guidelines. The Public Advocate is a member of the DJAG Guardianship Implementation Reference Group which was established in 2017-18 to provide advice and support for the development of the amending Act and the review of the forms. The substantive provisions of the amending Act are due to commence in early 2020.

DJAG Human Rights Implementation Working Group

DJAG is leading the whole-of-government implementation of the *Human Rights Act*. The DJAG Human Rights Implementation Working Group was established to assist the department and its portfolio agencies to prepare for the commencement of *Human Rights Act*. The Working Group consists of representatives from each business unit within DJAG, who meet on a monthly basis to guide the process associated with the implementation of the Act at an operational level.

More specifically, the group is responsible for contributing to and approving plans for human rights implementation in DJAG which align with government priorities, identifying and managing any implementation risks, promoting a positive approach to human rights implementation, sharing information, learnings, challenges and successes, and assisting to resolve identified issues.

Speaking engagements, workshops and events

In 2018-19, the Public Advocate spoke at events and participated in numerous panel discussions on issues impacting people with impaired decision-making capacity. The Public advocate was also featured in media reports regarding the use of restrictive practices in residential aged care, the proposed closure of the Halwyn Centre and other issues relating to people with impaired decision-making capacity. These speaking engagements and media reports are listed in Appendix 3.

Consultations, workshops and events which the Public Advocate and staff of the office attend provide opportunities to advance systemic advocacy for people with impaired decision-making capacity, contribute to broader community and policy debates, and develop and maintain our relationships with stakeholders. Appendix 4 lists the consultations, workshops and events in which the Public Advocate and staff of the office participated in 2018-19.

Major systems

Given the diversity of people who experience impaired decision-making capacity, the scope of work undertaken by the Public Advocate is necessarily broad.

While some people with impaired decision-making capacity have limited involvement with service systems, others interact with a variety of systems, such as disability, aged care, health, mental health and justice.

Fulfilling the statutory functions of the Public Advocate therefore requires a wide-ranging knowledge and understanding of these service systems and how they interact with people with impaired decision-making capacity.

Achieving positive change for people with impaired decision-making capacity requires the use of a range of approaches to our work and our engagement with stakeholders. This includes building positive and collegiate relationships with key stakeholders, staying abreast of systems issues, and creating and capitalising on opportunities for change.

Disability

The introduction of the NDIS remained a key feature of the Queensland disability sector in 2018-19, as was the review of various disability agreements, frameworks and strategies. These included the National Disability Agreement (NDA), National Disability Strategy, National Disability Advocacy Program and the Queensland Disability Advocacy Strategy.

In early 2019, the Australian Government announced a Royal Commission into Violence, Abuse Neglect and Exploitation of People with Disability. Due to commence in September, the Commission will make recommendations regarding policy, legislative, administrative and structural reforms required to uphold the rights of people with disability to live and participate in safe environments free from violence, abuse, neglect and exploitation.

With all of these processes occurring simultaneously, we can expect that change will be a continuing feature of the disability services environment in the immediate future. It will be important to ensure that the changes that come with these reviews and inquiries address the key challenges and concerns of people with disability and introduce appropriate safeguards and systems of accountability that will uphold their human rights and promote an inclusive community.

National Disability Agreement and Strategy

At the time of preparing this report, the Australian Government had not yet responded to the Productivity Commission's Review of the NDA nor had they released a revised version of the NDA for consultation.

The Public Advocate made a submission to the Productivity Commission's Review of the NDA. The submission focussed on the continuing need for the NDA to be the key expression and driver of disability policy and service provision for all levels of government across Australia, with the NDIS being just one part, albeit an important one, of national disability service provision. The submission also highlighted the broader function of the NDA, being to enhance the quality of life of all people with disability in Australia, including through the provision of decision-making supports, legal and disability advocacy and employment.

Many of the Public Advocate's comments were echoed in the Productivity Commission's final report released in February 2019. The Commission recommended that a new NDA agreement be developed as an aspirational document articulating government roles and responsibilities, with the focus on the key outcome of people with disability and their carers having an enhanced quality of life and being able to participate fully as valued members of the community. The NDA should then be supported by contemporary policy and address the existing gaps in the roles and responsibilities of governments in a range of areas, including the NDIS, advocacy services, community access and inclusion programs, carer services and services to people with psychosocial disability.

To measure progress, the Productivity Commission recommended that the NDA include a single national performance reporting framework, with progress towards outcomes tabled in Parliament every two years.

Disability Royal Commission

The Public Advocate welcomes the announcement of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.

In March 2019, the Public Advocate made a submission to the Royal Commission in response to consultation about the Commission's Terms of Reference. The submission supported the Terms of Reference focusing on safety, and taking a broad perspective, including people with disability being safe from violence, abuse and neglect, as well as being able to access quality and responsive health care and appropriate accommodation and supports. These rights should be afforded equally to all Australians but are not always available to people with disability.

The final Terms of Reference articulate a potential reach for the Royal Commission that is both broad and deep. The Royal Commission will be tasked with inquiring into all matters that have regard to preventing, protecting, reporting and responding to violence, abuse, neglect and exploitation of people with disability as well as what should be done to promote a more inclusive society that supports the independence of people with disability and their human rights.

The Terms of Reference for the Royal Commission also specifically note that all aspects of the quality and safety of services are to be investigated, which includes the NDIS and the NDIS Quality and Safeguarding Framework.[12]

The Public Advocate will prepare a series of submissions for the Royal Commission in 2019-20.

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[12] Governor General, *Commonwealth Letters Patent* (September 2019) Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability <https://disability.royalcommission.gov.au/about/Pages/Terms-of-reference.aspx>.

National Disability Insurance Scheme

As at 30 June 2019, 52,249 Queenslanders were being supported by the NDIS. Of these, 14,925 participants are receiving government-funded disability support for the first time.[13] This is a significant outcome that will make a positive difference to lives of many people with disability. However, the June 2019 participation figures for Queensland represent only 5 per cent of the anticipated 91,217 participants at full scheme.[14] In recognition of this significant shortfall, the NDIS Transition Bilateral Agreement between the Queensland and Australian Governments was extended for 12 months, with the Full Scheme Agreement now expected to commence on 1 July 2020.[15] This means that the NDIS is effectively still in transition for an additional 12 months, with the Queensland Government continuing to support people with disability to enter the scheme during that period.

The NDIS Quality and Safeguards Commission will officially commence operations in Queensland in 2019-20. The Commission is an independent agency established to improve the quality and safety of NDIS supports and services. The Public Advocate welcomes the commencement of the Commission in Queensland, acknowledging the extremely important role the Commission will play in working with NDIS participants, service providers, workers and the community to maximise the ability of participants to access appropriate services and supports in ways that promote choice, control and dignity.[16] The Public Advocate anticipates working closely with the Commission over the forthcoming year.

Legislative amendments

During the year, the Public Advocate participated in a legislative review process resulting in the development and passing of the *Disability Services and Other Legislation (NDIS) Amendment Act 2019*. The Act introduced new definitions for ‘visitable sites’ (sites that are visited and monitored by the OPG’s official Community Visitor Program) and ‘deaths in care’ that are reportable to the State Coroner.

It was the view of the Public Advocate that the proposed narrower definitions of visitable site and reportable death could result in fewer Queenslanders with disability having these protections than prior to the legislative change. This outcome would be contrary to the Queensland Government’s commitment that no person would receive fewer supports or protections as a result of the introduction of the NDIS. At this time it is difficult to determine whether this has occurred.

The *Disability Services and Other Legislation (NDIS) Amendment Act* will commence from 1 July 2019. The impact of the changes in these definitions for people with disability living in care or supported accommodation will need to be monitored closely as one of the continuing risks and challenges associated with the full roll out of the NDIS in Queensland.

Level 3 residential services

Level 3 residential services are accommodation services that are registered with the Queensland Department of Housing and Public Works. These services provide residents with accommodation, meals, personal care and hygiene support, security, medication and health support, social and leisure activities, and access to external support services. Level 3 residential services include hostel and boarding house style accommodation.

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[13] National Disability Insurance Scheme, COAG *Disability Reform Council Quarterly Performance Report – Queensland 30 June 2019* (2019), National Disability Insurance Scheme, 5 <https://www.ndis.gov.au/media/1610/download>.

[14] Ibid.

[15] O’Rourke, Coralee (Minister for Communities and Minister for Disability Services and Seniors) and Robert, Stuart (Minister for the National Disability Insurance Scheme and Minister for Government Services), ‘Future of the NDIS secured for Queensland’ (media release, 10 July 2019).

[16] NDIS Quality and Safeguards Commission, *What we do* (2019) <https://www.ndiscommission.gov.au/about/about-the-ndis-commission/what-we-do>.

Many people living in level 3 residential services now access disability supports through the NDIS. A number (believed to be significant but not yet known) of level 3 residential service providers have registered as NDIS service providers. The level 3 residents who were previously receiving disability supports from DCDSS, but are ineligible for the NDIS should continue to receive support from the Queensland Government under the 'grandfathering' arrangements it has put in place for this group of people.

The effect of the transition to the NDIS on the supports and safeguards available to people who reside at level 3 residential services has been difficult to predict. However, the sector is now beginning to show some signs to indicate how these changes may impact the Queensland residential services environment following transition. It is feared that these changes may affect the levels of oversight and accountability of level 3 services.

As noted above, many level 3 service providers have registered as NDIS providers and may now be funded by the NDIS to deliver many of the personal care, hygiene, medication, health, and possibly some social and leisure services that were previously provided in the course of their level 3 residential services arrangements. Under existing regulations, there appears to be no requirement on level 3 residential service providers to maintain their level 3 accreditation in order to provide NDIS services to residents — they will only be required to have the minimum level of residential service accreditation under Queensland housing regulations. If residential services are no longer level 3 accredited, they will no longer receive visits from the OPG's Community Visitor Program and the deaths of these residents will not be reportable to the Coroner, unless the services provided to residents meet the narrower definition of particular NDIS classes of support included in the amendments to the *Disability Services Act* (NDIS amendments) noted above.

It is also going to be challenging for the OPG to identify those accommodation services that are providing the particular classes of NDIS supports to people with disability that would define them as a visitable site for the purposes of the OPG's Community Visitor Program.

The end result of these changes is potentially less oversight and protection for the vulnerable people living in these residential services than prior to the introduction of the NDIS.

During stakeholder meetings attended by the Public Advocate, support workers from community organisations and hospital and health services staff, issues were raised in relation to the quality of accommodation, food and supports available at some residential services. These issues were identified when advocates and/or workers visited services, or residents presented at hospital emergency departments. Without the requirement for higher level accreditation and other safeguards such as visits from the Community Visitor Program there is a strong possibility that these service deficiencies will become worse, with fewer opportunities for government agencies to identify issues and protect residents from neglect.

The transition to the NDIS is also likely to result in a significant number of new NDIS accommodation and service providers operating in Queensland from facilities previously owned and operated by DCDSS or from new purpose built or modified accommodation funded under the NDIS. It is not yet clear what oversight mechanisms will apply to these facilities.

The Public Advocate is involved in a cross-agency working group to monitor level 3 residential service issues, including representatives from the Department of Housing and Public Works, the OPG, the Public Trustee and the Office of Fair Trading. This group will continue to meet in 2019-20 to identify and address systemic and operational issues associated with level 3 accommodation services as the roll out of the NDIS continues.

Health needs of people with disability

Queensland Government response to the *Upholding the right to life and health* report

The Public Advocate's report *Upholding the right to life and health: A review of the deaths in care of people with disability in Queensland* reviewed 73 cases involving the deaths in care of people with disability. The report published findings about the health and mortality of Queenslanders living with cognitive and intellectual disability which included:

- more than half of all deaths reviewed (59%) were identified by the expert advisory panel as unexpected;
- many of these deaths involved relatively young men and women (median age at death was 51 years); and
- more than half (53%) of the deaths were potentially avoidable.[17]

The most common underlying causes of death were:

- respiratory diseases (mostly aspiration pneumonia and pneumonia) — 34%;
- circulatory system diseases (mostly heart disease) — 22%;
- disease of the nervous system (epilepsy) — 11%;
- cancers — 10%; and
- external causes (including choking and food aspiration) — 8%.[18]

The report provided numerous examples where adverse health outcomes were experienced by people with disability due to factors such as inadequate support for health-related conditions, poor access to adequate medical assessment and health care, and lack of training for disability support staff and medical/health care professionals.

The report made 10 systemic recommendations in three key areas:

1. Governance and accountability;
2. Health practice and standards; and
3. Disability practice and standards.[19]

In January 2019, close to three years after the report was tabled in the Queensland Parliament, the Queensland Government released its response to the report, *An Action Plan: Meeting the health needs of people in care with a disability*.[20] The Action Plan lists a large number of initiatives related to the provision of health and disability services by Queensland Government agencies, most of which were being delivered at the time of the deaths that were reviewed.

The Action Plan includes only two new initiatives:

- a trial of the Julian's Key Health Passport – which allows a person with disability to share their care and support information with health workers to improve their health care quality and safety and;
- a commitment to encourage each Hospital and Health Service in Queensland (16 in total) to develop a Disability Service Plan.[21]

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[17] Public Advocate, *Upholding the right to life and health; A review of the deaths in care of people with disability in Queensland, A systemic advocacy report* (28 June 2019) Public Advocate, 16,18 <https://www.justice.qld.gov.au/public-advocate/activities/current/deaths-of-people-with-disability-in-care>.

[18] Ibid 23.

[19] Ibid xi-xvii.

[20] Queensland Government, *An Action Plan: Meeting the health needs of people in care with disability* (28 June 2019) Public Advocate <https://www.justice.qld.gov.au/public-advocate/activities/current/deaths-of-people-with-disability-in-care>.

[21] Ibid.

Considering the complexity of the health and service coordination issues identified in the *Upholding the right to life and health* report, these two initiatives are not enough to make any measurable difference to the health outcomes for people with disability in Queensland.

As noted in the Public Advocate's 2017-18 Annual Report, the only way to effectively improve health outcomes for people with disability with complex health needs, is through a coordinated approach. This approach needs to engage Hospital and Health Services, Primary Health Networks/general practitioners and the NDIA to coordinate the disability and health supports people with disability need to maintain their health and well-being.[22]

Moving forward, the Public Advocate has identified a need for a series of national and state responses that include:

- the inclusion of specific training on the health needs of people with disability in medical and nursing degrees;
- acknowledgement in NDIS plans of people with complex health needs and the inclusion in NDIS plans of the disability supports necessary to address health care needs, provide for adequate coordination of essential health care supports and support attendance at medical and therapeutic appointments. NDIS plans should also include actions to improve the integration and communication between mainstream health services, registered NDIS service providers and other disability support services to ensure people with disability with complex health conditions are accessing the health services they need;
- the development of individual health care plans for people with disability that are reviewed annually and used to inform the NDIS supports required to adequately access health services;
- regular systemic reviews of the deaths of people with disability in care; and
- support for pilot projects demonstrating best practice in coordination between health care providers and disability support provides and support improved training for health and disability workers about appropriate care for people with disability with complex health conditions.

Health and Intellectual Disability Roundtable

In March 2019, a roundtable event was co-convened by the Public Advocate, Queenslanders with Disability Network, Queensland Centre for Intellectual and Developmental Disability and ICAN! – the Institute for the Clinical Advancement of Neuroplasticity. It brought together more than 80 people and a wide variety of speakers, ranging from people with intellectual disabilities and their families through to professors, clinicians and advocates.

Outcomes from roundtable discussions focused on improvements to individual patient care, education and training of medical and disability support staff, the delivery of direct health services and care (primary, sub-acute, acute and community health services) and integration and collaboration across health and disability systems.

Other activities

During 2018-19 the Public Advocate also:

- presented on the topic of safeguarding the health of NDIS participants at the AGAC national conference;
- wrote to the National Disability Insurance Agency and Minister for Family and Social Services about the need or the NDIS to provide funding for dysphagia (difficulty swallowing) related conditions. This letter was in support of the 'Hard to Swallow' campaign which was led by the New South Wales Council for Intellectual Disability and Inclusion Australia;
- wrote to the Commonwealth Minister for Health and the Shadow Minister for Health to advocate for the NDIS to provide funding for dysphagia-related conditions. These letters were also in support of the 'Hard to Swallow' campaign; and
- wrote a letter of support for a submission from the Professional Association of Nurses in Developmental Disability Australia for the Independent Review of Nursing Education in Australia.

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[22] The Public Advocate, *Annual Report 2017-18* (25 July 2019) Public Advocate <https://www.justice.qld.gov.au/public-advocate/about-us/performance>.

The submission advocated for future nursing curricula to include mandatory content about the health of people with intellectual and developmental disability, and how to adapt nursing care to better accommodate their needs.

In June 2019, the Disability Reform Council announced that the NDIS will fund specific disability-related health supports where the supports are a regular part of the participant's daily life, and result from the participant's disability.[23] This represented a significant step forward, meaning that NDIS participants will be able to access supports related to conditions including dysphagia, diabetes, incontinence, epilepsy, wounds and pressure sores, respiratory issues, nutrition and foot care. This is a welcomed decision. The Public Advocate will continue to closely monitor the provision of health supports for NDIS participants with complex health needs.

This will be partially achieved through the Public Advocate's participation in the Metro South Hospital and Health Service Disability Action Committee, and the Brisbane North Primary Health Network's Health Alliance group investigation into the needs of people with complex health conditions who frequently attend hospital emergency departments.

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[23] Department of Social Services, *Meeting of the COAG Disability Reform Council Gold Coast 28 June 2019 Communique* (9 July 2019) Department of Social Services <https://www.dss.gov.au/disability-and-carers-programs-services-government-international-disability-reform-council/communique-28-june-2019>.

Deinstitutionalisation

Many younger Queenslanders with disability continue to permanently reside in Queensland public health facilities, despite these arrangements conflicting with contemporary thinking about the positive impacts of deinstitutionalisation of people with disability and their inclusion in the community.

The Public Advocate's report, *People with intellectual disability or cognitive impairment residing long-term in health care facilities: Addressing the barriers to deinstitutionalisation*, highlighted the need to transition people with intellectual disability or cognitive impairment living in health facilities to appropriate and inclusive community-based accommodation and support services. The report also highlighted the need to plan and support their transition into the NDIS.[24]

In response, the Queensland Government launched the *Joint Action Plan – Transition of long-stay younger people with disability from Queensland public health facilities* to support younger people with disability who are long-stay residents in Queensland public health facilities access the NDIS (if eligible) and move to community-based living arrangements.[25]

Since the commencement of the Joint Action Plan in 2013-14, 180 younger people with disability have been supported to transition to community living from public health facilities.[26] It is a positive outcome that this many people are now living in the community rather than in a public health facility.

In 2018-19, $192,000 was allocated to support four people to transition from living long-term in public health facilities to community living under the Joint Action Plan. Of these four people, one person returned to living at home with their family, one person lives in their own home, one person lives in a rental property and one person lives in purpose designed accommodation.[27] While the transition from residing long-term in a public health facility to community living is a positive outcome, it is disappointing that only four people were transitioned in the final year of the Joint Action Plan when in previous years, between 20 and 50 people were being transitioned annually under the Plan.

Despite the extension of the NDIS roll out until 30 June 2020, the Joint Action Plan will not continue beyond 30 June 2019. DCDSS has advised, for those people residing in public health facilities that are not eligible for the NDIS, that:

- under the NDIS Bilateral Agreement, the continuity of support provisions will apply to people who receive specialist disability supports but do not meet NDIS access requirements and where the funding for the support is attributed to a program/services that will cease when the NDIS is introduced; and that
- in line with this provision, people under the Joint Action Plan who do not meet NDIS access criteria, will continue to be supported by the Queensland Government (if under 65 years of age) to access specialist disability supports, or by the Australian Government (if 65 years of age and over, or 50 years of age and over for Aboriginal and Torres Strait Islander people).[28]

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[24] Public Advocate, *People with intellectual disability or cognitive impairment residing long-term in health care facilities: Addressing the barriers to deinstitutionalisation* (17 September 2019) Public Advocate <https://www.justice.qld.gov.au/public-advocate/activities/past/people-with-disability-residing-long-term-in-health-care-facilities>.

[25] Queensland Government, the *Joint Action Plan – Transition of long-stay younger people with disability from Queensland public health facilities* (17 September 2019) Public Advocate <https://www.justice.qld.gov.au/public-advocate/activities/past/people-with-disability-residing-long-term-in-health-care-facilities>.

[26] Letter from Ms Clare O'Connor, Director-General, Department of Communities, Disability Services and Seniors to Ms Mary Burgess, Public Advocate, 29 August 2019.

[27] Ibid.

[28] Ibid.

Queensland Health has advised that there are still 412 Queenslanders that are medically ready for discharge and still residing long term in public health facilities.[29] It is not known how many of these people may have an intellectual disability or cognitive impairment.

Queensland Health has reconfirmed its commitment to ensuring patients who do not require medical treatment can access more appropriate, community-based living arrangements and has indicated it is exploring opportunities to partner with other government and non-government organisations to improve hospital discharge processes. This work includes building Hospital and Health Service staff capacity for navigating NDIS pathways and case management for patients with highly complex needs. It also includes exploring interim accommodation options that will better meet the needs of long-stay patients while appropriate long-term arrangements are being secured.[30]

The Public Advocate will continue to liaise with the relevant Queensland Government departments to support the transition of more people from living long-term in public health facilities to community living, particularly for people with intellectual disability or cognitive impairment.

The Public Advocate continues to have long-standing concerns about the many people with impaired decision-making capacity living long-term in other state institutions who may not be deemed eligible for NDIS funding. This group includes people with mental illness and cognitive and intellectual disability living in Queensland Health Authorised Mental Health Services, as well as people with cognitive and intellectual disability in the Forensic Disability Service (FDS). There is an ongoing and critical need for the Queensland Government to support the patients/residents of these services to secure NDIS-funded supports where possible, and to plan their transition from these services to living in the community.

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[29] Letter from Ms Bronwyn Nardi, Assistant Deputy Director-General, Strategy Policy and Planning, Department of Health to Ms Mary Burgess, Public Advocate, 26 September 2019.

[30] Ibid.

Halwyn Centre

The Halwyn Centre is a residential care facility, built in 1979, that is operated by Queensland Health. The Centre provides care for clients with both intellectual and physical disabilities with complex care needs. The centre provides permanent residential and respite care for clients from six years of age. The Centre is home to 39 people with varying levels of disability and complex health conditions.

In January 2019, Metro North Health and Hospital Service staff informed residents and their families that the Halwyn Centre would close in November 2019, and that all permanent residents would be required to transition into community-based accommodation prior to that date, a period of approximately 10 months. The Centre's respite care facilities were scheduled to cease the following month.

While all Halwyn residents have engaged with the NDIS and have NDIS plans, the plans do not include funding for specialist disability accommodation (SDA) which would usually be required for people with the levels of physical disability and health needs that most Halwyn residents have. If Halwyn residents wanted to move from the facility they would need to have their plans reviewed in terms of whether they could be funded for SDA. If they could not get SDA funding or SDA accommodation was not available, or could not be built, Halwyn residents wanting to transition into the community would need to rely on available accommodation. Residents' plans would also need to be reviewed on the basis that they would be living in accommodation with fewer co-residents, which would likely require higher levels of funding for their day-to-day supports. Further, residents' current plans do not include any specific funding for nursing supports, which are considered critical by Halwyn residents' families to the ongoing management of the complex health conditions experienced by residents and currently provided at the Halwyn Centre.

Following the announcement of the closure, the Public Advocate was contacted by a number of families of residents at Halwyn and the Queensland Nurses and Midwives Union, to raise concerns regarding the transition and the ongoing health supports required for Halwyn residents. The Public Advocate and Public Guardian made representations to Queensland Health, advocating for a longer and better coordinated transition of residents into community-based accommodation. They also sought a commitment to providing the nursing and other health supports necessary to maintain resident's health, and health care plans to assist with the management of the residents' complex health conditions. The Halwyn residents' families sought a commitment from the Minister that the facility would remain open.

Following these communications, the Honourable Steven Miles MP, Queensland Minister for Health, made a commitment to the Halwyn families that the facility will continue to operate until all residents have transitioned to 'appropriate supported accommodation with the level of disability and health support to meet their needs'.[31] This commitment was soon followed by a Queensland Health commitment to continue to operate the Centre's respite service until such time as alternate arrangements can be secured for the families affected. These commitments were welcomed by the Public Advocate.

Since then, the Public Advocate has been working with the Halwyn families, Queensland Health, the Public Guardian and the Metro North Hospital and Health Service to address the concerns of Halwyn families about the ongoing operation of the centre and to progress issues associated with transition to community living for individual residents and their families as appropriate.

While the Public Advocate fundamentally supports the deinstitutionalisation of people with disability, we want to support the Halwyn residents and their families to have their views heard about their care and where they want to live, while ensuring that if and when they choose to transition to alternate accommodation, they have an appropriate disability and health supports in place to ensure their on-going health and well-being.

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[31] Janelle Miles, 'Lifeline for residents of Halwyn Centre disabled facility' (Courier Mail online subscription, 30 January 2019).

The Public Advocate will remain engaged with this process in 2019-20, including participating in a multi-agency working group convened by the Metro North Hospital and Health Service to provide a formal mechanism to address strategic and operational issues and share information and advice relating to the future of the Halwyn Centre.

The Halwyn Centre provides a strong illustration of the issues that need to be addressed when people with disability and complex health conditions transition from health facilities to the NDIS and community-based accommodation, including the:

- critical need for the provision of appropriate and on-going health supports that are integrated with the disability supports and acknowledged in NDIS plans; and
- lack of suitable accommodation in the community for people with disability and complex health conditions, which is, in part, resulting from a lack of government investment in the provision of universally accessible community and public housing options.

If these issues are not addressed for members of this particularly vulnerable group when they transition into the community, they face a very real risk of poor health and mortality outcomes.

Young people with disability residing in residential aged care

It is well recognised that residential aged care is not an acceptable living arrangement for a younger person with disability. However, it has become the 'last resort' accommodation for people with particularly complex disability and care needs, often on the basis that aged care facilities are the only places that can provide the level of health and disability supports that this cohort of people require, often on a 24/7 basis.

As at 30 September 2018, a total of 5,905 people with disability under the age of 65 years were residing in aged care facilities.[32] Around 1,200 (20 per cent) resided in Queensland.[33]

In April 2019, the Public Advocate made a submission to the Royal Commission on Aged Care Quality and Safety. The submission highlighted that more than one in twenty young people residing in residential aged care facilities have been determined as ineligible for NDIS funding. It also noted that when young people who live in residential aged care have an NDIS plan, the median amount of funding is $104,563.[34] Of this, $77,539 is allocated to costs relating to the provision of aged care support, leaving only $31,990 for disability related supports, including making plans for alternate accommodation and transition out of residential aged care facilities.[35] While 996 SDA places are currently under construction in Australia, only 22 young people with disability in residential aged care currently have SDA included in their SDA plans.[36]

In the submission, the Public Advocate explained that the available evidence demonstrated the urgent need for SDA to be constructed to better address the needs of young people with disability who need high levels of care. While SDA funding can provide for this type of accommodation in individual NDIS plans, the number of NDIS participants with SDA funding in their plans and the rate of construction indicates there is a significant shortfall in terms of meeting demand.

The Public Advocate argued for a comprehensive national review of the SDA program, and that the review address issues relating to the respective roles and contribution of State and Territory governments as well as service providers and investors in the SDA market. The Public Advocate also encouraged the initiation of a new and/or fast-tracked construction program for SDA.

In April 2019, the Public Advocate made a submission to the Queensland Parliamentary Inquiry into Aged Care, End-of-Life and Palliative Care and Voluntary Assisted Dying. The Public Advocate's submission suggested that the issue of younger people with disability residing in aged care facilities has significant implications for the Queensland Government.

Before a young person living in residential aged care can transition out to living in the community the health care supports that they require need to be identified and a model of care put into place to ensure this care is available. For many people with disability living in residential aged care, it is their complex health care needs that is the principal reason they reside in aged care.

The Public Advocate's submission explained that the NDIS does not fund the provision of what it considers to be mainstream health supports, which can include on-site care from registered nurses, monitoring and responding to seizures and other medical care such as respiratory checks for residents with respiratory and/or swallowing issues. Many young people with disability living long-term in health facilities and residential aged care require these types of care.

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[32] Department of Social Services, *Younger People in Residential Aged Care – Action Plan* (8 October 2019) Department of Social Services, 1 <https://www.dss.gov.au/disability-and-carers-programs-services-for-people-with-disability-younger-people-with-disability-in-residential-aged-care-initiative/younger-people-in-residential-aged-care-action-plan>.
[33] Summer Foundation, *NDIS report card: Outcomes for younger people in residential aged care June 2018*, Summer Foundation, 4 <https://www.summerfoundation.org.au/wp-content/uploads/2018/06/ndis-report-card-june-2018.pdf>.
[34] Ibid 2.
[35] Ibid.
[36] Ibid.

This can result in the situation where there may be no specialised health supports in place when young people are moved from residential aged care into community-based accommodation. Living without these necessary health supports means that people with very complex health conditions (including epilepsy, respiratory and circulatory system diseases, cerebral palsy and dysphagia) and intellectual and physical disabilities need to rely on mainstream health services (emergency, hospital, and general practitioners) to both monitor and manage their conditions, and respond in emergency situations.

While this may seem to be acceptable, the complex nature of the conditions with which many young people with disability live requires proactive and timely medical interventions using the services and skills of health professionals and specialists, rather than relying on disability support workers.

The Public Advocate encouraged the Queensland Government to urgently:
- ensure that individual health care plans are developed for Queenslanders with disability in care, especially those transitioning from residential aged care and Queensland Health facilities to community living arrangements;
- require that those plans are reviewed and updated annually;
- ensure that the person's health care needs, as identified in their plans, inform their disability service providers of the supports required to adequately meet their health care needs and inform their NDIS plans; and
- clarify and finally settle with the Australian Government the funding issues associated with the provision of necessary health supports for people with disability seeking to transition from residential aged care facilities and other health and disability facilities, so that they can live healthy lives in the community.

Forensic Disability Service

The FDS is a purpose-built, medium security, residential and treatment facility with the capacity to accommodate and provide care for up to 10 people who are subject to a Forensic Order (Disability) under the *Mental Health Act*. The service, which is established and operates under the *Forensic Disability Act 2011*, is managed by DCDSS and has been operating since July 2011.

The *Forensic Disability Act* and the FDS were established in response to concerns raised in separate reviews undertaken by Brendan Butler AM SC and the late Honourable William Carter QC identifying the need for a more appropriate model of care for people with intellectual disability or cognitive impairment who are found to be of unsound mind or unfit for trial.

The original aim of the FDS was to provide a specialised model of care for people with intellectual or cognitive impairment who were found unfit for trial by the Mental Health Court, which would offer them opportunities to complete programs to assist in their habilitation and rehabilitation, while protecting their human rights.

Forensic Disability Service system and *Forensic Disability Act 2011* review

During the reporting period, the Public Advocate participated in a confidential review of Queensland's forensic disability service system and the *Forensic Disability Act 2011* initiated by the DCDSS and co-chaired by that department and Queensland Health. The review resulted in the release of two reports, *Section 157: Review of the operation of the Forensic Disability Act, Final report*[37] and the related *Addressing Needs and Strengthening Services: Review of the Queensland Forensic Disability Service System.*[38]

One of the key recommendations of the *Addressing Needs and Strengthening Services* report (tabled in the Queensland Parliament) is that the forensic disability service system and the mental health system should be brought together within a single agency, under the auspices of Queensland Health. The report writers recommended that forensic disability should not be subsumed by mental health, but a division of forensic disability should remain to ensure that forensic disability expertise is retained and 'ring-fenced' within the system.[39]

In the view of the Public Advocate (and the disability sector more generally), the inclusion of the forensic disability service system under mental health services in Queensland Health would be a regressive step and would be inconsistent with the recommendations and vision of the Carter Report, which led to the original (albeit flawed) establishment of the FDS. The reason for the establishment of the FDS was that people with disability were being held in Authorised Mental Health Services as forensic patients and were not receiving appropriate care and treatment. A significant factor in the current failures of the forensic disability service system is that many people with disability on forensic orders, continue to be detained in Authorised Mental Health Services being managed by psychiatrists and other allied health professionals with an expertise in mental health and little, or no, knowledge or training in the treatment of people with disability.

The preferred view of the Public Advocate, is that if the forensic disability service system and the FDS are to be housed in a department other than DCDSS, it should be its own independent Disability division of Queensland Health with an equivalent management and governance structure to that in place for mental health services in Queensland, including a Chief Disability

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[37] The State of Queensland (Department of Communities, Disability Services and Seniors), *Section 157: Review of the operation of the Forensic Disability Act 2011 Final Report*, Queensland Government (Department of Communities, Disability Services and Seniors, <http://www.parliament.qld.gov.au/documents/tableOffice/TabledPapers/2018/5618T1581.pdf>.

[38] Ogloff, J. R. P., Ruffles, J., & Sullivan, D., *Addressing Needs and Strengthening Services: Review of the Queensland Forensic Disability Service System.* Centre for Forensic Behavioural Science, 2018 Swinburne University of Technology as cited in The State of Queensland (Department of Communities, Disability Services and Seniors), *Section 157: Review of the operation of the Forensic Disability Act 2011 Final Report*, Queensland Government (Department of Communities, Disability Services and Seniors, <http://www.parliament.qld.gov.au/documents/tableOffice/TabledPapers/2018/5618T1581.pdf>.

[39] Ibid.

Practitioner appointed at the same level as the Chief Psychiatrist, with similar roles and responsibilities across the forensic disability service system. The report contained 30 recommendations, many of which the Public Advocate supports, including time-limited orders detaining people to the FDS, and a less restrictive form of forensic order to promote transition of people with disability on forensic orders through the system by providing a 'step-down' option before revocation of the order entirely.

The Public Advocate awaits the Queensland Government's announcement of its intentions regarding the future of the FDS.

Data about clients of the Forensic Disability Service

Since opening in 2011, the FDS has been a focus of successive Public Advocates. Data is obtained from DCDSS each year regarding the number of clients entering and transitioning from the service, the profile of clients and the developmental, habilitation or rehabilitation programs in place for clients.

In 2016-17, eight of the original 10 clients admitted in 2011 were still detained in the service. One client had died while another had been transitioned into the community.[40] There were some positive developments in 2017-18, with four clients transitioned from the service. This meant that four of the original clients remained, while two new clients were detained to the service. This brought the total number of clients to six as at 30 June 2018.[41]

In 2018-19, three new clients were detained to the FDS and one was transitioned out of the service, bringing the total number of clients to eight as at 30 June 2019.[42] Three of the eight clients at the FDS have now been detained in the service for more than 5 years. One of these clients is, however, transitioning out of the service and currently resides outside of the service in a nearby location.[43]

It remains of concern that Aboriginal and/or Torres Strait Islander people are overrepresented at the FDS. In 2018-19, three of the eight clients in the FDS were Aboriginal or Torres Strait Islander.[44]

Ongoing concerns about the treatment of FDS clients

The Public Advocate has continued to raise concerns about the service and its restrictive and segregated approach to the support and care of people with disability under a Forensic Order. As reported in the Public Advocate's *Annual Report 2017-18*, throughout that year the Public Advocate met with various senior staff at DCDSS to advocate on a systemic level to improve the treatment, conditions and supports for clients detained at the service.

The Public Advocate has been particularly concerned about the treatment of at least one FDS client who has been subject to an extraordinary regime of ongoing seclusion since being transferred into the service more than six years ago. Concerns about this client's treatment have been consistently raised over several years by the Public Guardian, with no apparent change to the client's regime.

The *Forensic Disability Act* only permits the seclusion of a FDS client in limited circumstances, namely, if a senior practitioner:

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[40] The Public Advocate, *Annual Report 2016-17* (10 October 2019) Public Advocate, 9 <https://www.justice.qld.gov.au/public-advocate/about-us/performance>.

[41] Letter from Ms Vanda Wieczorkowski, Director of Forensic Disability, to Ms Mary Burgess, Public Advocate, 27 July 2018.

[42] Letter from Ms Karen Nankervis, Director of Forensic Disability, to Ms Mary Burgess, Public Advocate, 4 September 2019.

[43] Ibid.

[44] Ibid.

> … is reasonably satisfied—
>
> (a) the seclusion is necessary to protect the client or other persons from imminent physical harm; and
> (b) there is no less restrictive way to protect the client's health and safety or to protect others.[45]

The provisions of the *Forensic Disability Act* are not intended to permit ongoing seclusion as a standard management regime for any client of the FDS. Section 63 requires the recording of the time the client was placed in seclusion, the name of the practitioner that placed the client in seclusion, and the time the client was released from seclusion.[46] This clearly indicates that the intention of the legislation is that seclusion should be an exceptional condition for a FDS client rather than the norm. However, in relation to this particular client, it appears that seclusion has been used in a continuous way as a form of behaviour management since the client arrived at the FDS.

In the Public Advocate's view, there can be no reasonable excuse for what amounts to the prolonged and unlawful treatment of a person with disability in a government-operated facility. These circumstances are particularly concerning when it is well-recognised that the use of seclusion and isolation can cause profound negative psychological impacts for those subject to such treatment. It is difficult to understand how seclusion can be justified as a standard regime of treatment in a government-operated service charged with providing rehabilitation programs to its clients with disability. Considering the length of time the client has been subject to this regime of treatment, it is likely that, rather than being rehabilitated, they have suffered harm.

During the reporting period, the Queensland Ombudsman announced an investigation into the detention of people at the FDS. The investigation was announced in an environment where the DCDSS had been aware for some time about the concerns of a range of agencies about the treatment of clients in the FDS and the lengthy periods of their detention at the service.

The Public Advocate looks forward to the Queensland Ombudsman's investigation report. It is hoped, as the Queensland Government takes steps to implement the recommendations of the review of the forensic disability service system and the *Forensic Disability Act*, as well as the Queensland Ombudsman's report, that it will take genuine action to address the problems with the operation of the FDS, and the treatment of its clients. This should include holding those officers responsible for the mistreatment of FDS clients to account, as well as those who were aware of the mistreatment, and taking the decision to ultimately close the service if that presents as the most appropriate course of action.

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[45] *Forensic Disability Act 2011* (Qld) s 61.
[46] The requirements for the recording of the use of restrictive practices or other 'behaviour controls' is outlined in the *Forensic Disability Regulation 2011*, section 3.

Disability advocacy

DCDSS commenced a review of the State Disability Advocacy Strategy in late 2018. The Public Advocate made a submission that highlighted the importance of advocacy as a process to help inform people with disability about their rights, as well as providing assistance for them to enforce their rights and enjoy greater social inclusion.

The submission also noted that the large number of Queenslanders transitioning into the NDIS in 2018-19 and beyond had placed immense pressure on existing advocacy resources. The submission acknowledged that demand for advocacy supports for people seeking to engage with the NDIS may potentially decline over the next few years. However, there will still be a significant proportion of Queenslanders with disability, whether or not they are supported by the NDIS, who will require advocacy support to address issues arising from their dealings with essential state-based systems, including health, housing, transport, education, child safety and justice.

The *Queensland Strategy – Disability Advocacy,* for people with impaired decision-making capacity, was released by DCDSS in July 2019.[47] The framework outlined in the strategy underpins a sound approach to establishing the fundamentals of a comprehensive and effective disability advocacy strategy that will support Queenslanders with impaired decision-making capacity to access services and support and to make complaints about their treatment and services. However, at this point there is no funding committed to delivering disability advocacy services beyond 2021.

In particular, DCDSS has committed to:
- improving the availability of disability advocacy;
- strengthening advocacy for people from Aboriginal and Torres Strait Islander communities and from culturally and linguistically diverse backgrounds;
- establishing a service delivery framework for disability advocacy, including complaints management processes;
- developing clear and consistent guidelines for funding, service standards and performance reporting for disability advocacy services;
- using data to identify trends and issues; and
- engaging with stakeholders to understand people's experiences and improve systems.[48]

The strategy will be monitored by the Queensland Disability Advisory Council and reviewed and updated by DCDSS following advice from the Queenslanders with Disability Network and the Queensland Disability Advisory Council.

The Public Advocate looks forward to contributing to the refinement and implementation of the strategy in 2019-20.

Brisbane City Council Inclusion Plan

In February 2019, the Public Advocate made a submission to Brisbane City Council regarding the *A City of Everyone: Draft Inclusive Brisbane Plan 2019-29*. This submission focussed on inclusive employment strategies, access to public transport services, the participation of people with disability in consultation on local matters, and plan implementation monitoring. The submission included a suggestion for the Brisbane City Council to consider monitoring the use of its services utilising the Standardised Disability Flag developed by the Australian Institute of Health and Welfare in 2016.

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[47] Queensland Government, *Queensland Strategy – Disability Advocacy* (23 July 2019) Queensland Government Publications <https://publications.qld.gov.au/dataset/queensland-strategy-disability-advocacy-2019/resource/8c3a9385-0e9a-4bff-a7d5-df69c1743f20>.

[48] Ibid.

Contribution to whole-of-government initiatives

Transition to the National Disability Insurance Scheme

The Public Advocate has continued to contribute to the Queensland Government processes associated with implementing the structural and legislative changes required to implement the NDIS, as well as ensuring the provision of appropriate safeguards for people not eligible for supports under the NDIS who previously have received State-based support.

In 2018-19, the Public Advocate continued as a member of the DJAG NDIS Transition Working Group, which provides whole-of-department oversight in relation to the NDIS transition.

At this group, the Public Advocate has noted the issues highlighted in this report as continuing risks and challenges associated with the NDIS roll out and its consequent impact on the supports and safeguards available for Queenslanders with impaired decision-making capacity.

All Abilities Queensland

All Abilities Queensland: Opportunities for All, is the Queensland Government's *Disability Plan for 2017-20*. It represents a commitment from the Queensland Government to uphold the intent of the National Disability Strategy 2010-20 and build an inclusive community that enables people with disability to fulfil their potential as equal citizens.[49]

In 2018-19, the Public Advocate continued to contribute to the following actions in the DJAG Disability Service Plan:

- Maintaining a strong voice for Queenslanders with impaired decision-making capacity;
- Placing a focus on issues regarding elder abuse across all cultures and communities including law reform; and
- Develop strategic relationships with private and public stakeholders to protect the rights of vulnerable citizens, particularly those in regional and remote areas.

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[49] Queensland Government, *All Abilities Queensland: Opportunities for All, State Disability Plan 2017-2020*, All Abilities Queensland <https://www.communities.qld.gov.au/campaign/all-abilities-queensland>.

Older people

The Public Advocate's activities in 2018-19 have been primarily focused on advocacy to protect the rights and interests of older Queenslanders experiencing impaired decision-making capacity. Over the reporting period, widespread concerns associated with the structure, management and operation of the aged care sector in Australia culminated in the announcement of a Royal Commission into Aged Care Quality and Safety, which has dominated media and public discussion in this space since its commencement.

Similar to the disability sector, it is expected that change will be a continuing feature of the aged care sector for the short to medium term. It will be important to ensure that the changes that are delivered in response to the various reviews and inquiries are effective in addressing the key challenges and concerns of older people and introduce appropriate safeguards and systems of accountability, which will uphold their human rights and promote an inclusive community.

National Plan to respond to the abuse of older Australians

On 19 March 2019, the Australian Government launched the National Plan to respond to the Abuse of Older Australians (Elder Abuse) 2019-2023[50]. The Plan was developed in collaboration with state and territory governments and includes five key priority areas:

1. Enhancing our understanding of the abuse of older Australians;
2. Improving community awareness and access to information;
3. Strengthening service responses;
4. Planning for future decision making; and
5. Strengthening safeguards for vulnerable older adults.[51]

The Public Advocate welcomed the announcement of funding for two Queensland projects under the National Plan: a health-justice partnership program operated by Caxton Legal Centre in collaboration with Metro South Health and Hospital Service; and a case management and medication program operated by Relationships Australia (Queensland).

In 2018-19, the Public Advocate contributed to the National Plan by providing input into two AGAC projects:

- development of a national best practice resource to inform people about enduring appointments (i.e. making an enduring power of attorney or an advance health directive) and the rights and responsibilities of parties to enduring documents; and
- Tribunal guidelines to maximize the participation of the person in guardianship and/or administration proceedings.

The Public Advocate has contributed to the following actions that are included in the Queensland implementation strategy for the national plan:

- Supporting the Australian Research Council Linkage Project on 'Effective Decision Making Support for People with Cognitive Disability' led by La Trobe University.
- Advocating on behalf of older persons with impaired capacity through consultation with key stakeholders and participating on various committees, reference groups, forums and conferences that relate to the abuse of older Australians.
- Advocating for adequate long-term funding for advocacy supports for older people, particularly those who experience impaired decision-making capacity.
- Advocating for improved policies, service standards and care of older Australians with impaired decision-making capacity.
- Continuing to monitor the legislative, policy and practice aspects of Queensland's guardianship and administration system, and contribute to positive system changes.

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[50] Council of Attorneys-General, *National Plan to respond to the Abuse of Older Australians (Elder Abuse) 2019-2023*, Australian Government (Attorney-General's Department) <https://www.ag.gov.au/RightsAndProtections/protecting-the-rights-of-older-australians/Pages/default.aspx>.

[51] Ibid 8.

Royal Commission into Aged Care Quality and Safety

The Royal Commission into Aged Care Quality and Safety conducted its first hearings in February 2019, and has been moving across the country, convening hearings and forums, since that time. The evidence provided by witnesses to the Royal Commission has exposed significant systemic issues across the sector, many of which are consistent with issues that have been pursued by the Public Advocate for some time.

In May 2019, the Public Advocate provided a detailed submission to the Royal Commission. This detailed submission addressed:

- the unregulated use of restrictive practices in residential aged care;
- a lack of effective complaint and investigation mechanisms for aged care residents;
- end-of-life planning and care;
- the aged care workforce; and
- younger people living in residential aged care.[52]

Not all of these issues are discussed in this Annual Report. The Public Advocate's submission to the Royal Commission can be accessed at https://www.justice.qld.gov.au/public-advocate/submissions.

The suggestions included in the Public Advocate's submission were about more than just superficial policy change. They attempt to help drive a fundamental shift in the way the Australian community thinks about, and treats, people as they age. The Public Advocate advocated that the process of ageing should not be associated with a degradation of human rights, facilitated by a system where care is delivered under a regime encumbered by inadequate standards, oversight and regulation.

Use of restrictive practices in aged care

The unregulated use of restrictive practices in residential aged care has been a focus of the Public Advocate for a number of years. Restrictive practices can include detention, seclusion, physical, chemical and mechanical restraint and electronic forms of restraint and monitoring such as tracking bracelets, camera surveillance or restrictions on the use of media devices. These practices are being used in aged care settings despite research indicating their use may result in negative physical and psychological impacts on the person being restrained and may also constitute a breach of law and human rights.

The Royal Commission has heard harrowing stories of aged care residents being physically restrained for long periods and inappropriately prescribed anti-psychotics and benzodiazepines that are heavily sedating them and increasing the risk of falls and other health complications.

The Public Advocate's submission to the Royal Commission included detailed information about:

- the illegal use of restrictive practices and the related breaches of human and legal rights;
- the precarious legal situation in which the illegal use of restrictive practices places residential aged care providers and their staff:
- how Australia lags behind comparable Western countries (e.g. New Zealand, the United Kingdom, Scotland, the United States of America and most provinces of Canada) in terms of having proper legal frameworks regulating the use of restrictive practices in residential aged care; and
- best practice case studies that illustrate how the use of innovative and low cost programs and activities can significantly reduce the need for restraint among aged care residents with challenging behaviours.

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[52] Public Advocate, Submission to the Royal Commission into Aged Care Quality and Safety, May 2019. Available online at https://www.justice.qld.gov.au/public-advocate/submissions.

In January 2019, the Public Advocate appeared on the ABC's 7.30 program to discuss issues associated with the use of unregulated restrictive practices in residential aged care. Since that time, numerous articles have been published, supported by media releases and interviews by the Public Advocate, as well as a range of medical experts and advocates across the country.

As a result of this continuing pressure, the then Commonwealth Minister for Indigenous Health and Minister for Senior Australians and Aged Care, the Honourable Ken Wyatt AM MP, committed to improve the regulation of chemical and physical restraint in residential aged care facilities.[53]

On 3 April 2019, the Minister released the *Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019*.[54] The Principles introduced a new approach to restrictive practices in aged care that appears to rely on a process of consent for physical restraint and notification and/or consent for the use of chemical restraint. Consent and/or notification is to be provided by or to the resident, or where the resident has lost capacity, by or to the resident's representative. There is an obvious absence of obligations on aged care providers to explain the purpose of the restraint, for how long it will be used, or what type of positive behaviour supports will be employed to reduce or eliminate the need for the restraint in the future.

There are a number of key features absent from the proposed new restraints scheme:
- There is no provision for the appointment of a formal independent decision-maker who is at arms-length from the provision of care to the person subject to the restrictive practice.
- There is no appeal process.
- There is no requirement that the use of restrictive practices be regularly reviewed.
- There is no requirement that providers develop a behaviour support plan to guide the care provided to the person and ensure the focus is on reducing and eliminating the use of restrictive practices.
- There is no requirement that the restrictive practices be applied for the shortest time possible.
- There is no requirement that the restrictive practices be proportionate to the risk of harm.
- The regime only requires that the consumer pose 'a risk of harm' which is a much lower threshold than the Australian Law Reform Commission's recommendation that restrictive practices only be used to 'prevent serious physical harm'.[55]

It is concerning that the proposed regime allows a doctor (commonly a general practitioner), nurse practitioner or registered nurse to make decisions in relation to the use of restrictive practices, when most of these health practitioners do not have any formal training or recognised specialty in the provision of clinical aged care, the management of dementia or positive behaviour support.

This concern is further compounded by the fact that many health practitioners making these decisions also have an interest in the outcome of the decision, in terms of the management of the resident, the workloads of staff and the operation of the facility (because they also work there or provide services to the residents through an arrangement with the service provider). When people in these positions are empowered to make decisions to prescribe medication to 'manage' residents who are displaying challenging behaviours, their decisions will necessarily be influenced by considerations other than the rights of the residents and the immediate risk of harm to them or others. Those other considerations may include the views of management, the availability/numbers of staff and their skills in dealing with challenging residents, as well as convenience.

When decisions are being made to use chemical or other restraints on aged care residents by people who are not sufficiently independent of the provision of services, or trained in this type of decision-making, there is a risk that decisions to use restrictive practices may give too much weight

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[53] Ken Wyatt AM MP, Minister for Indigenous Health, Senior Australians and Aged Care, 'Aged Care Restraint Regulations to Protect Senior Australians' (media release, 17 January 2019).

[54] Ken Wyatt AM MP, Minister for Indigenous Health, Senior Australians and Aged Care) 'Stronger Restraint Regulations to Protect Senior Australians' (media release, 30 March 2019).

[55] Public Advocate (Qld), Submission No 5 to Parliamentary Joint Committee on Human Rights, *Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019,* August 2019. Available online at https://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Human_Rights/QualityCareAmendment/Submissions.

to certain considerations or may take other, irrelevant, considerations into account, which will ultimately affect the quality and validity of the decision.

Other key legal issues that arise from the proposed new *Quality of Care Principles 2014* (Cth) is that they only require the aged care provider to obtain 'the informed consent of the consumer or the consumer's representative' to the use of restraint.[56] Further, the way the Principles are drafted, suggests consent is not required in relation to the use of chemical restraint, apparently on the basis that it is a 'clinical' decision.

The law is unclear about whether a person's guardian or formal decision-maker can consent to the use of restrictive practices on a person for whom they are appointed.

> … absent specific legislative authorisation either through restrictive practices or coercive powers provisions in the legislation, questions remain about authorising restrictive practices through the guardianship system. This is despite the apparent widespread reliance on it, including with some apparent endorsement of this position by guardianship bodies.[57]

It is concerning that the Australian Government is proposing an approach to correct the current inadequacies of the law around the use of restrictive practices in residential aged care that relies on the consent of guardians and other substitute decision-makers when the law is uncertain about whether guardians can lawfully consent to these practices. Instead of providing legal clarity to protect the rights and interests of aged care consumers and those who would be giving consent to restrictive practices, the new changes to chemical and physical restraint only raise further legal questions and leave residents, substitute decision-makers and staff in a legal limbo.

The problems associated with representatives' consent to the use of restrictive practices is compounded by the very informal 'representation' arrangements that are provided for under the *Aged Care Act 1997* (Cth). Under section 5 of the *Quality of Care Principles,* other than under an enduring power of attorney or guardianship appointment, the following representative arrangements can be made:

- the consumer can nominate 'a person to be told about matters affecting the consumer';
- a person can nominate themselves to be 'a person to be told about matters affecting a consumer' and the approved provider 'is satisfied the person has a connection with the consumer' and is concerned for that person's safety, health and well-being;
- the person can be 'a partner, close relation or other relative of the consumer'; or
- it can be as relaxed as 'the person represents the consumer in dealings with the approved provider.'[58]

It is unclear who can make the determination that the person can be regarded as the consumers' representative. However, again it seems wholly inappropriate that a person accepted as a 'representative' in most of the circumstances outlined under section 5 of the Principles, should also be the authority for providers to physically restrain a person in aged care or be the person notified about the use of chemical restraint. It is difficult to envisage how most ordinary people trying to fulfil such a role could provide 'informed consent' to the use of restraint on the person they are supporting. Most members of the public confronted with such a decision would not know what questions to ask and would have great difficulty challenging the proposed use of the restrictive practice. Quite rightly, they would feel they did not have enough knowledge or authority to question or challenge the aged care provider or its medical or nursing staff.

Consent and the use of chemical restraint

The 'use of chemical restraint' provisions under the *Quality of Care Principles* also raises significant concerns. The definition of 'chemical restraint' is deficient because it does not require that the behaviour that the chemical restraint is administered to influence or control, is causing harm to the person or others,

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[56] *Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019* (Cth) s 15F(1)(e).

[57] Kim Chandler, Ben White and Lindy Willmott, 'What role for adult guardianship in authorising restrictive practices?' (2017), *Monash University Law Review,* (Vol 43, No 2) p 496.

[58] *Quality of Care Principles 2014* (Cth) s 5.

These problems are further compounded by the approach to consent in relation to chemical restraint. Section 15G(1)(c) of the recent amendment to the *Quality of Care Principles* proposes that the consumer's representative be informed 'before the restraint is used if it is practicable to do so' [emphasis added].[59] Such an approach is not consistent with usual medical practice about obtaining consent to treatment. It is unlawful to administer any medical treatment to a person without their consent (or the consent of their substitute decision-maker), except in an emergency.

In a document prepared by the Aged Care Minister's Aged Care Clinical Advisory Committee titled, *Reducing the inappropriate use of chemical restraints in residential aged care: Options Paper* (Cth.1007.1007.03) filed with the Royal Commission into Aged Care Quality and Safety and posted on the Royal Commission website, the Advisory Committee states:

> The Committee agreed that there was clearly a problem with the overuse of antipsychotic medications and benzodiazepines in RAC [residential aged care], noting that a small proportion (estimated at about 10%) of the current use was clearly justified in the treatment of (often pre-existing) mental illness and some rare, acutely psychotic, manifestations of dementia. Most of the inappropriate prescribing was in the context of behavioural and psychological symptoms of dementia (BPSD) … They expressed the strong view that any prescription of these drugs for BPSD should be limited, closely monitored by a multidisciplinary team and decreased or discontinued whenever possible.[60]

The Advisory Committee Options Paper also noted that 'formal or implied consent is currently not commonly obtained by prescribing practitioners'. Again, as noted above, the provision of medical treatment without the informed consent of the patient or the patient's decision-maker is unlawful unless in an emergency.

The approach to consent to the use of chemical restraint in aged care is inconsistent with the usual definition of informed consent used in the health sector and contained in the National Safety and Quality Health Service Standards:

> Informed consent: a process of communication between a patient and clinician about options for treatment, care processes or potential outcomes. This communication results in the patient's authorisation or agreement to undergo a specific intervention or participate in planned care. The communication should ensure that the patient has an understanding of the care they will receive, all the available options and the expected outcomes, including success rates and side effects for each option.[61]

Clearly, aged care residents have not been receiving medical care and treatment, including the administration of medication as chemical restraint, in accordance with this definition of medical treatment. Not only is it clear that medical practitioners prescribing these medications to chemically restrain people in residential aged care have not been having these types of conversations with the resident/patient or their decision-makers, it would appear on the advice of the Aged Care Minister's Clinical Advisory Committee and the evidence before the Royal Commission, that medical practitioners are routinely prescribing antipsychotics and benzodiazepines without obtaining any consent, formal or implied.

The concern with the proposed new chemical restraint provisions under section 15G of the *Quality of Care Principles*, is that they appear to be suggesting to medical practitioners that they can prescribe and administer medications without informed consent and transfer all responsibility for the notification of residents or their representatives to aged care providers, as well as responsibility for documenting the basis for the treatment and monitoring its effects on the residents. This approach is dangerous and inappropriate and does not hold medical practitioners properly and

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[59] *Quality of Care Principles 2014* (Cth) s 15G(1)(c).

[60] Department of Health Clinical Advisory Committee, *Reducing the inappropriate use of chemical restraints in residential aged care: Options Paper* (Cth,1007.1007.03) filed with the Royal Commission into Aged Care Quality and Safety, 1.

[61] Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards* (2019) Australian Commission on Safety and Quality in Health Care, 10 <https://www.safetyandquality.gov.au/standards/nsqhs-standards>.

professionally accountable for their prescribing practices and the treatment of their elderly patients in residential aged care.

These restrictive practice provisions amount to clear breaches of the human rights of people in residential aged care, including their rights to dignity and respect and quality health care.

We all have the fundamental right to be free from physical restrictions and to bodily integrity. These rights do not diminish with age or infirmity. The Australian community should be extremely concerned about the poor treatment and practices that we have allowed to proliferate in parts of the aged care sector. These recent amendments are likely to exacerbate these problems. Considering what we now know about the problem of physical and chemical restraint in aged care, it is reasonable to anticipate that the recent amendments to the Aged Care Quality Principles in relation to chemical restraint are unlikely to achieve the stated objective of reducing chemical restraint and may actually result in an increase in inappropriate prescribing practices and harm to residents.

National Aged Care Quality Indicator Program

The resource manual accompanying the National Aged Care Quality Indicator Program has not been updated to reflect the recent amendment to the *Quality of Care Principles* associated with chemical restraint. Accordingly, the resource manual provides no guidance on this issue. However, it provides considerable detail in relation to the use of physical restraint, what constitutes physical restraint and how to count instances of it in 'Chapter 6 Quality Indicator 2: Use of physical restraint'.[62]

Chapter 6 of the resource manual notes that there are a number of adverse clinical events associated with physical restraint, including death, mental health decline, depression, social isolation, development of pressure injuries, falls, confusion, aggression and pain. The manual also provides additional key facts and other useful, but confusing information for aged care staff looking for guidance about how to make a decision about using physical restraint.[63]

Those key facts include the following statements:

- Physical restraint is an infringement of the individual's right to freedom, dignity and autonomy.
- A family member and legal representatives do not have the legal right to request that a resident be restrained.
- There are many reasons why physical restraint is used but there is no evidence that demonstrates any benefit of its use to aged care residents.
- The evidence indicates that restraint does not prevent falls or fall-related injuries and is likely to exacerbate behaviours.
- A restraint free environment is the recommended standard of care.[64]

A concerning aspect of the *Quality Indicator Program Resource Manual* regarding its handling of the use of physical restraint is that it requires providers to assess every resident for physical restraint on a quarterly basis. It is a matter of great concern that there is an assumption that all aged care residents may be subject to this treatment at some point during their care rather than the use of restraint being considered the exception and a last resort approach to managing challenging behaviours. Such an approach is inconsistent with a least restrictive approach to the care of residents and is symptomatic of a lack of respect for the legal and human rights of consumers in the residential aged care sector. Again, it is difficult to understand why the manual would require that every resident be assessed for physical restraint while acknowledging that it is an infringement of their right to freedom, dignity and autonomy, that the evidence indicates it does not prevent falls or fall-related injuries and is likely to exacerbate behaviours.

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[62] Department of Health (Australian Government), *National Aged Care Mandatory Quality Indicator Program Manual 1.0* (24 June 2019) Department of Health, Australian Government <https://agedcare.health.gov.au/quality/quality-indicators/national-aged-care-mandatory-quality-indicator-program-manual-10>.

[63] Ibid 6.

[64] Ibid 56.

An equally concerning aspect of the relevant chapter of the resources manual dealing with the use of physical restraint is that it contains no guidance for aged care staff or clinicians about the relevant considerations when making a decision about the use of physical restraint on a resident. This is a significant and dangerous oversight. It is unacceptable that a resource manual held out as a 'Handbook for residential aged care facilities' providing them with 'a set of meaningful and measureable QIs [quality indicators] to assist in monitoring and improving important aspects related to quality of care'[65] provides no specific guidance or quality indicators relating to the decision-making of care providers using physical restraint on their residents. The relevant chapter of the resource manual also makes no mention of the *Decision-making tool: supporting a restraint free environment in residential aged care*[66] which has been held out by the Aged Care Minister as a significant aspect of the government's response to public concerns about the use of restrictive practices.

The physical restraint chapter of the manual is supplemented by further material contained in 'Appendix 5 – Quality Indicator 2: Use of physical restraint'.[67] The appendix informs the reader that 'the reasons for the decision to restrain and the process by which the decision was reached should be documented, as those making the decision are legally accountable for the decisions and their consequences'. This effectively amounts to an admission that the use of restraint is not lawful (without proper informed consent) and will potentially expose staff at residential aged care facilities to legal risks.

Effective complaint and investigation mechanisms

A particularly important issue raised in the Public Advocate's submission to the Royal Commission relates to the complaint management framework within the aged care sector.

The CRPD places responsibility on Australia to take appropriate measures to ensure the accessibility of services and systems to all people (including those with aged-related impairments) and provide appropriate assistance and support.[68] Further, the CRPD requires that States ensure that people receive the support they need to exercise their legal capacity and make decisions for themselves.[69] This reasonably includes assisting people to enforce their rights as consumers and to exercise choice to change service providers when they are dissatisfied with their care and treatment. Accordingly, all complaints and consumer protection mechanisms in the aged care sector must uphold the principles of the CRPD and, to the greatest extent possible, support older people to exercise their autonomy and legal capacity.

The Australian Government funds the National Aged Care Advocacy Program, which provides free, independent and confidential advocacy support and information to older people receiving, or seeking, Commonwealth-funded aged care services. It is critical that the National Aged Care Advocacy Program is adequately funded to meet current and future demand for aged care advocacy services. Insufficient funding could become a significant barrier to aged care consumers being able to seek redress for mistreatment and abuse and to access consumer protection mechanisms.

The Commonwealth-funded aged care community visitor scheme also has potential to reduce the incidence of the abuse and neglect of aged care residents. At present, the Commonwealth scheme links volunteer community members with aged care residents for the purpose of companionship and friendship.[70] It is unclear whether the volunteers have the skills or inclination to identify and address issues relating to the mistreatment of residents appropriately and effectively.

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[65] Ibid 6.

[66] Ibid 56.

[67] Ibid 59.

[68] *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007 [2008] ATS 12 (entered into force 3 May 2008) ('*Convention on the Rights of Persons with Disabilities*') art 9.

[69] Ibid art 12.

[70] *Aged Care Act 1997* (Cth) ch 5 pt 5.6 div 82 s 82-1(1)(a)-(c).

In contrast, the Queensland Community Visitor Program for adults with impaired decision-making capacity employs community visitors to undertake regular visits to specified accommodation sites for the purpose of protecting the rights and interests of residents.[71] Queensland community visitors have legislative authority to lodge and resolve complaints on behalf of residents with impaired decision-making capacity, talk with staff and residents to clarify issues and concerns, and review documentation and programs relating to their support and care.[72] Community visitors can lodge reports with the OPG[73] who must provide the report to the service provider for follow-up action.[74]

The Public Advocate has suggested the establishment of an Australian Government-funded aged care community visitor scheme based on the community visitor program model operating under the Queensland Public Guardian. Such a program, along with an expanded National Aged Care Advocacy Program, would form a significant part of a comprehensive government response to abuse in residential and community-based aged care services.

Aged care workforce

The number and mix of appropriate skills, qualifications and experience within the aged care workforce has a direct impact on the quality of care aged care residents receive. Calls for the development and implementation of staffing ratios within aged care facilities, similar to those used in childcare centres, are now being made by various peak bodies, including the Australian Nursing and Midwifery Federation, the Australian Medical Association and various politicians and advocates.

In the submission to the Royal Commission, the Public Advocate proposed that the Aged Care Quality and Safety Commission be directed by the Australian Government to undertake further research and feasibility work, to develop a staff ratio and skill/experience mix for residential aged care facilities based on the Aged Care Funding Instrument and the level of need of residents. The Public Advocate also proposed the Australian Government require residential aged care providers to publish information about the staff and skill mix the facility provides for the profile of aged care residents, so that consumers can make more informed choices about what services best suit their needs. Uniform standards for the provision of this information may need to be set to ensure the information published by providers is accurate and that aged care consumers and their supporters can make ready comparisons between facilities.

The House of Representatives Standing Committee on Health, Aged Care and Sport released an Advisory Report in December 2018 on the *Aged Care Amendment (Staffing Ratio Disclosure) Bill 2018 (Cth)* recommending the passing of an amendment which will require the Department of Health to publish staffing ratio data for residential aged care facilities in a form that allows consumers to consider resident levels of need when comparing facilities.[75]

The Committee also reiterated recommendations made in its report on the *Inquiry into the Quality of Care in Residential Aged Care Facilities in Australia*, including that the Australian Government:

- legislate to ensure that residential aged care facilities provide for a minimum of one Registered Nurse to be on site at all times; and
- specifically monitor and report on the correlation between standards of care (including complaints and findings of elder abuse) and staffing mixes to guide further decisions in relation to staffing requirements.[76]

On 10 April 2019, the Senate Community Affairs References Committee released its Final report into the effectiveness of the Aged Care Quality Assessment and accreditation framework. Among other matters, the Committee recommended:

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[71] *Public Guardian Act 2014* (Qld) s 40(1).

[72] Ibid s 41(2)-(3), s 44(1).

[73] *Public Guardian Act 2014* (Qld) s 47(1).

[74] Ibid s 47(3).

[75] Standing Committee on Health, Aged Care and Sport, Parliament of Australia, *Advisory Report on the Aged Care Amendment (Staffing Ratio Disclosure) Bill 2018* (2018) xiii.

[76] Ibid xiv.

> … that the Aged Care Quality and Safety Commission work collaboratively with the Department of Health, the Australian Commission on Safety and Quality in Health Care and aged care stakeholders to develop benchmarks for staffing levels and skills mix, which includes the requirement to roster a Registered Nurse on duty at all times, to assist residential aged care providers in staff planning and aged care assessors in regulating safe and appropriate staffing.[77]

The debate surrounding the development and implementation of staffing ratios in residential aged care does, initially, look like a simple one – if you want residents to receive a good standard of care you need to make sure that there are sufficient staff to provide that standard of care. The fewer staff you have, the lower the standard of care and vice versa.

However, if thought is given to staffing ratios in terms of resident outcomes, namely the quality of care they receive, the application of ratios may oversimplify the issues involved.

The Productivity Commission considered the issue of quality care in residential aged care facilities in its report *Caring for Older Australians*. In this report, the Commission recognised that defining and measuring the quality of care and support in aged care facilities is not straightforward.[78] The Commission did, however, identify some common themes associated with quality care including effectiveness, safety, efficiency and the experience of care consumers.[79]

The Commission concluded that an across-the-board simple staffing ratio is a 'relatively blunt instrument for ensuring quality care', particularly given that the care resident profile of every facility will be ever changing.[80]

Instead, the Commission suggested that there could be a more direct link between the funding provided for the complex health needs of aged care residents and how much care providers allocate to health care funding, including wages for nurses, over a period of time. They suggested that aged care providers should be required to make available information about the staff and skill mix for the profile of aged care residents, so that consumers could make more informed choices about what services best suit their needs.[81] Such an approach will also encourage aged care providers to aspire to higher levels and quality of care as a point of differentiation, rather than only focusing on meeting minimum standards that might be set by a minimum staff-to-resident ratio. Uniform standards for the provision of this information may need to be set to ensure the information provided is accurate and that aged care consumers and their supporters can make ready comparisons between facilities.

This position has been echoed more recently by The Council on the Ageing. In its position paper released in late 2018 – *Keep fixing Australia's aged care system … taking the next steps in tandem with the Royal Commission,*[82] The Council on the Ageing took the view that mandated staffing ratios are not necessarily 'the answer' to issues around quality of care in aged care facilities and that, on their own, will not reduce or resolve whatever quality or safety concerns or gaps a facility may have.

The Council on the Ageing, in calling for 'the right staffing levels and skill mixes' for particular facilities, supports a report commissioned by the Australian Nursing and Midwifery Federation prepared by Flinders University, which proposed a skill mix of 30 per cent registered nurses, 20 per

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[77] Community Affairs References Committee, Parliament of Australia, *Effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised:* Final report (2019) xiv.

[78] Productivity Commission, *Caring for Older Australians: Productivity Commission Inquiry Report Volume 2, No 53 (*2011) 185.

[79] Ibid.

[80] Ibid 206.

[81] Ibid.

[82] Council of the Ageing Australia*, Position Paper: Keep fixing Australia's aged care system,… taking the next steps in tandem with the Royal Commission* (2019) Council of the Ageing Australia <https://www.cota.org.au/publication/keep-fixing-australias-aged-care-system/>.

cent enrolled nurses and 50 per cent personal care workers in aged care facilities.[83] This skill mix approach has, however, also been questioned.

An alternative approach may lie in the development of a staffing ratio or mix that is directly and legislatively related to the care levels provided at each aged care facility, based on the *Aged Care Funding Instrument*. The instrument assesses each resident of an aged care facility, focusing on the main areas that discriminate core care needs. It then assesses core care needs as a basis for allocating funding. Given that the instrument provides for high, medium and low rating scores for each resident in three main areas (activities of daily living, behaviour, and complex health care) it may be possible to link staffing ratios to actual care requirements that are already documented in a cost and time effective way. Of course, as new residents enter the facility the assessment levels will change and staffing ratios will also need to be altered, however there are examples in other areas of health service provision (e.g. operating theatres in hospitals) where rostering based on care needs is undertaken, providing evidence that such an approach to staffing may be effective.

A staffing ratio system of this nature would require further research and feasibility work, including the identification of the skill mix required for each level of care. However it would potentially provide an additional layer of protection for residents that is transparent and accountable to government (i.e. directly linked to the funding instrument and funding model for aged care) and would be consistent across all aged care facilities. It could also be used to set the minimum standards that need to be met, thereby encouraging residential aged care providers to adopt higher staffing ratios and skill mixes than the minimum as a point of differentiation in the market.

Palliative care for people with dementia

The Public Advocate's submission to the Royal Commission argued for the Australian Government to incorporate the *Principles for Palliative and End-of-Life Care in Residential Aged Care*[84] into the *Quality of Care Principles* for aged care, and require that compliance with these standards be a component of the assessment for accreditation of aged care providers.

Palliative and end-of-life care has been the subject of numerous reports and inquiries over the last 15 years in Australia, including the Senate's Community Affairs Reference Committee's inquiry into *Palliative Care in Australia*[85] completed in 2012 and the Productivity Commission's Inquiry Report, *Introducing competition and informed user choice into human services: reforms to human services,*[86] which was completed in late 2017 and included a chapter on end-of-life care.

The Productivity Commission report acknowledged that end-of-life and palliative care is the core business of residential aged care and that the quality of end-of-life care provided in Australian aged care facilities does not meet the needs of those who require such support.[87]

The right to palliative care is also recognised by both the United Nations and The World Health Organisation. The World Health Organisation has released a set of recommendations as a guide to the minimum standards expected by the international community.[88]

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[83] Willis, E., Price, K., Bonner, R., Henderson, J., Gibson, T., Hurley, J., Blackman, I., Toffoli, L and Currie, T. (2016) *Meeting residents' care needs: A study of the requirement for nursing and personal care staff*. Australian Nursing and Midwifery Federation.

[84] Palliative Care Australia, Alzheimer's Australia, Council of the Aging Australia, *Principles for Palliative and End-of-Life Care in Residential Aged Care,* Palliative Care Australia, <https://palliativecare.org.au/wp-content/uploads/dlm_uploads/2017/05/PCA018_Guiding-Principles-for-PC-Aged-Care_W03-002.pdf>, <https://palliativecare.org.au/consensus-principles-palliative-end-life-care-residential-aged-care>.

[85] Senate Community Affairs Reference Committee, Parliament of Australia, *Palliative Care in Australia*, Canberra (2012).

[86] Productivity Commission, *Introducing Competition and Informed User Choice into Human Services: Reforms to Human Services*, Report No. 85, (2017), 169.

[87] Ibid 2, 11.

[88] World Health Organization, *Palliative Care* (2019) World Health Organisation <https://www.who.int/news-room/fact-sheets/detail/palliative-care>.

The 2018-19 Commonwealth budget recognised the need for the provision of comprehensive palliative care in the aged care sector and, as a component of its commitment to an increase in aged care funding of $5 billion over 5 years, allocated $32.8 million to facilitate the development and implementation of new models of palliative care in aged care facilities.[89]

While this budget allocation is a commendable initiative, the provision of palliative care in aged care facilities for residents with dementia remains an ongoing issue. In a joint policy statement, Palliative Care Australia and Dementia Australia highlighted that many aged care providers are 'not equipped to address the unique palliative care needs of people living with dementia due to limited resources or appropriately trained staff'.[90]

This statement is supported by statistics from the Australian Institute of Health and Welfare about the characteristics of aged care residents requiring palliative care. The figures indicate that of the very small percentage of aged care residents who receive palliative care (2 per cent), residents with a dementia diagnosis are under-represented (43 per cent compared with 52 per cent of the general residential aged care population).[91]

Personal stories also illustrate the need. An article that appeared in the Ageing Agenda in early 2017 highlighted the issues faced by families and carers of people living with dementia who are often not made aware of palliative and end-of-life care services and supports. The article tells the story of Rosemary and her husband Don, who had become a resident of an aged care facility following a diagnosis of Lewy Body Dementia seven years previously. While recognising Don's condition was terminal, Rosemary said that palliative care for Don had never been raised, however it was offered immediately when her son was diagnosed with terminal cancer. In Rosemary's view, "people with dementia, let alone their families and carers, don't seem to be considered worthy of palliative care. And yet their need can be much more protracted than others with dying relatives or family".[92]

Given that dementia is the second most common underlying cause of death in Australia and that over a million Australians will be diagnosed with the disease by 2058,[93] recognition of the condition as terminal is essential, along with the adoption of a standard and consistent approach to palliative care in residential aged care facilities.

A number of peak bodies nationwide, including Palliative Care Australia, Alzheimer's Australia, Council of the Ageing, Aged and Community Services Australia, Leading Age Services Australia, Catholic Health Australia and the Aged Care Guild have released *Principles for Palliative and End-of-Life Care in Residential Aged Care*.[94] The principles demonstrate a commitment to the diverse needs of residential aged care consumers, families, carers, aged care staff and service providers in providing palliative and end-of-life care.

To ensure adoption and compliance with these principles across the aged care sector, the principles should be incorporated into the appropriate residential aged care standards, and assessed as a component of the accreditation process.

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[89] Department of Health (Australian Government), *Health Portfolio Budget Statements 2018-19: Budget Related Paper No. 1.9*, Department of Health, 16, 26 <https://www.health.gov.au/resources/publications/health-portfolio-budget-statements-2018-19>.

[90] Palliative Care Australia and Dementia Australia, *Policy Statement – Palliative Care and Dementia* <https://palliativecare.org.au/wp-content/uploads/dlm_uploads/2015/04/Dementia-Policy-Statement-2018_Final-New-Template.pdf>, originally published October 2013, updated May 2018.

[91] Australian Institute of Health and Welfare, *Palliative care services in Australia* (13 September 2019) Australian Institute of Health and Welfare <https://www.aihw.gov.au/reports/palliative-care-services-in-australia/palliative-care-services-in-australia/contents/palliative-care-in-residential-aged-care>.

[92] Megan Stoyles, *People living with dementia face a lack of support on end-of-life care*, Australian Ageing Agenda (1 March 2017) <https:\\www.australianageingagenda.com.au/2017/03/01/people-living-with-dementia-face-a-lack-of-support-on-end-of-life-care>.

[93] Dementia Australia, *Dementia statistics* (April 2019), Dementia Australia <https://www.dementia.org.au/statistics>.

[94] Palliative Care Australia, Alzheimer's Australia, Council of the Ageing Australia, *Principles for Palliative and End-of-Life Care in Residential Aged Care,* Palliative Care Australia, <https://palliativecare.org.au/wp-content/uploads/dlm_uploads/2017/05/PCA018_Guiding-Principles-for-PC-Aged-Care_W03-002.pdf>, <https://palliativecare.org.au/consensus-principles-palliative-end-life-care-residential-aged-care>.

Inquiry into the *Aged Care Quality and Safety Commission Bill 2018*

In September 2018, the Public Advocate made a submission to the Standing Committee on Community Affairs in relation to the *Aged Care Quality and Safety Commission Bill 2018* (Cth). The submission highlighted the importance of effective complaints systems for aged care services. It also sought more specific requirements in terms of annual reporting by the Commissioner. The broad level of reporting that was available at the time did not enable the public, or agencies such as the Public Advocate, to determine whether there are any, or many, complaints about the use of restrictive practices or other conduct that would amount to elder abuse in residential aged care facilities, whether those complaints were substantiated, or whether they are increasing.

The Public Advocate argued that, considering the number of complaints made about residential aged care, the unregulated use of restrictive practices, the vulnerability of many consumers and the importance of respecting their human rights, the public should be provided with greater detail about the type and nature of complaints received and their outcomes.

Improving banking experiences

In May 2019 the Public Advocate made a submission to the Australian Banking Association on the *Better Banking for Vulnerable Customers draft Guideline*. The submission suggested:

- the incorporation of the Australian Law Reform Commission's National Decision Making Principles in the guideline;
- improved communication via the use of Easy Read and Easy English documents;
- additional staff training about identifying and dealing with vulnerable customers; and
- the introduction of more robust and reliable procedures associated with third party authorisation forms, which are used by financial institutions to facilitate third party access to bank accounts.

New aged care funding model

In June 2019, the Public Advocate made a submission to the Commonwealth Department of Health regarding their proposal for a new residential aged care funding model. The submission focused on the need for the calculations of the adjustment payment under the proposed funding model to include provision for the time and supports required to appropriately support a person to participate in making decisions that affect their lives. It also supported the proposed classification assessment tool and process.

Importantly, the submission advocated for the inclusion of an additional re-assessment trigger in the model. This trigger was when there was a significant change in the behaviour of a resident. Behavioural changes are often associated with the progression of conditions such as dementia, and can, if not managed correctly, lead to significant risks to the person, fellow residents, and aged care staff. The incorrect management of challenging behaviours can also contribute to inappropriate and prolonged use of restrictive practices in residential aged care.

The re-assessment of the funding allocation applicable to a resident, following a significant behavioural change, would allow for a resident to be assessed to determine if specialist behavioural management is required for their ongoing care or potentially a transfer to a different section of the facility or to a specialist program that can better cater for their ongoing needs. It could also help to identify any required changes to the resident's health care. It is anticipated that this type of specialist care may require additional funding for things such as the development of behaviour management support plans, and the implementation of strategies, standards and staff ratios that will provide adequate support for the resident, making the use of restrictive practices (once they are properly, legally regulated) a true last resort.

Finally, the submission encouraged the development of a best practice needs identification and care planning assessment tool for use by residential aged care providers. Each aged care resident should have their care planning undertaken at least annually. It is vital that all assessments and whatever changes to care they entail are discussed in detail with the resident, their family and other supporters. Such an approach will facilitate an important and transparent communication and feedback process between residents, families and staff that will help to build confidence in the care being provided as well as demonstrating respect for the rights, needs and preferences of the resident.

Inquiry into aged care, end-of-life and palliative care and voluntary assisted dying

In April 2019, the Public Advocate made a submission to the Queensland Parliamentary Inquiry into aged care, end-of-life and palliative care and voluntary assisted dying. In relation to the issues of aged care and end-of-life palliative care, the submission reflected many of the issues addressed in the Public Advocate's submission to the Royal Commission into Aged Care Quality and Safety.

Reporting deaths in residential aged care

The submission advocated for the Queensland Government to amend the *Coroners Act 2003* to treat deaths in residential aged care facilities across Queensland as reportable deaths. This could provide an important oversight mechanism for the protection of consumers of aged care services – an investigation by the Coroner of an aged care death when the death may be related to the quality of care provided at a residential aged care facility.

There is no system or framework in Australia for reviewing deaths in residential aged care facilities unless a number of circumstances make the death reportable to the Coroner. Currently, residential aged care facilities are:

> … not a prescribed setting in any Australian coronial legislation. Consequently, a death in a residential aged care facility does not automatically trigger coronial investigations. A death in a residential aged care facility may trigger a report to the Coroner if the death was violent, unnatural, suspicious, health-care related or where the death certificate was not issued.[95]

In many Australian jurisdictions age is used as a constraint on the reporting of deaths in care, including in New South Wales, where the age of 72 is used to limit deaths that are reportable to the Coroner. It appears that under-reporting of deaths in residential aged care facilities to the Coroner is prevalent, particularly in cases associated with advanced bed sores.[96]

In recent years, the Public Advocate has been invited by the Coroner's Court to make submissions in inquests into the deaths of people with complex health needs in disability and aged care facilities.

One particular case involved the death of a younger person with disability residing in an aged care facility who died from choking on food.

It is important to note, in relation to this case, that the Autopsy Report identified significant deterioration in the health of the deceased's lungs that evidenced serious ongoing difficulties with eating and swallowing. In the opinion of the forensic pathologist, this deterioration was due to food aspiration, which causes severe necrotising pneumonia and over time can lead to death. Had the deceased not died from choking on food, an event which caused his death to be viewed as 'unnatural' and therefore reportable under the *Coroners Act*, he may well have died from aspiration pneumonia. Had he died from aspiration pneumonia, the death would have been considered 'natural', because without an autopsy it would only be identified as death by pneumonia. As a consequence, there would have been no basis to investigate the death and improve the level of care provided to patients with these type of conditions, even though it would have been a preventable death resulting from lack of appropriate care and mealtime supervision.

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[95] Catherine Sharp, Jennifer Schulz Moore and Mary-Louise McLaws, 'The Coroner's Role in the Prevention of Elder Abuse: A study of Australian Coroner's Court Cases Involving Pressure Ulcers in Elders' (2018) *Journal of Law and Medicine*, Vol 26, No 2, p 494, Lawbook Co. Australia.

[96] Ibid.

While it is acknowledged that Australians entering residential aged care facilities or using services provided by the aged care sector in their homes are potentially suffering from conditions that are life-limiting, not actively reviewing deaths in aged care has the potential to allow poor practices and quality of care to go unchecked. The ultimate objective (and indeed the objective reinforced in the revised Aged Care Quality Standards) should be to treat older people with dignity and respect, and this standard should apply to their deaths as well as their lives.

An epidemiological analysis of deaths in residential aged care by Professor Ibrahim et al, found that a significant number of deaths in aged care are 'premature' and potentially 'preventable', challenging the misconception that all deaths of frail, older people living in residential aged care are natural.[97] It also found that the incidence of these deaths of nursing home residents has increased over the past decade. The research noted that, although there are mechanisms to actively monitor residential aged care, there is no one organisation responsible for the reduction of harm by improving practice. In contrast, general health care has a leading national agency, the Australian Commission on Safety and Quality in Health Care which monitors and investigates preventable harm and provides resources, training, education and research to address problems and improve care.

Reporting of the deaths of people in residential aged care and investigation by the Coroner is the first step towards greater scrutiny of deaths in residential aged care to improve practices, so that the prevalence of preventable deaths can be addressed and reduced.

Voluntary assisted dying

The debate surrounding voluntary assisted dying is complex, and involves significant moral, ethical, medical and values based considerations. Essentially, and at its purest level, the debate is about choice and control being extended to people who wish, on the basis of a life-limiting condition, to voluntarily end their life.

Legislation providing for choice and control to voluntarily make a decision of this nature inherently assumes that a person making this decision is doing so of their own free will and having the legal capacity to make that decision. The Public Advocate's submission argued for any future voluntary assisted dying legislation to include the necessary safeguards to ensure that only people with decision-making capacity can access voluntary assisted dying. It also argued that there should be no opportunity for voluntary assisted dying to be provided for in Queensland advance care planning documents, such as Enduring Powers of Attorney or Advance Health Directives, or in any other health planning documents (e.g. Statement of Choices, Advance Health Directive for Mental Health etc.).

The Public Advocate cautioned the Committee to ensure that there be no possibility that a person can make a decision to voluntarily end their life after losing their legal capacity to make their own decisions. The power to make such a decision should never be able to be conferred on a substitute decision-maker such as an enduring attorney, guardian or statutory health attorney. Existing guardianship and power of attorney legislation does not allow for particular decisions to be made by substitute decision-makers, including, for example, consent to marriage, the making or revoking of a will, voting, the termination of a pregnancy, sterilisation or organ donation.[98]

Most international laws, and the voluntary assisted dying legislation recently passed in Victoria, require that a person must have capacity to request to die voluntarily.[99] In Victoria, two separate tests of capacity are required to be conducted by two different health professionals, prior to any request being considered.[100] However, it is noted that two countries in Europe (the Netherlands and

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[97] Ibrahim, Joseph et al, Premature deaths of nursing home residents: an epidemiological analysis, *Medical Journal of Australia* 206 (10), 5 June 2017, Australia <https://www.mja.com.au/journal/2017/206/10/premature-deaths-nursing-home-residents-epidemiological-analysis>.

[98] *Guardianship and Administration Act 2000* (Qld) sch 2 s 3.

[99] *Voluntary Assisted Dying Act 2017* (Vic), Pt 2, 9 (c).

[100] Ibid, Pt 3.

Belgium) are now beginning to grant access to voluntary assisted dying for people suffering from dementia or psychiatric illnesses.[101]

The Public Advocate was asked to appear before the Committee at a public hearing held on 5 July 2019. At this hearing, questions and discussion were primarily associated with the Public Advocate's position in relation to voluntary assisted dying.

Advance care planning

Queensland has a plethora of documents available to assist with advance care planning that are potentially confusing for people who want to plan for their end-of-life health care and decision-making. There are only two legally binding advance care planning documents available in Queensland: [102]

1. Advance Health Directive – this form is a legally binding document that states a person's instructions for health care in specific circumstances. It must be completed with a doctor and signed in front of a qualified witness.
2. Enduring Power of Attorney – this form is also a legally binding document that can appoint one or more people to make personal, health and/or financial decisions on another's behalf. It must also be signed in front of a qualified witness

When a person is unable to make or communicate their own health care decisions, Queensland legislation establishes a statutory hierarchy of substitute decision-makers as follows:

1. Advance Health Directive – A legally binding document used to give consent and direct medical management in specific health circumstances.
2. Tribunal appointed guardian – A guardian appointed by QCAT to make health care decisions on behalf of a person;
3. Attorney appointed under an advance health directive or enduring power of attorney – A person appointed for personal/health decisions in an Advance Health Directive or Enduring Power of Attorney document;
4. Statutory health attorney – A relevant person who has authority to make health care decisions in the absence of the above decision makers.

There are also two additional documents that do not have a formal legal status:

- Statement of Choices – this document has a focus on the wishes, values and beliefs of the person. It is a form used in Queensland hospitals, residential aged care facilities and medical clinics to support advance care planning discussions, as a guide for decision-making about the person's health when the person is no longer able to make or communicate their decisions.
- Acute Resuscitation Plan – this was implemented in Queensland Health facilities in 2009 as a state-wide form to replace Not for Resuscitation Orders. The Acute Resuscitation Plan is a medical direction signed by the most senior doctor available and is designed to provide clinical direction in the event of acute deterioration in the patient's condition. The Acute Resuscitation Plan records resuscitation planning outcomes, following discussions with the patient or their substitute decision maker (if the person lacks capacity), and other members of the multidisciplinary team.

The Statement of Choices form and the Acute Resuscitation Plan complicate the advance care planning process, particularly as they do not have formal legal status. Further complicating (and concerning) aspects of these documents is that they can be completed by a third party on behalf of the person about whom the health decisions are being made and they do not require formal witnessing by a qualified witness.

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[101] Emanuel EJ, Onwuteaka-Philipsen BD, Urwin JW, Cohen J. 'Attitudes and practices of euthanasia and physician-assisted suicide in the United States, Canada and Europe. JAMA. 2016; 316(1): 79-90.

[102] Under the *Power of Attorneys Act 1998 (Qld)* s 28.

This range of advance care planning documents can lead to situations where people, particularly in their later stages of life:

- have multiple advance care planning documents that potentially conflict with each other, which may result in their wishes not being taken into account, or being applied differently from what was intended when they prepared the documents;
- complete a Statement of Choices form under the misapprehension that it will override or revoke an earlier Enduring Power of Attorney or Advance Health Directive, when it does not; or
- complete a Statement of Choices form with a representative of a Health and Hospital Service that is recorded on the Queensland Health electronic filing system, while having a valid Enduring Power of Attorney document, and the hospitals and medical practitioners acting on the Statement of Choices document rather than consulting the person's Attorney.

The Public Advocate's submission explained that while it was clear that the development of these non-legal advance care planning documents was intended to assist people to have their views and wishes about their end-of-life care recorded and acted upon, they have also had the effect of creating some confusion and uncertainty about what documents take priority and how they can be identified and recorded in appropriate systems for access when necessary.

The Public Advocate suggested that the appropriateness, legality and relative risks of these various documents be reviewed, with a goal to simplifying the range of advance care planning documents that members of the public have to consider before making a decision. Such a review should:

- establish a consistent State-wide approach to advance care planning and enduring documents;
- clarify the goals of advance care planning for the community, e.g. to ensure people can record their end-of-life views and wishes in relation to their health care and treatment; establish a system for registering these documents so they can be accessed when necessary and in an emergency; and/or to reduce futile care and unnecessary costs to the health system etc.;
- provide community education to ensure that people understand what the documents are for and how to effectively use them and ensure their wishes are acted upon;
- establish a system for registering advance care documents to ensure they can be accessed when necessary, and in an emergency, to guide decisions about the person's health care at end-of-life.

Contribution to whole-of-government plans

The Queensland Government initiated the *Queensland: An Age-Friendly Community* strategy with a view to create a community where older people are valued, respected and actively engaged in their community. Age-friendly communities are more livable for everyone.[103]

In 2018-19, the Public Advocate continued to contribute to the Respect and Social Inclusion component of the *Queensland: An age-friendly community Action Plan*. Under the plan, the Public Advocate has committed to advocating for the implementation of particular Australian Law Reform Commission Elder Abuse Inquiry recommendations, and for the national regulation of the use of restrictive practices in residential aged care.

The Public Advocate also continued to participate in the Queensland Age-Friendly Community Strategy Senior Officers Group convened by the Office for Seniors within DCDSS.

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[103] Department of Communities, Disability Services and Seniors, *Queensland: an age-friendly community* (18 June 2019) Department of Communities <https://www.communities.qld.gov.au/seniors/queensland-age-friendly-community>.

Mental health

Mental health conditions affect how people feel, think and act, as well as how they handle stress and relate to other people.[104] For some people, mental health issues can impact their decision-making capacity. This may be episodic or temporary and require support for decision-making at different times, or a person may need this support for their lifetime.

People with mental health issues who are subject to involuntary treatment are some of the most vulnerable members of our community. For this reason, the Public Advocate has had a continuing interest in the operation of Queensland's mental health system, particularly the areas of the system that relate to the involuntary treatment of people with mental health issues.

Mental Health Review Tribunal

The Mental Health Review Tribunal (MHRT) is established under the *Mental Health Act* and has the primary purpose of reviewing the status of people with a mental illness and/or a cognitive disability who are subject to a treatment authority or forensic order. The Tribunal also provides approval for the performance of electroconvulsive therapy and non-ablative neurosurgical procedures.

In last year's annual report, the Public Advocate raised concerns about the MHRT not electronically recording its proceedings. The *Recording of Evidence Act 1962* requires that all legal proceedings heard in any Queensland court or tribunal established under any Queensland law, be recorded. The way in which this requirement is met is generally by way of electronic audio recording to enable transcription at a later time. The *Recording of Evidence Act* also requires there to be appropriate arrangements in place to ensure the availability of copies of records or transcripts to be available for purchase or at no, or a reduced, cost.[105]

Legal proceedings are recorded in all courts in Queensland, including the Mental Health Court, as well as tribunals such as QCAT. To date, MHRT members have been recording proceedings through hand-written notes, taken during proceedings.

As reported last year, the Public Advocate has made a number of representations to both the MHRT and the Minister for Health in relation to the need for the full, electronic recording of proceedings to achieve better transparency and accountability in MHRT proceedings.

During the year, the MHRT commenced a project, Electronic Audio Recording of Mental Health Review Tribunal Hearings. As part of that project the Tribunal undertook a consultation process with stakeholders and other statutory bodies, via an online survey and taking written submissions about the electronic recording of Tribunal proceedings. The MHRT has now completed phase one of its project and has produced a report, which is available on the Tribunal's website.

Based on the findings of the project report, the Tribunal has agreed in principle to proceed with audio recording of hearings. The Tribunal will now investigate the most appropriate way to implement electronic recording to maximise the benefits and minimise the potential risks identified in the project.

The Public Advocate congratulates the MHRT on undertaking the electronic recording project and will continue working with the Tribunal and other stakeholders to support the commencement of electronic recording of Tribunal proceedings.

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[104] MentalHealth.gov, *What is mental health?* (4 May 2019) MentalHealth.gov <https://www.mentalhealth.gov/basics/what-is-mental-health>.

[105] For people experiencing financial hardship, victims of a personal offence the subject of a criminal proceeding in the District or Supreme Court and defendants in a criminal proceeding in the District or Supreme Court, *Recording of Evidence Regulation 2018*, Div 3.

Working with the Chief Psychiatrist

Under the *Mental Health Act*, the Chief Psychiatrist's functions are to protect the rights of patients in authorised mental health facilities, and make policies and practice guidelines that must be complied with by people performing functions in authorised mental health facilities and to investigate matters where appropriate.

Last year, the Public Advocate reported about a number of concerns relating to the operations of the involuntary mental health system, including the processes for approval of electroconvulsive therapy in Queensland and the monitoring of its use.

This year, the Public Advocate has been regularly meeting with the Chief Psychiatrist to discuss these concerns, alongside other issues such as the treatment of patients and conditions in mental health units of Queensland hospitals. This engagement has opened up a positive dialogue between the Public Advocate and the Chief Psychiatrist. The Public Advocate appreciates the efforts of the Chief Psychiatrist to address her concerns, and will continue to work through issues relating to the rights and interests of patients in authorised mental health services in the coming year.

Queensland Mental Health Commission

The Queensland Mental Health Commission has commissioned a project to investigate the oversight mechanisms of the *Queensland Mental Health Act* to protect the human rights of people with living with a mental illness. The Public Advocate continued to participate in the advisory group for the implementation of the project throughout 2018-19.

Law and justice

Human rights

Human Rights Act 2019

While the Public Advocate strongly supports the new *Human Rights* Act, there are significant concerns that the definition of 'registered provider'[106] in the Act does not extend to publicly-funded aged care providers in addition to registered NDIS service providers. There are undeniable similarities between the issues and risks for people receiving aged care services and those receiving disability services funded by the NDIS. Both service systems are administered and regulated by the Australian Government, operate within Queensland and many of the recipients of both service types are vulnerable members of our community. Unfortunately, human rights abuses have occurred in Queensland in both the disability and aged care systems. If the definition of registered provider does not include publicly-funded aged care providers there will be a significant gap in the potential protections available to vulnerable older Queenslanders under the new *Human Rights Act*. There are also younger people with disability who are residing in aged care facilities because other appropriate accommodation is not currently available. They should also have the benefit of the protections available to other people with disability who are receiving NDIS-funded services.

Criminal Code

Section 216 of the *Criminal Code* criminalises sexual activity with a person who has an 'impairment of the mind'.[107] This provision effectively outlaws any sexual contact with a person who has a condition that falls within the definition of impairment of the mind, regardless of whether the person has the capacity to consent to and understand the nature of such activities. This law imposes significant and unjustified restrictions on the rights of people with impaired capacity to exercise autonomy and agency and to freely engage in sexual relationships.

Although there are potential challenges in ensuring appropriate protections against abuse or exploitation of people with impaired capacity and upholding their right to independence and autonomy, it is appropriate that section 216 of the *Criminal Code* be reviewed and updated to reflect modern values and the rights of people with disability.

There have been some delays in preparing a paper exploring this issue, however this work remains a priority for the Public Advocate.

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[106] *Human Rights Act 2019 (Qld)* s 9(5).

[107] *Criminal Code 1899* (Qld) s 216.

Legal interventions

The main function of the Public Advocate is to undertake systemic advocacy. While this generally excludes the Public Advocate investigating specific complaints or allegations that concern an individual, the Public Advocate may also intervene in legal proceedings involving the protection of the rights or interests of adults with impaired decision-making capacity.

Legal interventions can provide an excellent opportunity to closely examine and test the operation of government systems and their treatment of people with impaired decision-making capacity. However, legal processes of any type require a significant commitment, financially and in terms of staff resources. This office will only become involved in a legal matter where there are significant systems and/or rights issues for consideration. Our legal interventions are part of a broader advocacy strategy promoting the particular rights or issues under consideration in the case.

Coroner's Court of Queensland

The Public Advocate was invited by the Deputy State Coroner to make submissions regarding an inquest into the death of a man, JD, with impaired decision-making capacity in a supported residential setting.[108] JD was 50 years old and had multiple disabilities primarily resulting from complications associated with an acquired brain injury at birth. For a number of years he had resided in supported residential accommodation.

JD died from choking on food he consumed while eating lunch at his supported accommodation. There had been previous medical examinations in the context of possible swallowing issues but at the time of his death there were no documented concerns regarding JD's capacity to swallow and eat a relatively normal diet.

On the day of the incident, JD had been eating lunch when his carer, who was in another room, heard him collapse to the ground. Emergency services were called and cardiopulmonary resuscitation (CPR) commenced, but there was no indication at the time that the carer was aware of the food obstruction that blocked JD's airway. Ambulance officers arrived and took over CPR, and although JD's airway was checked again, no obstruction was observed. It was not until other paramedics arrived that the airway obstruction was found and removed. JD was without oxygen for a prolonged period of time and suffered a severe brain injury. He passed away a few days later.

In the Public Advocate's 2016 report, *Upholding the right to life and health*, a review was conducted of the deaths of 73 people with disability who were living in care in Queensland between 2009 and 2014. Choking on food/food asphyxia was identified in the report as a common cause of death in the cases reviewed.[109] Swallowing and eating difficulties are common in people with particular types of disability, placing them at high risk of choking and aspiration. A number of recommendations were made in the report to prevent such deaths, including better training of disability carers in dealing with swallowing issues, closer working relationships with health practitioners and strict compliance and review of mealtime management plans.[110]

The Public Advocate made a number of submissions to the Deputy State Coroner in this inquest. It was noted from the evidence available to the Public Advocate, that the care provided to JD was generally thorough and demonstrated a high degree of care. It was noted that JD had two hospital presentations in 2014 and 2016 that indicated he potentially had swallowing difficulties. However, JD's file with his service provider did not record these issues or note any swallowing difficulties. The Public Advocate submitted that this case demonstrates that issues with swallowing, however minor, can impose a significant ongoing risk to a person's life and health, and it is critical

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[108] Coroners Court of Queensland, *Inquest into the death of John Davis* (17 April 2019) 2018/1612.

[109] Public Advocate, *Upholding the right to life and health; A review of the deaths in care of people with disability in Queensland, A systemic advocacy report* (28 June 2019) Public Advocate, 16 <https://www.justice.qld.gov.au/public-advocate/activities/current/deaths-of-people-with-disability-in-care>.

[110] Ibid xi-xvii.

that swallowing difficulties are reported and recorded and disability support workers are informed about them and the dangers they pose to health and treat such them as a serious health issue.

The Coroner concluded that in this case, there were a number of concerns in relation to the initial ambulance response, which had already been addressed through an internal Queensland Ambulance Service review into the case.[111]

The service provider in this case identified a number of deficiencies in the regular medical assessment checklist and implemented their own *Nutrition and Swallowing Risk Checklist* as a resource to assist them to better understand and record the nutrition and swallowing needs of clients and implement strategies to proactively identify any nutrition and swallowing risks. The Public Advocate noted that this new checklist is far more comprehensive and should be a useful resource to assist in identifying future residents who have swallowing/choking risks.

The Coroner forwarded these findings to the appropriate disability care association to note the issues in the case and to pass onto its members a recommendation that similar checklists be considered for use by other disability care providers.

QCAT limitation order application

In May 2019, the Public Advocate intervened in a matter before the Queensland Civil and Administrative Tribunal that involved a person subject to guardianship and administration. This matter involved a number of limitation orders (which restrict publication of information about the matter) and therefore the details of the matter cannot be published. The Public Advocate's submissions focused on the rights of people to be able to publicly identify themselves as being subject to guardianship or administration orders, and to criticise their treatment by public agencies, on the basis that while they may not have capacity for certain other personal and financial decisions, they may still retain capacity to make a decision to consent to their public identification.

Contribution to whole-of-government initiatives

DJAG is leading the whole-of-government implementation of the *Human Rights Act*. In 2019, the Public Advocate participated in DJAG's Human Rights Implementation Working Group. The role of the group is to ensure that all units of the department are informed about the requirements of the *Human Rights Act* and how to meet their new obligations. The group also promotes a positive approach to the implementation of the Act and identifies and responds to any implementation issues. Through this group, the Public Advocate continues to advocate for Easy Read versions of publications and resources about the *Human Rights Act* be made available to people with impaired decision-making capacity and other members of the community.

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[111] Coroners Court of Queensland, *Inquest into the death of John Davis* (17 April 2019) 2018/1612.

Guardianship and administration

Throughout 2018-19, the Public Advocate continued to monitor the operation of legislation, policy and practice aspects of Queensland's guardianship and administration system and contributed to system improvements through working with DJAG, the Public Guardian, the Public Trustee and QCAT.

Review of enduring power of attorney and advance health directive forms

Following the passing of the *Guardianship and Administration and Other Legislation Amendment Act*, DJAG is reviewing the Enduring Power of Attorney and Advance Health Directive forms, introducing explanatory guides and developing capacity assessment guidelines (as provided for under the amendments).

The Public Advocate has contributed to this work as a member of the DJAG Guardianship Implementation Reference Group. Our goal in contributing to this process is to ensure that any changes to the forms address issues that have been identified with the current forms, and that the new forms are simpler and more user friendly.

Achieving this is a complex task. DJAG must ensure that the new forms continue to meet legislative requirements, but also achieve an important balance between the benefits associated with introducing more detail in the forms versus the negatives that come with greater complexity, including the risk of forms being incorrectly completed or being too challenging for people and not being used at all.

The importance of enduring documents in representing the views and wishes of members of the community about who they want to make decisions for them, after they have lost decision-making capacity, cannot be understated. We want to maximise this opportunity to ensure that the new forms have strong recognition and acceptance among the general community and those who will be relying on these documents to make decisions.

Tribunal guidelines to maximise the participation of the person

In May 2019, AGAC endorsed *Guidelines for maximising the participation of the person in guardianship proceedings*. AGAC prepared the guidelines in response to a recommendation by the Australian Law Reform Commission that proposed the development of best practice guidelines on how tribunals around the country can support a person who is the subject of an application regarding guardianship and/or administration. The Commission considered that AGAC was well placed to develop such guidelines.

The guidelines were developed following broad consultation with individuals and organisations, including community organisations representing and advocating on behalf of people with impaired capacity. The guidelines provide practical guidance to tribunals regarding measures that can be taken to maximise the participation of the person subject to a guardianship or administration order in proceedings before the tribunals.

As a member of AGAC, the Public Advocate contributed to and provided feedback on the guidelines as they were developed. The guidelines can be accessed on the AGAC website.[112]

The guidelines should provide tribunals across the country with a clear and consistent approach that places the person subject to an application for guardianship or financial management 'at the centre' of proceedings, and will ensure the recognition and facilitation of their rights to be fully informed, be in attendance, be heard, and meaningfully participate in the proceedings.

Decision-making support

In 2018-19, the Public Advocate continued to contribute to the Australian Research Council Linkage research partnership led by La Trobe University on effective decision-making support for people with cognitive impairment. The Public Advocate is a partner investigator in this four year project, which focuses on people with intellectual disability or acquired brain injury who require decision-making assistance.

The research aims to address the gaps in knowledge, expertise and resources that exist in respect of the provision of support for decision-making. An educational program that trains people to provide decision-making support has been developed and will be evaluated. The educational program aims to improve the quality of the decision-making support provided to people with cognitive impairment. The evaluation of the program will assess whether it results in better outcomes for the person requiring decision-making assistance. The learnings from the research are expected to be able to be applied to a broader range of people with cognitive impairment requiring decision-making support.

The chief investigators and project partners met in March 2019 to discuss the research and initial insights from preliminary analysis. The final research findings are expected to be released in 2019-20.

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[112] Australian Guardianship and Administration Council, *Guidelines for Australian Tribunals: Maximising the participation of the Person in guardianship proceedings, Guidelines for Australian Tribunals* (3 July 2019) Australian Guardianship and Administration Council <*https://agac.org.au/images/AGAC%20-%20Best%20Practice%20Guidelines.pdf*>.

National redress scheme

The National Redress Scheme was established in response to the recommendations of the Royal Commission into Institutional Responses to Child Sexual Abuse. The purpose of the Scheme is to hold institutions accountable for abuse that occurred, and helps people who have experienced institutional child sexual abuse to access counselling, receive a direct personal response and a redress payment.

In November 2018, the Public Advocate hosted a forum to inform guardianship system stakeholders about the Redress Scheme, how to connect their clients with the scheme and consider their obligations in terms of identifying past clients who may be eligible for the scheme. The forum was attended by representatives from the OPG, the Public Trustee, DJAG and a range of non-government organisations who provide support and advocacy for people with disability, older people and people who experience mental health issues and/or impaired decision-making capacity.

Financial summary

The Public Advocate is not a statutory body for the *Statutory Bodies Financial Arrangements Act 1982* or the *Financial Accountability Act 2009*. Funding for the office is appropriated from the Queensland Government as part of the appropriation for DJAG, with the Director-General of the department being the accountable officer pursuant to the *Financial Accountability Act*. Detailed financial information relating to the operations of the department are reported in the annual report for DJAG.

A summary of the expenditure for the office in 2018-19 is presented below. Expenditure figures are rounded to the nearest $100.

Expenditure item	Amount
Employee related expenses	$672,800
Supplies and Services	$106,600
Grants	$14,900
Depreciation[#]	$2,300
Other	$300
Total	$796,900

Grants

In 2018-19, our office contributed a $5,000 grant to the Australian Research Council Linkage research project into ‘Effective decision-making support for people with cognitive impairment’ led by La Trobe University. This project is funded by an Australian Research Council Linkage Grant and other project partners.

A grant of $9,900 was provided to Queensland Advocacy Incorporated to conduct appeals and other applications under the *Mental Health Act*.

Appendices

Appendix 1: Annual report compliance checklist

The Queensland Government requires that all agencies include a compliance checklist as part of their Annual Report. The following checklist presents references to where each disclosure requirement has been addressed in this report.

The *Annual report requirements for Queensland Government agencies* is represented as 'ARR' in the compliance checklist.

Summary of requirement		Basis for requirement	Annual report reference
Letter of compliance	Letter from accountable officer to the Minister	ARR 7	ii
Accessibility	Table of contents	ARR 9.1	vii
	Glossary of acronyms	ARR 9.1	79
	Public availability	ARR 9.2	i
	Interpreter service statement	Queensland Government Languages Services Policy ARR 9.3	i
	Copyright notice	*Copyright Act 1968* ARR 9.4	i
	Information licencing	QGEA-Information Licensing ARR 9.5	i
General information	Introductory information	ARR 10.1	1,6
	Agency role and main functions	ARR 10.2	3-4
	Operating environment	ARR 10.3	7
Non-financial performance	Whole-of-government plans	ARR 11.2	39,57,64
	Agency objectives	ARR 11.3	3-4
Financial performance	Financial summary	ARR 12.1	69
Governance – management and structure	Organisational structure	ARR 13.1	9
	Public Sector Ethics Act 1994	*Public Sector Ethics Act 1994* ARR 13.4	9
	Queensland Public Service Values	ARR 13.5	9
Governance – risk management and accountability	Risk management	ARR 14.1	7
	Internal audit	ARR 14.3	10
	External scrutiny	ARR 14.4	10
	Information systems and record keeping	ARR 14.5	11
Governance – Human Resources	Strategic workforce planning and performance	ARR 15.1	10

Appendix 2: List of submissions

The following table presents a list of publicly available submissions made by the Public Advocate in 2018-19.

Date	Submitted to	Subject
24 August 2018	Productivity Commission	National Disability Agreement
6 September 2018	Australian Guardianship and Administration Council	Enduring powers of attorney (financial) options paper
15 October 2018	Standing Committee on Community Affairs	Inquiry into the *Aged Care Quality and Safety Commission Bill 2018* (Cth)
9 November 2018	Department of Communities, Disability Services and Seniors	Reshaping the *Disability Services Act 2006*: An inclusive and accessible Queensland
26 November 2018	Legal Affairs and Community Safety Committee	*Human Rights Bill 2018*
11 January 2019	Australian Guardianship and Administration Council	Maximising the participation of the person in guardianship proceedings: Draft guidelines for Australian tribunals
24 January 2019	Disability Services, Department of Communities, Disability Services and Seniors	Queensland Disability Advocacy Strategy
15 February 2019	Brisbane City Council	A City for Everyone: Draft Inclusive Brisbane Plan 2019-2029
6 March 2019	Mental Health Review Tribunal	Electronic audio recordings project
15 April 2019	Royal Commission on Aged Care Quality and Safety	Aged care quality and safety
15 April 2019	Queensland Health, Communities, Disability Services and Domestic and Family Violence Prevention Parliamentary Committee	Inquiry into aged care, end-of-life and palliative care and voluntary assisted dying
17 April 2019	Education, Employment and Small Business Parliamentary Committee	*Disability Services and Other Legislation (NDIS) Amendment Bill 2019*
10 May 2019	Australian Banking Association	Every customer counts: Better banking for vulnerable customers consultation
5 June 2019	Australian Government – Department of Health	Proposal for a new residential aged care funding model

Appendix 3: Speaking engagements and media

Queensland Health Social Work Mental Health Forum (Speaker)
Queensland Law Society
Edwin Tooth Auditorium, Royal Brisbane Women's Hospital Education Centre, Herston
21 August 2018

Queensland call for aged care restraints review (Media)
Ed Jackson, Australian Associated Press
news.com.au
20 September 2018

Aged Care: Are we getting it right? (Speaker)
Older People Speak Out
TriCare Retirement Village, 1748 Logan Road, Upper Mount Gravatt
29 October 2018

Independent Patient Rights Advisers Network Forum (Speaker)
Department of Health
Training Room 3, 15 Butterfield Street, Herston
11 December 2018

The use of restrictive practices in residential aged care (Media)
Anne Connolly, Australian Broadcasting Corporation
7.30 program
16 January 2019

2019 National Policy Lawyers' and Public Relations Forum – Panel Discussion on Elder Abuse (Panel Member)
Queensland Law Society
Law Society House, 179 Ann Street, Brisbane
28 February 2019

Upholding rights, preventing abuse and promoting autonomy (Speaker)
Australian Guardianship and Administration Council
Hyatt Hotel, 120 Commonwealth Avenue, Canberra
14-15 March 2019

Public Advocate calls for disability tug of war over nursing care to end (Media)
Janelle Miles
The Courier Mail, Brisbane
16 March 2019

Roundtable: Health and Intellectual Disability – Upholding the right to health and life (Speaker)
Queenslanders with Disability Network
53 Albert Street, Brisbane
22 March 2019

***Disability Services and Other Legislation (NDIS) Amendment Bill 2019* Public Hearing and Public Briefing (Witness)**
Queensland Parliamentary Service
Parliamentary Annexe, Alice Street, Brisbane
26 April 2019

Capacity, Supported and Substitute Decision-Making (Panel Member)
Australian Council for Health Law Research / QUT Faculty of Law
QUT Gardens Point Campus, 2 George Street, Brisbane
15 May 2019

World Elder Abuse Awareness Day Breakfast (Chair)
Queensland Law Society
Law Society House, 179 Ann Street, Brisbane
14 June 2019

The Royal Commission – Chemical Restraint (Media)
Anne Connolly, Australian Broadcasting Corporation
ABC News Weekend
23 June 2019

Restraints 'breach of rights' (Media)
Patrick Billings
The Sunday Mail, Brisbane
30 June 2019

Appendix 4: Consultations, workshops and events

Queensland Health Social Work Mental Health Forum
Queensland Health
Edwin Tooth Auditorium, Royal Brisbane Women's Hospital Education Centre, Herston
21 August 2018

Brisbane Hot Topics Digital Stories Launch
Queensland Disability Network
Griffith Film School, South Bank, Brisbane
11 September 2018

Aged Care: Are we getting it right?
Older People Speak Out
TriCare Retirement Village, 1748 Logan Road, Upper Mount Gravatt
29 October 2018

Knowledge Hub Consultation
Elder Abuse Action Australia
HopgoodGanim Lawyers, 1 Eagle Street, Brisbane
12 November 2018

Spotlight: Living on the streets in Brisbane: A public forum shining a light on housing, healthcare and homelessness
Micah Projects Limited
Brisbane Square Library, 266 George Street, Brisbane
14 November 2018

ASID Conference 2018
Australasian Society for Intellectual Disability
Gold Coast Convention and Exhibition Centre, Broadbeach
14-16 November 2018

Knowmore the National Redress Scheme for people who have experienced institutional child sexual abuse
Office of the Public Advocate and Knowmore
Supreme Court Library, Queen Elizabeth II Courts of Law, 415 George Street, Brisbane
19 November 2018

Complex Care Support Services Queensland Launch Breakfast
Mind Australia Ltd
Next Hotel, 72 Queen Street, Brisbane
23 November 2018

Changing Lives, Changing Communities
Queensland Council of Social Service
The Gabba, Vulture Street, Woolloongabba
28 November 2018

Palliative Care in Queensland Annual Summit
Palliative Care Queensland
Brisbane Convention and Exhibition Centre, South Bank
2 December 2018

Changing Lives, Changing Communities - Caboolture
Queensland Council of Social Service
Caboolture Hub, 4 Hasking Street, Caboolture
3-4 December 2018

Independent Patient Rights Advisers Forum
Queensland Health
15 Butterfield Street, Herston
11 December 2018

An Uncertain Path: Navigating voluntary assisted dying laws in Australia
Caxton Legal Centre Inc., University of Queensland, Queensland University of Technology, Griffith University
Wesley House, 140 Ann Street, Brisbane
21 February 2019

2019 National Policy Lawyers' and Public Relations Forum
Queensland Law Society
Law Society House, 179 Ann Street, Brisbane
28 February 2019

Upholding rights, preventing abuse and promoting autonomy
The Australian Guardianship and Administration Council
Hyatt Hotel, 120 Commonwealth Avenue, Canberra
14-15 March 2019

Health and Intellectual Disability Roundtable: Upholding the right to life and health
Queenslanders with Disability Network Ltd
53 Albert Street, Brisbane
22 March 2019

QUT Presentation on Laws relating to end-of-life and voluntary assisted dying
Queensland Law Society
Law Society House, 179 Ann Street, Brisbane
4 April 2019

***Disability Services and Other Legislation (NDIS) Amendment Bill 2019* Public Hearing and Public Briefing**
Queensland Parliamentary Service
Parliamentary Annexe, Alice Street, Brisbane
26 April 2019

A national disability strategy for beyond 2020
Department of Social Services
Rydges South Bank, Glenelg Street, Brisbane
29 April 2019

Capacity, Supported and Substitute Decision-Making
QUT Faculty of Law
QUT Gardens Point Campus, 2 George Street, Brisbane
15 May 2019

Disability Inclusive Disaster Risk Reduction Consultation
Queenslanders with Disability Network
Merthyr Road Uniting Church, New Farm
16 May 2019

Launch of QDeNgage
Queenslanders with Disability Network
Royal on the Park, 152 Alice Street, Brisbane
28 May 2019

2019 Crown Law Legal Conference
Department of Justice and Attorney General
Hilton Hotel, 190 Elizabeth Street, Brisbane
6 June 2019

Improving End-of-Life Care for Frail Older People Conference
Office of Advanced Care Planning, Queensland Government
Brisbane Convention and Exhibition Centre, South Bank
11 June 2019

World Elder Abuse Awareness Day Breakfast
Queensland Law Society
Law Society House, 179 Ann Street, Brisbane
14 June 2019

QCOSS State Budget Breakfast 2019
Queensland Council of Social Service
Brisbane Convention and Exhibition Centre, South Bank
18 June 2019

Appendix 5: Glossary of acronyms

AGAC	Australian Guardianship and Administration Council
CRPD	Convention on the Rights of Persons with Disability
DCDSS	Department of Communities, Disability Services and Seniors
DJAG	Department of Justice and Attorney-General
FDS	Forensic Disability Service
MHRT	Mental Health Review Tribunal
NDA	National Disability Agreement
NDIS	National Disability Insurance Scheme
OPG	Office of the Public Guardian
QCAT	Queensland Civil and Administrative Tribunal