

Office of the Public Advocate (Qld)

Systems Advocacy

Submission to the Senate Standing Committee on Community Affairs

Violence, abuse and neglect
against people with disability in
institutional and residential settings

June 2015



Queensland
Government

Introduction

The Public Advocate (Qld)

The Public Advocate was established by the *Guardianship and Administration Act 2000* (Qld) to undertake systems advocacy on behalf of adults with impaired decision-making capacity in Queensland. The primary role of the Public Advocate is to promote and protect the rights, autonomy and participation of Queensland adults with impaired decision-making capacity (the adults) in all aspects of community life.

More specifically, the functions of the Public Advocate are:

- promoting and protecting the rights of the adults with impaired capacity;
- promoting the protection of the adults from neglect, exploitation or abuse;
- encouraging the development of programs to help the adults reach their 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.¹

In 2015, the Office of the Public Advocate estimates that there are approximately 115,745 Queensland adults with impaired decision-making capacity (or 1 in 32 adults).² Of these vulnerable people, most have a mental illness (54 per cent) or intellectual disability (26 per cent).

Interest of the Public Advocate

Relevant advocacy and research projects

A number of advocacy and research projects undertaken by the Office of the Public Advocate over the past two years have focused on promoting the protection of people with impaired decision-making capacity from neglect, exploitation or abuse. These have included:

- **Continuing deinstitutionalisation in Queensland:** where the Public Advocate gathered evidence on the number of people with intellectual disability or cognitive impairment residing long-term in health facilities in Queensland and the care and support provided to them there;³
- **Protecting the rights of adults subject to restrictive practices:** where the Public Advocate took part in the review of the legislative framework for restrictive practices in Queensland and provided feedback on the implementation of the reforms;⁴
- **Improving safeguards in state-based disability services and under the forthcoming NDIS:** where the Public Advocate has commented on changes to the regulatory safeguards for state-based disability services and continues to engage with the consultation process being undertaken by the Commonwealth Government on the Quality and Safeguarding Framework for the NDIS;⁵
- **Exploring the responsiveness of various complaints systems to people with impaired decision-making capacity:** where the Public Advocate is applying best practice considerations to examine the extent to which complaints management systems are effective at identifying, progressing and addressing the concerns of service users with impaired decision-making capacity;⁶ and

¹ *Guardianship and Administration Act 2000* (Qld) s 209.

² Office of the Public Advocate, 'The Potential Population for Systems Advocacy' (Fact Sheet, Office of the Public Advocate (Queensland), April 2015).

³ Office of the Public Advocate, *People with Intellectual Disability or Cognitive Impairment Residing Long-Term in Health Care Facilities: Addressing the barriers to deinstitutionalisation* (October 2013).

⁴ Office of the Public Advocate, *Review of the Regulation of Restrictive Practices in the Disability Services Act 2006 and the Guardianship and Administration Act 2000* (Submission, August 2013).

⁵ Office of the Public Advocate, *Submission to the Health and Community Services Committee for the Communities Legislation (Funding Red-Tape Reduction) Amendment Bill 2014* (February, 2014).

⁶ Office of the Public Advocate, *Strengthening Voice: A Scoping Paper about complaints management systems for adults with impaired capacity* (February 2015).

- **Ensuring the responsiveness of the justice system to people with impaired decision-making capacity who have been subject to abuse, neglect and exploitation:** where the Public Advocate has identified both the over-representation of people with disability as victims of abuse, neglect and exploitation and highlighted numerous barriers in the justice system’s capacity to adequately respond to people with disability who are victims of crime.⁷

This submission is informed by both the outcomes of these research and advocacy projects and a recognition of the extreme vulnerability of people with impaired decision-making capacity to abuse, neglect and exploitation evidenced by the history of such abuse and neglect, as detailed below in respect of Queensland’s disability services system.

Rights-based framework

The Public Advocate advocates within the context of a rights-based framework.

Representing the first time that all international human rights Covenants had been brought together under one umbrella, the United Nations *Convention on the Rights of Persons with Disabilities* (the Convention) emphasises the obligation of the state to take a positive approach to rights – to protect people, rather than just refrain from discriminating against them.⁸

The Convention acknowledges that societal constructs are the primary issues faced by people with disability, and seeks to address this by requiring that ‘in order to promote equality and eliminate discrimination, State Parties shall take all appropriate steps to ensure that reasonable accommodation is provided’.⁹ Reasonable accommodation is defined to mean:

‘necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others of all human rights and fundamental freedoms.’¹⁰

The Convention recognises the right of people with disability to equal recognition before the law. In particular, the Convention provides that people with disability should be recognised by State parties as ‘enjoy(ing) legal capacity on an equal basis with others in all aspects of life’,¹¹ and that State parties should take appropriate measures to enable persons with disability to access support that they may require to exercise their legal capacity.¹²

The Convention requires that people with disability be protected from exploitation, violence and abuse. This is experienced by people with disability at alarmingly high rates and is insufficiently addressed by existing criminal justice or anti-discrimination measures.¹³ The Convention requires State parties to:

‘take all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects’.¹⁴

Further, the Convention requires that States do so by providing ‘gender-and-age-sensitive assistance and support... [on] how to avoid, recognise and report instances of exploitation and abuse’,¹⁵ and by ensuring effective and independent monitoring of facilities and programs for persons with disabilities.¹⁶

⁷ Office of the Public Advocate, *The need for a Disability Justice Plan in Queensland: Submission to the Inquiry on Strategies to Prevent and Reduce Criminal Activity in Queensland* (July 2014).

⁸ *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007 [2008] ATS 12 (entered into force 3 May 2008) art 5(3) (‘Convention on the Rights of Persons with Disabilities’) preamble.

⁹ *Ibid* art 5(3).

¹⁰ *Ibid* arts 1 -3

¹¹ *Ibid* art 12(2).

¹² *Ibid* art 12(3).

¹³ Kevin Cocks AM, *Justice for All – or – Just for Some*, Speech presented at 2014 Criminal Justice Symposium: Intellectual Disability and the Criminal Justice System ,9, 11-12

¹⁴ *Convention on the Rights of Persons with Disabilities*, art 16(1).

¹⁵ *Convention on the Rights of Persons with Disabilities*, art 16(2).

¹⁶ *Convention on the Rights of Persons with Disabilities*, art 16(3).

Finally, State parties are required to ‘put in place effective legislation and policies... to ensure that instances of exploitation, violence and abuse against persons with disabilities are identified, investigated and, where appropriate, prosecuted’.¹⁷

Finally, the Convention recognises the importance of access to justice, stating that people with disability should be provided with ‘effective access to justice... on an equal basis with others, including through the provision of procedural and age-appropriate accommodations’.¹⁸

Structure of this submission

This submission is divided into two parts. Given the Public Advocate’s role and functions it is focused on people with impaired capacity.

Part One provides a short history of abuse and neglect of people with disability in institutional and residential services in Queensland. This includes references up to the present time with some of the Public Advocate’s continuing concerns, arising from our advocacy and research projects, detailed.

Part Two describes some suggested strategies for strengthening safeguards for people with impaired decision-making capacity, particularly in seeking to prevent abuse and neglect. This is influenced by the Public Advocate’s current project examining the responsiveness and effectiveness of complaints management systems for people with disability as well as the Public Advocate’s engagement in the consultation on a Quality and Safeguarding Framework for the NDIS.

¹⁷ *Convention on the Rights of Persons with Disabilities*, art 16(5).

¹⁸ *Convention on the Rights of Persons with Disabilities*, art 13(1).

Part One: Queensland – A short history

History of institutionalisation

Beginnings of institutionalisation

The history of institutionalising people with intellectual disability in Queensland is similar to the history of institutionalisation of people with intellectual disability in many other western and developing countries, including the United States and the United Kingdom.

Up until the 1980s in Australia, it was common practice for people with disability to reside in large institutions on the outskirts of cities. These institutions housed both children and adults with disability in congregate living environments, with all day-to-day decisions made on their behalf by staff.

Originally people with intellectual disability in Queensland were placed in asylums and described as ‘lunatics’ or ‘insane’. Historically in Queensland, like many other places, there was little or no distinction between the care for people with intellectual disability and that provided for people with mental illness. In Queensland, a number of large government institutions for people with mental illness and intellectual disability were built on the outskirts of Brisbane, Ipswich and Toowoomba.

People with intellectual disability were housed with people with mental illness in the Ipswich Special Hospital, Woogaroo Lunatic Asylum (Wacol, Brisbane) and the Baillie Henderson Hospital (Toowoomba) under the control of the Health Department.

Early ‘reforms’ in the 1960s saw the separation of many people with intellectual disability from people with mental illness and the development of training centres and other facilities specifically for people with intellectual disability. This began with the decision by Cabinet in 1966 to designate the Ipswich Special Hospital as a training centre for ‘intellectually handicapped’ adults and rename it as the Challinor Centre. The section of Wolston Park Hospital that accommodated ‘intellectual handicapped children’ was designated as the Basil Stafford Training Centre.

Conditions in institutions

Institutional settings were custodial in nature. They provided all services within the institution, rather than allowing people with intellectual disability to venture into the community. In these settings people with intellectual disability had few rights, were subject to containment in hospitals and asylums under the authorisation of medical practitioners with no opportunities for review, and personal decisions about treatment, life style and education were made by the staff of the institution. They were under the complete control and direction of the institutional staff and government. Medical treatment could be carried out without consent.

Eileen Thomson describes the conditions at what is now known as the Baillie Henderson Hospital (Toowoomba) during the inter-war years.

“The custodial care was restrictive to many patients and staff and not unlike military discipline, and yet it was tempered by sympathetic care especially for the young, sick and elderly. Overcrowding and difficulties with classifying patients in the large wards made treatment difficult. Staff worked long shifts e.g. 6.00a.m. to 6.00p.m. During the day, staff members spent two hours at a time in yards with a variety of unpredictable patients, some of whom were aggressive enough to require physical restraint. [...] At night most patients slept in dormitories where there were rows of beds. Violent patients had single cell-like rooms with wooden shutters.”¹⁹

¹⁹ E Thomson, *Baillie Henderson Hospital Toowoomba: A Century of Care* (1990) 21.

Further to this, are the recollections of an official visitor to what was to become Challinor Centre, 1966.

“On my initial visit, I found an institution used mainly as a place for keeping certain people out of circulation. Remedial treatment and turnover were practically nil. Patients were eking out a 24 hour daily existence in impoverished conditions and some practically in squalor. Many requests for discharge were ignored and not worth recording. Paramedics were unknown. I could have been forgiven had I returned to the gate to see if I had missed a caption reading, ‘Abandon hope all ye who enter here.’”²⁰

Queensland, like other Australian states progressed the closures of many large institutions and relocated many people with disability to community-based living in the 1980s and 1990s. This coincided with increases in community accommodation provided by government and non-government service providers.

This movement was also given impetus by investigations into cultures of abuse and neglect of people with disability in some of these facilities.

Findings of violence, abuse and neglect

Yet not all institutional facilities were closed during this period of deinstitutionalisation in Queensland. For those that remained, a number of key investigations and inquiries uncovered patterns of neglect, abuse and exploitation in these settings.

A number of reports were tabled in the Queensland Parliament from the mid-1990s up to and including the Public Advocate’s own report in November 2013; these reports either concerning abuse and neglect of people with disability in institutional-type living environments and/or inappropriate models of support and care including:

- *Report of an Inquiry Conducted by the Honourable D G Stewart into Allegations of Official Misconduct at the Basil Stafford Centre*, tabled in the Legislative Assembly 11 March 1995;
- *Report to the Minister for Health and the Parliament of Queensland on Investigations by the Health Rights Commissioner at Baillie Henderson Hospital, Toowoomba*, tabled in the Legislative Assembly 26 November 1996;
- *Ministerial Inquiry into the Cootharinga Society Townsville*, tabled in the Legislative Assembly 15 September 1998;
- *A Review of the Basil Stafford Centre Recommendations: Report to Disability Services Queensland by the Honourable W J Carter QC*, tabled in the Legislative Assembly 1 June 2000;
- *Challenging Behaviour and Disability: A Targeted Response, A Report by the Honourable WJ Carter QC*, tabled in the Legislative Assembly 22 May 2007; and
- *People with Intellectual Disability or Cognitive Impairment Residing Long-Term in Health Care Facilities: Addressing the Barriers to Deinstitutionalisation*, tabled in the Legislative Assembly 7 November 2013.

Collectively these reports detailed findings of abuse and neglect, insidious institutional cultures, and inappropriate models of care.

Basil Stafford Centre (1995)

In 1993, D G Stewart was appointed by the Criminal Justice Commission to undertake an investigation into allegations of official misconduct involving staff at the Basil Stafford Centre, a residential facility for adults and children with disability operated by the then Department of Family Services and Aboriginal and Islander Affairs. The investigation commenced because of a number of complaints to the Criminal Justice Commission alleging abuse and gross neglect of residents, and that fellow staff members who reported such incidents were subject to harassment and intimidation.

²⁰ E McRobert, *Challinor Centre: The End of the Line: A History of the Institution also known as Sandy Gallop* (Department of Families, Youth and Community Care, Brisbane Queensland, 1997) 112, quoted in University of Queensland, Ipswich Campus: Progression of an Institution, University of Queensland: Ipswich Library Online Exhibition <<http://www.library.uq.edu.au/ipswich/uqihistory/>>.

The Inquiry ultimately substantiated these claims, finding that there was a pattern of client abuse and gross neglect at the Centre including a number of substantiated unlawful assaults perpetrated by staff upon severely and profoundly intellectually disabled people residing there;²¹ as well as many instances of neglect of residents by staff including gross negligence.²² For example substantiated incidents included that:

- One (former) staff member had pleaded guilty to a charge of unlawful abuse (carnal knowledge) of an intellectually disabled person, an offence committed while employed at the centre which resulted in the resident becoming pregnant and giving birth to a child while at the centre;²³
- Another officer was found guilty of seriously assaulting a resident resulting in lacerations to the resident's face and the loss of two teeth;²⁴ and
- One child suffered an extensive and totally unacceptable series of injuries (including teeth fractures), with at least some arising from unlawful assaults committed by persons unknown.²⁵

The inquiry also focused extensively on the culture of the Centre which enabled the abuse and neglect to flourish. Stewart reported that:

'An insidious institutional culture existed at the Centre. This culture promoted the occurrence of client abuse and gross neglect, and the harassment or intimidation of staff members who reported or could have reported such occurrences, by other staff members. This culture provided the climate, and thus the opportunity, for acts of official misconduct to take place and minimised the likelihood of both the act and the offender being detected. The situation existing at the Centre had the effect of discouraging, to the point of stifling, the reporting of such acts of official misconduct. The situation cannot be explained away as arising from the actions of a few individual 'rotten apples'.²⁶

The inquiry found that there was extensive harassment and intimidation of staff who tried to raise concerns that included:

- Threatening or disturbing telephone calls;
- Direct personal abuse;
- Interference with personal property such as motor vehicles;
- Receipt of abusive mail;
- Placing of dead animals and faeces in places designed to be discovered by the staff member; and
- Unwanted or undesirable transfers.²⁷

Stewart made a number of recommendations relevant to both the standard of care and support, and the development of staff skills, capacity and knowledge in relation to the appropriate response to abuse and neglect of clients, but also emphasised the importance of strong individual advocacy for clients of the centre and the investigation of allegations of client abuse or neglect by appropriate external bodies such as the Criminal Justice Commission or the Police.²⁸ Given the prevalence of such a culture that promoted client abuse and neglect at Basil Stafford Centre however, Stewart recommended the complete closure of this particular centre at the earliest opportunity.²⁹

²¹ Criminal Justice Commission, *Report on an Inquiry Conducted by the Honourable D G Stewart Into Allegations of Official Misconduct at the Basil Stafford Centre* (1995) xi.

²² *Ibid* xi.

²³ *Ibid* 7.

²⁴ *Ibid* 8.

²⁵ *Ibid* xiii.

²⁶ *Ibid* xii.

²⁷ *Ibid* 208.

²⁸ *Ibid* xviii.

²⁹ *Ibid* xvi. Despite the recommendation to close the Basil Stafford Centre in 1995 it was still operating in 2000 when the Honourable WJ Carter was appointed by the Criminal Justice Commission to review the implementation of the Commission's previous recommendations. Although many of the former residents had been moved from the centre, 69 clients continued to reside there. The review found that although there were many improvements, complaints of criminal conduct and misconduct continued to be made to the Queensland Police Service and the Criminal Justice Commission. (See Criminal Justice Commission, *A Review of the Basil Stafford Centre Recommendations: Report to Disability Services Queensland* by the Honourable W J Carter QC, May 2000)

Baillie Henderson Hospital (1996)

This inquiry was conducted by the Health Rights Commissioner in response to a complaint from a registered nurse to the Health Rights Commission who worked at Baillie Henderson Hospital, a psychiatric hospital that cared for both patients with mental illness and people with intellectual disability. The staff member referred to a particular culture that was flourishing on her particular ward: ‘a learned behaviour within a group, condoned, encouraged and participated in by members of the group.’³⁰ She reported that management had passively condoned this culture that included practices (later confirmed by the investigation) such as:

- The regular and severe humiliation and degradation of residents;³¹
- The rough handling of residents;³²
- The medication of residents, locking them in their rooms, and sending them to bed early because staff were too busy to take care of them (with some residents spending up to 18 hours in their bed clothes in bed);³³
- Physical, verbal and psychological abuse of residents;³⁴
- The inappropriate use of resident’s money;³⁵ and
- The extensive use of seclusion.³⁶

The Health Rights Commissioner reporting on the outcome of the investigation stated that:

‘In incident after incident, the results of this investigation have revealed actions towards patients which should never have happened. Not a few of them are individually scandalous; but we encountered a toleration – indeed, rationalised justification – of this behaviour by staff colleagues and even senior members of staff which is corporately scandalous, and a general lack of accountability for the material rights of the residents which is in breach of Government standards and ethical practice.’³⁷

Many of the Health Rights Commissioner’s recommendations focused on organisation culture and building the capacity of staff such as:

- A workforce development plan commissioned by Queensland Health for staff;³⁸
- High priority given to regular training in such areas as the directions and goals of mental health policy; appropriate models of care; the duty of confidentiality; alternatives for patient management such as negotiation and defusing aggression; principles of intervention in critical incidents; preparation and use of care and treatment plans; standards for documentation and policies and procedures for administering medication and the use of seclusion;³⁹ and
- Informing staff of the protections of the *Whistleblowers Act* and the reprisal penalties for making complaints under the *Health Rights Commission Act*.⁴⁰

In relation to the residents with intellectual disability and no mental illness, the Commissioner recommended the transfer of responsibility from Health to the Department of Family, Youth and Community Care, and that the inappropriate use of medication, the lack of allied health services and appropriately trained staff to provide support should be immediately addressed.⁴¹

30 Health Rights Commission, Report to the Minister for Health and the Parliament of Queensland on the Investigations by the Health Rights Commission at Baillie Henderson Hospital, Toowoomba (1996) 7.

31 Ibid 9.

32 Ibid 4.

33 Ibid 9.

34 Ibid 13-18.

35 Ibid 21-24.

36 Ibid 35.

37 Ibid 69.

38 Ibid 3.

39 Ibid 3.

40 Ibid 4.

41 Ibid 6.

Cootharinga Society Townsville (1998)

This inquiry was undertaken in response to allegations received by the Health Rights Commissioner about the treatment of children and adults, including those with disabilities, at the Cootharinga Society's Nursing Home and the services provided by the Cootharinga Society to people with disability. Specifically with respect to the nursing home, the allegations (received from ex-residents, family members, staff members and ex-staff members) included:

- That adults and children with disabilities were subject to physical, psychological and verbal abuse;
- The regular use of physical restraint on both adults and children (including tying children as young as 3 years to their beds);
- The extensive use of cages and pens;
- The over-use of psychotropic medication to control resident's behaviour, including children;
- The denial of medical treatment to 'seriously ill patients' who were placed in a 'dying room' rather than sent to hospital; and
- The provision of overall poor quality care, including inappropriate medical care.

The Health Rights Commissioner's findings included that:

- The complaints of verbal, physical and psychological abuse including the extensive use of cages and pens were substantiated;⁴²
- Psychotropic medication to control residents' behaviour was used, including on children, with nurses altering the prescribed dosages without medical authority;⁴³
- There was a persisting reticence to obtain medical treatment for residents, including sick children;⁴⁴
- Actions of staff where cruel, discriminatory and unprofessional in this regard;⁴⁵ and
- There were instances where medical care was not sought for residents in need of treatment for undiagnosed fractures; pressure sores; medication reactions and viral infections.⁴⁶

Importantly the Health Rights Commissioner found that the objections of staff to the treatment of residents were either ignored or their employment was terminated.⁴⁷ There was also inadequate record keeping and documentation of the residents' care and support, medical treatment and medication administered.⁴⁸

The Care Independent Living Association, Bribie Island (2004)

In 2004, the Adult Guardian provided a report detailing instances of serious abuse against people with disability at the Care Independent Living Association on Bribie Island (Care Bribie) to the then Minister for Communities, Disability Services and Seniors, the Honourable Warren Pitt MP.⁴⁹

A number of people were subsequently charged in relation to allegations of abuse that were both disturbing and shocking. The allegations that were subsequently proven included, for example, the following, as described by the Supreme Court in relation to a child with autism:

"..the applicant tied the young boy's arms and legs to the railings on the side of a toilet and left him restrained on the toilet seat. She went to the kitchen in the care facility to get a camera and asked a co-employee to "come and have a look at this". The co-employee did so, and saw that the complainant was trying unsuccessfully to free himself. He looked really distressed and was squealing, which was how he attempted to communicate. The applicant told her co-employee

⁴² Health Rights Commission, *Ministerial Inquiry into the Cootharinga Society Townsville* (Edited Version, June 1999) 6.

⁴³ *Ibid* 7.

⁴⁴ *Ibid* 4.

⁴⁵ *Ibid* 4.

⁴⁶ *Ibid* 4.

⁴⁷ *Ibid* 12.

⁴⁸ *Ibid* 12.

⁴⁹ Statement by Honourable F.W.Pitt (member for Mulgrave, Minister for Communities, Disability Services and Seniors) Queensland Parliament, 31 August 2004.

that the child would not be allowed off the toilet until he had defecated. She took a picture of him restrained on the toilet”.

“the applicant struck the same young boy on his arms and back, and the back of his head with a plastic fly swatter a number of times. The applicant hit him because he was not eating his dinner, but would do so when hit enough times with the fly swatter. He was upset and crying. He put his arms up to try to push the applicant away”

“the applicant held the complainant down whilst another rubbed chilli on to his mouth”.⁵⁰

This conduct was found to have been supported by those managing the facility.⁵¹ The sentencing judge observed that this conduct “went beyond what could be regarded as reasonable in a civilised society and inflicted unjustifiable suffering on unfortunate and very vulnerable children.”⁵² Other allegations that were given in evidence to an Australian Parliamentary inquiry by a registered nurse who was employed at the facility included the following:

“The behavioural management was unreal. They were often denied food and had cold showers. They held someone down to cut their fingernails, using half-a-dozen people, until their fingers bled. Buckets of water were thrown over them. They had chillies put in their mouths. The Adult Guardian has also agreed with this. They were deprived of sleep. There was emotional and physical abuse. They were hitting residents with a broom handle and a fly swat. There was intimidation and harassment and there was extreme verbal abuse. Residents were often locked in their bedrooms and were often publicly humiliated in front of other people. The treatment for head lice was fly spray. The residents were often tied to chairs and toilet seats. One boy, who was an amputee who had been in a car accident and who was still going to school, often had his leg removed and he would have to crawl. The withholding of meals and food and water was a very common abuse. There was sexual abuse as well.”⁵³

Challenging Behaviour and Disability (The Carter Report) (2006)

In 2006, the Honourable William Carter QC commenced a review in relation to the “existing provisions for the care, support and accommodation of people with an intellectual/cognitive disability who represent a significant risk of harm to themselves or the community”.⁵⁴

Carter found a crisis-driven and reactive response to the issue with an over-reliance by disability service providers on practices such as detention, seclusion and restraint, including chemical restraint, of people with disability. Carter found there continued to be a practice of grouping together in congregate care arrangements people with disability who exhibited ‘challenging behaviours’ and were subject to such restraints.⁵⁵ Many such clients continued to reside at the site of the former Basil Stafford Centre which Carter described as ‘prison like in character,’ ‘totally unacceptable,’ and representing ‘a gross infringement of the relevant person’s human rights.’⁵⁶ Carter referred to the inquiry into Basil Stafford by the Criminal Justice Commission and his own 2000 review of the recommendations of that report and stated:

“That experience confirmed the vulnerability of persons with intellectual disability and the corrupt and abusive practices to which so many were subjected. The power imbalances between the so called carers and those in receipt of “care and support” is immense. The BSC experience is now not only of historical interest but serves as a constant reminder that the exercise of power and influence is readily corruptible in the case of those who are vulnerable and often powerless. Whether the “insidious institutional culture” rejected by Stewart as synonymous with BSC has survived the Stewart Report is a moot point. There are not a few who will allege that it has.”⁵⁷

⁵⁰ *R v Lister* [2009] QCA 368.

⁵¹ *Ibid.*

⁵² *Ibid.*

⁵³ Mrs Kay McMullen, Transcript of Evidence to the Standing Committee on Legal and Constitutional Affairs, Inquiry into Crime in the Community: victims, offenders and fear of crime, (Australian House of Representatives, Canberra 18 June 2004) p1801.

⁵⁴ Carter William QC, *Challenging Behaviour and Disability: A Targeted Response*, (Report to Warren Pitt MP, Minister for Communities, 2006, 4.

⁵⁵ *Ibid* 74.

⁵⁶ *Ibid* 90.

⁵⁷ *Ibid* 148.

Some clients subject to such restrictive practices were also detained in Authorised Mental Health Services although they did not have a mental illness. His final report *Challenging Behaviour and Disability: A Targeted Response* (the Carter Report) identified the inappropriateness of placing people with intellectual disability in Authorised Mental Health Services.⁵⁸

The Carter Report⁵⁹ recommended a legislative framework for restrictive practices, inclusive of provisions for detention (where a person was not subject to a forensic order or another order of a court). However, this was only one of many recommendations aimed at “a fundamental process of reform, renewal and regeneration of the DSQ and disability sector’s response [to] provide an efficient, cost effective and financially sustainable outcome for the proper care and support of persons with intellectual disability and challenging behaviour across Queensland”.⁶⁰

Institutional culture and the role played in abuse

A common theme in the numerous inquiries above concerning abuse and neglect of people with disability in institutional and residential settings is the prominent role played by the institutional cultures in allowing abuse to go unreported and to flourish. The particular culture of an organisation sets the boundaries of behaviour and attitudes in an organisation, and is likely to be a significant determinant of the likelihood of abuse and neglect occurring.⁶¹

From organisational values, policy and procedure to the attitudes of staff, and the structures and processes about how the individual organisations operated, abuse and neglect of residents was promoted and able to occur largely unchecked.

A further key factor was the treatment of staff who did raise concerns and the lack of protection available to them when they did complain. Coupled with either the lack or failure of external oversight, abusive cultures were able to go unchallenged.

Finally a key role was ultimately played by external agencies with significant powers such as the Criminal Justice Commission, Health Rights Commission and the Adult Guardian in bringing the incidences of abuse and neglect to light once complaints were able to reach them.

The importance of both preventing the development of dysfunctional organisation cultures and the existence of powerful external agencies to whom complaints can be made will be discussed again in the final section on strategies to prevent abuse, neglect and exploitation of people with disability.

Queensland government response: regulation, quality and safeguards

A new era in regulation of quality and safeguards in disability services

Following the uncovering of the allegations of abuse at Care Bribie (discussed above), the Queensland Government at the time committed to developing the Disability Service Quality System (which was introduced in 2004 as a direct response to the allegations of abuse at Care Bribie), and strengthening legislative protections for people with disability.

A review of the *Disability Services Act 1992* was also undertaken with a view to improving “mechanisms for preventing abuse of any kind against anyone”.⁶²

⁵⁸ Ibid 87.

⁵⁹ Ibid.

⁶⁰ Ibid 9.

⁶¹ The Nucleus Group, *Abuse Prevention Strategies in Specialist Disability Services: Final Report* (2002) 37.

⁶² Honourable F.W. Pitt, Member for Mulgrave and Minister for Communities, Disability Services and Seniors, Ministerial Statement to Queensland Parliament (31 August 2004) 2079.

When the new Disability Services Bill was introduced into the Queensland Parliament in December 2005, it was acknowledged that the reforms that this bill introduced:

*“came about as a result of a commitment he [the minister] gave to strengthen protection for people with a disability after he received the Adult Guardian report into allegations of serious abuse and negligence at a Bribie Island facility. As I understand it, it became clear to the minister that the government needed more power to intervene to prevent such situations occurring again”.*⁶³

The reforms ultimately passed by Parliament in 2006 included mechanisms to ensure disability funded services meet standards that underpin the Disability Sector Quality System such as:

- Legislative recognition of the disability service standards;
- A legislated pre-approval process before an organisation is eligible to receive funding;
- A certification process that provides for an external/independent body to carry out regular audits of a service provider’s compliance with the disability service standards under the Disability Sector Quality System;
- The ability for a regulation to set out prescribed requirements in relation to the provision of disability services by funded providers including for example how an organisation protects people with disability from abuse, neglect and exploitation;
- A range of sanctions for non-compliance by funded disability service providers;
- Powers for investigating and monitoring funded disability service providers (including a power for authorised officers to apply for a warrant to enter a funded service to investigate non-compliance, or to enter without a warrant if there is an immediate risk of harm to a person with a disability);
- A complaints handling process; and
- Criminal history screening for employees of funded disability services.

Regulation of restrictive practices

In 2008, the *Disability Services Act 2006* and the *Guardianship and Administration Act 2000* were also amended to provide a regulatory framework for the use of restrictive practices such as containment, seclusion, physical, mechanical and chemical restraint. These legislative amendments were part of a broader system reform aimed at reducing and eliminating the use of restrictive practices. Central to the reforms, known as *Positive Futures*, was a focus on positive behaviour support.

The range of reforms that had been recommended by Justice Carter in the Carter Report and adopted by the Queensland Government included a new individualised approach to working with people with intellectual disability or cognitive impairment and challenging behaviours that involved comprehensive multi-disciplinary assessments and individualised positive behaviour support; a Queensland Centre for Best Practice in Positive Behaviour Support whose role would include research, community development and education; recruitment and development of qualified allied health and support staff; and the establishment of a range of accommodation options including community living for the target group.⁶⁴

⁶³ Honourable Mr Shine MP, Member for Toowoomba North, Second Reading Disability Services Bill, Queensland Parliament (9 March 2006) 792.

⁶⁴Carter above n54, 10.

Ongoing concerns

Ongoing institutionalisation

Of great concern to the Public Advocate is that while many institutional living environments have now closed and there has been an increase in community-based living arrangements, there are still many people with disability living in institutional type settings who are segregated from the community. Many of these individuals have limited opportunities to increase their autonomy, capability, participation and inclusion.

In June 2013, the Public Advocate released a position statement (on continuing deinstitutionalisation in Queensland) and called on the Queensland Government to develop a plan, based on consultation with people with disability and their families, to enable increased autonomy for people with disability living in institutional environments. The Public Advocate also sought information from the Queensland Government on the numbers of people with intellectual disability or cognitive impairment who continue to reside in health facilities, called for submissions from the community, and also visited a number of health facilities.

The Public Advocate's report – *People with intellectual disability or cognitive impairment residing long-term in health care facilities: Addressing the barriers to deinstitutionalisation* – was tabled in Parliament on 7 November 2013.

The Public Advocate found that as at May 2013, there remained **271 people with intellectual disability or cognitive impairment residing in health facilities**, inclusive of mental health services, in Queensland.

While acknowledging the individual circumstances of each resident, those who remain in long-stay health care facilities can be broadly characterised within two groups:

- First there are many people, notably people with intellectual disability, who 'missed out' on earlier deinstitutionalisation and have remained living in institutions for up to 65 years. Many were initially placed in these institutions as babies or small children, however for various reasons they were denied the opportunities that were given to other people with similar levels of disability to live in the community. Others came to these facilities later in life following a breakdown in supports and/or the inability to access the necessary services to be supported in the community.
- Second, there are people with acquired brain injuries (ABI) residing in hospitals and other health facilities who are unable to access crucial opportunities for rehabilitation and reintegration back into community. Some have lived in these facilities up to 35 years.

Of the 271 people who were the subject of the report, **131 people** with intellectual disability or cognitive impairment were long-stay residents in **public health facilities** inclusive of residential health care facilities, Baillie Henderson Hospital and the Park Centre for Mental Health; a total of **12 people** were residing in **public aged care facilities**; and **30 people** were residing in **various hospitals and other health services**. A further **98 people** were residing in **mental health services**.

Submissions to the Public Advocate confirmed that, despite the best intentions of staff, in many cases the models of care provided in health facilities where people with intellectual disability or cognitive impairment reside do not meet contemporary standards for people with intellectual disability or cognitive impairment. In particular, support is not provided to develop the functional skills and capability of people with disability. Neither do they receive adequate support to ensure the best outcomes for physical, social and emotional well-being. There are also few opportunities provided to enable choice or to participate in the community.

A family member of a resident in a long-stay health care facility stated:

"It is of great concern to me to witness how Sophie's* support needs have increased over time. Prior to being placed in the Centre she had limited speech, could feed herself, eat ordinary food once it was cut into bite sized pieces, walk small distances with support, support herself sitting up, and took minimal medication and had relative good health.

What I witness now is someone who has lost speech and language, lost ability to feed herself (eat and drink independently), lost ability to swallow solid food, lost all ability to walk, lost teeth, lost her good health (now taking many medications for systematic deterioration of eating, digestion, elimination), and her muscles have atrophied and stiffened.

Sophie has also been denied the right to a good education and work opportunities, and the right to develop healthy relationships. Instead she has lived a wasted life with a lack of purpose, loneliness and isolation, in a segregated environment filled with a medical routine.”⁶⁵

Many people in these facilities sleep in hospital beds in ‘ward-like’ environments, some have done so for up to 65 years, despite these places being described as their ‘homes’ and recognition that these arrangements are not required for ‘medical care’. The facilities are often noisy with little privacy. They are staffed by nursing and other health staff, and a medical model of care predominates. The low staff-to-resident ratio means that most of the day is taken up with personal care with few opportunities for personal support or to learn activities of daily living. Most things are done ‘to’ or ‘for’ residents. The size and nature of the facilities mean that there are rigid routines, for example strict ‘bed times’, regardless of a person’s age or desires they may have for a routine that suits their personal needs or wishes. Access to the community is limited and for some non-existent.

It was submitted to the Public Advocate that, under these conditions, people experience deterioration in their health and well-being and lose crucial skills (including communication skills) that would enhance their ability to live a good life in the community.

Parents of a man with intellectual disability who has been living in a health facility for 25 years submitted to the Public Advocate that they had given up hope of their son ever moving from the facility in which he was residing, or of him receiving better care.

These parents describe the care provided to Stuart* as being like hospital care. For example, everyone eats together, the same thing at the same time. Everyone must go to sleep at the same time, early evening, despite their age. All residents sleep in hospital beds. Stuart has slept in a hospital bed in a ward-like environment for the past 25 years, even though this is his ‘home’. He does not get any opportunity to learn daily living skills like cooking, as the staff do everything for him.

They described how over the years their son had not only been denied the opportunity to learn and develop, but that he has greatly deteriorated. For example, despite his non-verbal status, when Stuart was younger, they said, he showed more potential for understanding written words and numbers and even had an interest in maths.

However the facility where he resides has never worked to develop this potential or even to provide assistance with communication. They believe that despite his ‘limitations’ even now, after 25 years of living in the facility, Stuart is capable of doing more than he currently does.

Stuart’s parents believe their son should be living in the community and could live in the community with support and appropriate accommodation. They were concerned, however, that their son should not be placed in another institutional-type environment, for example in a home with other people with disability.

While assured of anonymity, the parents were greatly concerned not to be identified because they believed in some way it would affect their son’s support.

The family are still waiting on funding for Stuart to move out of the facility, but they are now getting older and, while still concerned for his future, have almost ‘given up’.⁶⁶

* The resident’s real name and the name of the facility have not been used.

⁶⁵ Confidential, Submission No 7 to the Public Advocate, *People with Disability in Long-Stay Health Care Facilities*, 2 August 2013.

* The resident’s real name and the name of the facility have not been used.

⁶⁶ Confidential, Submission No 2 to the Public Advocate, *People with Disability in Long-Stay Health Care Facilities*, 10 July 2013.

While the (previous) Queensland Government reported it had commenced the development of a Joint Action Plan – *Transition of long-stay younger people with a disability from Queensland public health facilities* (the Joint Action Plan), this plan has not been made public, nor has there been any consultation on the development of the plan.

The Public Advocate will continue to seek regular reports from key government departments on their progress towards ensuring people with disability in long-stay facilities are transitioned to more appropriate models of support with maximum opportunities for choice and control.

Restrictive Practices

People with intellectual disability or cognitive impairment who are subject to restrictive practices (such as containment; seclusion; physical, chemical and mechanical restraint; and/or restricted access) represent a significantly marginalised and vulnerable group of individuals.

Regulation of restrictive practices in Queensland was introduced in 2008, along with significant other service system reforms (described above), however there has been no evidence about the efficacy of the legislative and other reforms in reducing and eliminating the use of restrictive practices in disability services. While the previous Queensland Government did review the restrictive practices regime, the reforms were weighted heavily towards reducing the regulatory burden on non-government service providers that use such practices and have to comply with the regulatory regime.⁶⁷

One important reform however was to introduce a requirement for service providers who use such practices to report on these practices to the Department. The Public Advocate and the Public Guardian will have access to this data. This commencement of this requirement was delayed, however, and to date the Public Advocate has not received any such reports.

In the meantime highly vulnerable people continue to be subject to practices that impact significantly on their human rights without proper transparency. When you consider the impact of such practices on vulnerable people, this transparency is crucial. For example in the case of *MJI*, the Queensland Civil and Administrative Tribunal described the environment of a 23 year old man with autism and intellectual disability for whom ‘containment’ had been approved:

‘His physical environment is appalling. It is almost totally devoid of any furniture. It is poorly maintained, barren and lacks any personalised comforts or items. MJI generally receives his meals through a slot. He watches television by having the image projected on to a wall in one of his rooms. He has a relatively large yard area devoid of any equipment. This is totally enclosed via either a brick wall or fine wire mesh about 4 meters high. It has been described as a caged area.’⁶⁸

In another case, a support worker described the conditions under which a client subject to ‘restrictive practices’ was living when she first met him in a residential disability service in Queensland:

‘She said that she was greeted by a support worker who unlocked and unbolted the front door. We were immediately inside a small room. This appeared to be for staff. This was double locked by another half door with Perspex leading to a small kitchenette. This was again separated by a wall which was half Perspex with another big locked door in the middle; beyond which was a small, bare, what appeared to be lounge area which had a chair bolted to the ground, a sleeping area, and unmade single bed with a couple of wall shelves above it, small drawers and a toilet. There were no doors to any of these areas. P was stood in the middle of this area. The worker proceeded to join the other worker at a small dining table, where they had obviously been sat watching P through this observation room. One of the staff unlocked the door to where P was standing, to let us in...they then locked it immediately behind us. There was handwriting all over those grey concrete walls ...‘Help me, I want to die, I hate you.’⁶⁹

⁶⁷ Disability Services (Restrictive Practices and Other Legislation) Amendment Bill 2013.

⁶⁸ *MJI* [2010] QCAT 76.

⁶⁹ Annette Osborne, Presentation at QAI Forum: Human Rights v Restrictive Practices (Friday 31 August 2013).

Michael Kendrick has emphasised the importance of restrictive practices regulation not promoting a one-way door for people with disability, where it is easier to get into highly restrictive settings than to get out of them, remarking that:

*'If we do not meet that test, then we have got a trap that just holds people frozen, which is what we had with the old residential institutions we largely replaced many years ago but are now recreating under the guise of 'needing' a new generation of restrictive practice settings. Consequently, we are now facing an unintended policy of the expansion of a new generation of horribly restrictive institutions both within communities and on the site of the old institutions that were discredited and devolved many years ago. Most certainly this is an ominous sign that we have not learned from the past and our safeguards against the abuses of that period are proving to be laughably weak if non-existent.'*⁷⁰

In other states, restrictive practice are imposed in an unregulated manner, without the 'safeguards' that the regulatory frameworks for restrictive practices bring. This situation has come to the attention of the United Nations Committee on the Rights of Persons with Disabilities (UNCRPD), which has expressed concern about Australia's unregulated use of restrictive practices in Australia. In the Committee's concluding observations on Australia's initial report under the Convention on the Rights of Persons with Disabilities, the Committee said that:

*'The Committee is concerned that people with disabilities, particularly those with intellectual impairment or psychosocial disability, are subjected to unregulated behaviour modification or restrictive practices such as chemical, mechanical and physical restraint and seclusion, in environments such as schools, mental health facilities and hospitals.'*⁷¹

Further, even in states that do regulate the use of restrictive practices these regimes are limited in scope to state-funded or -operated disability services. This means that even in the four jurisdictions that have enacted legislation (Victoria, Queensland, Tasmania and the Northern Territory) restrictive practices used in privately funded services or in hospitals, aged care and other health facilities are not specifically regulated.⁷²

Australia is characterised by what has been described as a 'hotchpotch' of regulation or not.⁷³ The upcoming NDIS is an important opportunity to achieve national consistency premised on a best practice approach.

⁷⁰ Michael J Kendrick, Presentation at the Restrictive Practices Forum (Queensland Advocacy Incorporated, Brisbane, August 23, 2010).

⁷¹ Committee on the Rights of Persons With Disabilities, *Concluding Observations on the Initial Report of Australia* (adopted by the Committee at its tenth session 2-13 September 2013) 5.

⁷² Kim Chandler, Lindy Willmott and Ben White, 'Rethinking restrictive practices: a comparative analysis' (2014) 2 *QUT Law Review* 91.

⁷³ *Ibid* 120.

Part Two: Strengthening safeguards to prevent violence, abuse and neglect

Characteristics of a system to prevent violence, abuse and neglect

There are numerous existing publications that provide information and strategies on preventing and responding to violence, abuse and neglect of people with disability.⁷⁴ In the particular context of institutional and residential care, the Public Advocate believes that there should be a multi-level strategy to prevent violence, abuse and neglect where there is a focus on:

- Strong independent oversight and monitoring;
- Quality service provisions; and
- Strong support and advocacy provided to people with impaired capacity.

The history of abuse described above, and the closed nature of residential and institutional environments which tend to develop their own internal cultures, speaks to the importance of strong, independent oversight and monitoring, and ensuring the involvement of supporters and advocates external to services.

Strong independent oversight and monitoring

Independent statutory authority to receive and investigate complaints

Integral to an effective system is the existence of independent entities with strong investigative powers to handle complaints; these entities should be removed from the service provider, or department or agency funding the service.

Without such independent oversight and investigative powers there is a danger that cultures of violence, abuse and neglect go unchallenged. Apart from the service provider itself, even the department or agency responsible for funding the service also has a vested interest. For this reason there must be an independent statutory authority that can conduct investigations into serious, systemic and/or unresolved allegations of violence, abuse and neglect.

The independent entity or body should have powers to receive, resolve and investigate complaints; request information and conduct investigations both in response to complaints and of its own volition; report on the outcomes of investigations and make recommendations and/or directions to regulatory bodies concerning funding and registration of the service provider subject to the complaint.

Strong whistle blower protection

To facilitate such investigative processes there must be strong whistle blower protections for employees that are well promoted and respected by Government.

As evidenced in part one of this submission, many complainants were subject to retribution, harassment and bullying when they raised concerns. Some staff had their employment terminated. Fear of such retribution can be a key reason why employees of services where violence, abuse and neglect is occurring do not make complaints.

These strong whistle blower protections must be supported by strong internal policies and training and education to service provider employees on complaints systems and whistle blower protections.

⁷⁴ The Nucleus Group, *Abuse Prevention Strategies in Specialist Disability Services* (Final Report 2002); Disability Services Commissioner, *Safeguarding People's Right to be Free From Abuse* (Victoria 2012); Children with Disability Australia, *Enabling and Protecting: Proactive approaches to address abuse and neglect of children and young people with disability* (Australian Government 2012).

Strong compliance and enforcement powers

Internal (to the funding department) and external investigative organisations must also have strong compliance and enforcement powers that they are prepared to utilise in response to allegations of violence, abuse and neglect.

Some of those powers might include for example, if the agency believes the client to be at risk of harm, the power to enter a service unannounced, and without the service provider's consent, either with or without a warrant. These agencies must have the power to act swiftly and without delay and in a manner that does not provide the service provider time to prepare.

It is well known and understood that the abuse of vulnerable people, including many people with disability, is difficult to uncover. People with disability themselves may find it difficult to complain, or not know that they have a right to. It may be difficult to gather the evidence needed to support the application for a warrant or even an immediate police response.

Other powers might include:

- The power to install an interim manager (in serious cases where management are unsupportive of the investigation or seem to be complicit in the violence, abuse and neglect) to ensure all clients are safe;
- The power to direct that the agency is defunded/de-registered; and
- The power to issue 'show cause' notices in relation to why other compliance strategies should not be commenced (such as defunding, de-registration, or interim management).

The importance of investigative/inquisitorial mechanism

While there may be sophisticated complaints systems in existence that are consistent with international best practice and supported by educational material and training, people with impaired capacity can still face enormous barriers in making complaints not only about violence, abuse and neglect but also about service dissatisfaction.

To begin with, depending on the nature of the person's disability, supplying written information about your right to make a complaint may be of little use to a person who cannot read or communicate verbally. People with a pronounced intellectual or cognitive disability may not have the literacy skills to read documents, including their easy English accompaniments; may be unable to understand their written content; or may not grasp the significance that making a complaint may have as a means to improve their lives or stop violence, abuse or neglect. In effect, the usual 'passive' methods of promoting the right to complain and the pathways to enacting that right may be largely ineffective for many people with disability.

Other barriers to making complaints may include fear of retribution, being labelled a 'troublemaker', or if you are a family member of the service user, that the service may decide to relinquish the service provided to your family member.

There is therefore considerable need to develop and implement systems and strategies that are based on the proactive identification of complaints and dissatisfaction amongst service users who may not be able to directly express such a complaint or articulate their dissatisfaction in the form of a complaint as it is usually understood. External visitors to residential disability services (such as the existing state based community visitors) are a crucial part of such a strategy as well as a crucial part of a system of oversight and monitoring of disability services.

They are particularly important in the context of residential disability services and institutional living environments where there are people with disability with a high level of dependence. Like other 'closed environments' where access to the outside world is limited, for example due to conditions of detention (such as prisons or immigration detention centres), residential disability services and institutional living environments are similarly isolated. In such cases, however, it is often the level of intellectual or cognitive disability and the segregated nature of the environment from the rest of the community (many people with impaired capacity also do not have family or friends who visit them regularly) that means residents are particularly vulnerable to violence, abuse and neglect.

The Community Visitor Programs, or a similar inspectorate should operate as an inquisitorial process in terms of identifying, investigating and resolving complaints. These informal processes can be of great benefit particularly to people with impaired capacity who may have difficulty making complaints. However, they can and should have a role in referring complaints to external, independent complaints bodies.

Other systemic advocates

Other systemic advocates such as Public Advocates/Guardians and independent advocates and/or community advocacy organisations also play an important role and should always form part of a system of safeguards.

Quality Services

Processes and requirements that ensure that services that are high quality and safe for people with disability are also an imperative part of the system of preventing violence, abuse and neglect.

This includes provider registration/accreditation; safe recruitment practices; and good quality complaints systems. There should be nationally consistent policies on the prevention of and responses to violence, abuse and neglect, including requirements ensuring that services develop their own policies and procedures consistent with these policies.

Strong Support and Advocacy

Support

Although people with impaired capacity might find it difficult to raise issues about any number of matters ranging from service dissatisfaction to violence, abuse and neglect due to a number of barriers, such as communication, supporters can be of assistance in:

- Accessing and understanding information about the outcomes they want from their service provider, what constitutes abuse and neglect, and how to make a complaint; and
- Assisting the person to voice their dissatisfaction or complaint.

While some people with disability may have natural support networks made up of family and friends, many others do not.

Consistent with Australia's obligations under the United Nations *Convention on the Rights of Persons with Disabilities*,⁷⁵ people with disability, including those with intellectual and cognitive disabilities, must be provided with support to assist them with accessing and analysing information and making decisions.

A general principle of the Convention includes "respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons".⁷⁶ Article 12 imposes an obligation on State parties to recognise that people with disability enjoy legal capacity on an equal basis with others. This further includes the right to be recognised as a person before the law and the right to have one's decisions and choices legally validated and recognised.⁷⁷ Read with article 5, an overarching principle of equality and non-discrimination, there is an obligation on State parties to ensure support is provided to people with disability to enable them to exercise their legal capacity, so as to avoid discrimination. Discrimination includes the failure to ensure the provision of reasonable accommodation.⁷⁸

The recent Law Reform Commission report, *Equality, Capacity and Disability in Commonwealth Laws*,⁷⁹ recommended a new decision-making model for Australia, with national decision-making principles, based on both supporters and representatives to assist people who need decision-

⁷⁵ *Convention on the Rights of Persons With Disabilities*, above n 8.

⁷⁶ *Convention on the Rights of Persons With Disabilities*, above n 8, art 3.

⁷⁷ E Flynn and A Arstein-Kerlake, 'Legislation Personhood: Realising the Right to Support in Exercising Legal Capacity' (conference proceedings at the Australian Guardianship and Administration Council World Conference, Melbourne, 2012) 1.

⁷⁸ *Convention on the Rights of Persons With Disabilities*, above n 8, art 5.

⁷⁹ Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws* (August 2014, Report 124).

making support to make decisions in relevant areas of Commonwealth Laws. But supporters can play a broader role too. Enhanced and more coordinated access to general support can assist in keeping people out of formal guardianship systems and empower them to make decisions about their own lives.

Nationally and internationally, a variety of models have been implemented, legislated for and trialled. Sweden, for example, has legislated for the right of every person with severe physical or mental disabilities to have an entitlement to support services. The Bill (*Lag om stöd och service till vissa funktionshindrade*) came into effect in 1994 and gives people with functional disabilities the legal right to ten different kinds of support and services.⁸⁰ Importantly, the law makes a personal assistant a mandated support service for people with disability covered by the scope of the legislation, which can be provided directly by the government or by a cash allowance to the person with disability who can employ their own personal assistant.⁸¹

The forthcoming NDIS presents a particular opportunity for Australia to be brought into line with contemporary models of support provided to people with disability, as well as to fulfil our obligations under the *Convention on the Rights of Persons with Disabilities*. Recognising the role of and providing access to appropriate support to people with disability to exercise their legal rights should be a priority.

Advocacy

Independent and high quality advocacy plays an important role in supporting vulnerable people to understand their rights, and voice their issues and complaints. Advocates have specialist knowledge, expertise and skills in understanding the support and legal systems relevant to people with disability and play an important role in ensuring people with disability can exercise their rights and have their rights observed.

Funded advocacy services for people with disability in Australia are currently insufficient, despite them becoming increasingly important under the market-based approach that underpins the NDIS. Recent Australian Government Productivity Commission reports into disability support⁸² and aged care⁸³ reiterate the importance, and recommend the implementation, of funded independent advocacy supports for users of these systems.⁸⁴

Inclusive Communities

Isolation and segregation of people with disability, particularly people with impaired capacity living in institutional and residential settings, is a serious and ongoing issue in Australian society. Many people with intellectual disability and cognitive impairment live in group environments with other people with similar disabilities. While they may have occasional community access, this often does not involve them becoming part of their local communities, or forming relationships with other community members. Often institutions and/or residences are physically segregated from the local communities, by high fences or large grounds. Such isolation and segregation not only continues to promote negative ideas and stereotypes about people with disability but also makes them extremely vulnerable to violence, abuse and neglect.

Of crucial importance in reducing violence, abuse and neglect of people with disability is the need to build inclusive communities, raise awareness and address negative community attitudes about people with disability. While this needs to be driven at a strategic policy level by Commonwealth and State Governments, such strategies need to be implemented on the ground in people's local communities by involving mainstream community services such as neighbourhood houses.

⁸⁰ Ibid.

⁸¹ Stanley S Herr, *Self Determination, Autonomy and Alternatives for Guardianship* <<http://ruralinstitute.umt.edu/transition/Handouts/Self-Determination.Herr.pdf>>.

⁸² Byrne (cited in 'Draft Report on Caring for Older Australians' (Transcript of Proceedings at Brisbane on Friday, 25th March 2011, at 8.29 am, Australian Government Productivity Commission (AGPC), 2011e) 26; 'Disability Care and Support' (Vol. 2, No. 54, AGPC, 31 July 2011b) 560 <http://www.pc.gov.au/__data/assets/pdf_file/0013/111271/disability-support-volume2.pdf>.

⁸³ 'Draft Report on Caring for Older Australians' (Vol. 1, No. 53, AGPC, 28 June 2011c) LXIX, LXXXVI, XXXII, XLIX <http://www.pc.gov.au/__data/assets/pdf_file/0004/110929/aged-care-volume1.pdf>; 'Draft Report on Caring for Older Australians' (Vol. 2, No. 53, AGPC, 28 June 2011d) 129, 136, 165-166, 168, 170-1, 173 <http://www.pc.gov.au/__data/assets/pdf_file/0014/110930/aged-care-volume2.pdf>.

⁸⁴ The *Disability Services Act 2006* (Qld) s 32 also requires services to provide service users with access to necessary independent advocacy support.

Other issues

Broader integrated approaches

Conceptualising the issue as vulnerable adult protection

Violence, abuse and neglect of people with disability should be considered alongside other vulnerable populations including, for example, older people. Internationally such integrated approaches to protection of vulnerable adults have developed in countries such as Scotland, the United States, Canada and the United Kingdom. These schemes are supported by educative and advice strategies and importantly legislative frameworks that enable complaints, mandatory reporting, investigations and protective orders.

It makes sense when considering the development of new strategies for prevention, employment screening, investigation and other responses to also consider how such strategies could benefit other vulnerable adults, in addition to people with disability.

Need for systemic and legislative reform in the justice system

To enable a more responsive and effective response to people with intellectual impairment who have been subject to violence, abuse and neglect there also needs to be systemic and legislative reform of the justice system. From contact with the police through to possible court proceedings, people with disability who are victims of violence, abuse and neglect face numerous disadvantages in the justice system.

To begin with, many people with disability do not make a complaint to the police or if they do make a complaint, it is often not acted upon by police. Attitudes of key stakeholders in the justice system combined with rules of evidence may be particularly problematic for some adults with impaired capacity who may have their complaints and concerns dismissed as invalid or not credible because they are unable, or do not know how, to relay their experiences as a substantive and compelling argument that fits within existing intellectual and legal notions of evidence.

For example a number of barriers have been identified as experienced by women with intellectual disability who were victims of sexual assault and who were attempting to make statements to police.⁸⁵

It has been reported by Keilty and Connelly who conducted research into this area, that police officers tended to stereotype women with intellectual disability; were sometimes sceptical of the veracity of their claims; and perceived that complainants had low believability and exaggerated their complaints.⁸⁶ Police also considered their evidence insufficient in terms of detail and chronological accuracy.⁸⁷ Further, whether or not the issue was progressed was often dependent upon officers' beliefs about how well the evidence would stand up under scrutiny from the legal system.⁸⁸

Fairness for adults with impaired capacity is, therefore, integrally linked to the concept of access, with the Australian Human Rights Commission stating that if people with disability are not able to present their cause in accordance with the rules of evidence, they may lose meaningful access to justice.⁸⁹

Many people with intellectual impairment in particular may experience difficulty with communication. If those people were the victim of an offence, it is likely that they would be unable to make a complaint to the police. For example, the victim may lack the ability to communicate or be unable to adequately explain what occurred. In some instances, offences may be witnessed by others. Where this occurs, the witness' testimony must be able to operate as a complaint of criminal conduct against the victim. Further, it must be ensured that such complaints are properly investigated and, if warranted, the alleged offender prosecuted.

⁸⁵ Jennifer Keilty and Georgina Connelly, 'Making a Statement: An Exploratory Study of Barriers Facing Women with an Intellectual Disability when Making a Statement about Sexual Assault to Police' (2001) 16(2) *Disability & Society* 273-291.

⁸⁶ *Ibid* 283.

⁸⁷ *Ibid* 285.

⁸⁸ See also Australian Human Rights Commission (AHRC), *Background Paper on Access to Justice for People with Disability in the Criminal Justice System* (DLA Piper, 2013) 9>; Office of the Public Advocate Queensland, *Submission to the Australian Human Rights Commission for the Investigation into Access to Justice in the Criminal Justice System for People with Disability*, August 2013, 6 <http://www.justice.qld.gov.au/_data/assets/pdf_file/0012/208101/AHRC-Submission-Disability-and-Criminal-Law.pdf>; VEOHRC, above n 51, 35.

⁸⁹ AHRC above n 88, 7.

The Office of the Public Advocate in Queensland was informed of an incident in Queensland whereby a member of the public witnessed a physical assault committed against a person with disability. The member of the public took down specific details to assist in the identification of the perpetrator and, with these details on hand, approached police to make a complaint regarding the assault. However, she was unable to successfully file the complaint and was told by police that the victim was required to make the complaint. It should never be the case that a victim with disability or impaired decision-making capacity is required to personally make a complaint before an alleged offence against a person is investigated.

It should be noted that the Queensland Police Service Operational Procedures Manual states ‘members receiving a complaint or report of a suspected offence where a person with impaired capacity is a victim are to ensure that such offence is investigated and where appropriate, prosecution action taken against the offender’.⁹⁰ Compliance with this requirement is essential not only by police but also by all persons making decisions regarding the prosecution or progress of a matter involving persons with disability and/or impaired decision-making capacity.

At the heart of this matter is often a lack of awareness about the vulnerability of people with disability to abuse, neglect and exploitation and the difficulties people with disability may have in making a complaint. Numerous studies have consistently shown that people with intellectual disability experience abuse and neglect at high rates and that there is often both poor recognition of abuse and neglect as well as little access to justice as victims.⁹¹

People with disability are also disadvantaged in the court process. The criminal justice system must always ensure that provisions are made for people with intellectual and cognitive impairments to give evidence in court proceedings. The system must also ensure that people with intellectual or cognitive impairment are identified, and that these provisions are utilised for their benefit and in the way that will best accommodate them within the criminal justice system. If a person is properly accommodated within the justice system and is able to give their evidence to the best of their ability, then their evidence can and should be considered in the same way as the evidence of all other witnesses.

Some people with intellectual or cognitive impairment may also require assistance with communication or even interpreters to assist them to give evidence. While the justice system often only thinks of interpreters in terms of assisting people from non-English speaking backgrounds, interpreters can also be of assistance for people with disability. Many people with intellectual impairment communicate through means other than speech; such as by writing, typing, using symbols or pointing to words on a communication board. Further, there may be situations where a person with intellectual impairment can speak but is only properly understood by those with whom he or she is in close contact, or can only understand things said by others if they are carefully explained by a person with whom they can communicate effectively. In the United Kingdom, for example, where such situations arise, a ‘witness intermediary’ may be used.⁹² In that instance:

‘the function of an intermediary is to assist intellectually disabled and other ‘vulnerable’ witnesses to communicate by explaining the questions being asked of them and in turn explaining to the court the answers given by the witness. An intermediary effectively acts as a ‘go-between’ to facilitate communication between the witness and the court.’⁹³

A witness intermediary can also be used before trial to improve the person’s understanding of court processes and consequently enhance their ability to be involved in court proceedings and to appear as a witness.⁹⁴ Witness intermediaries must be trained, accredited, assessed and registered, and often come from professional backgrounds.⁹⁵

⁹⁰ Queensland Police Service, *Operational Procedures Manual* (18 January 2013) Queensland Police Service Operational Procedures Manual (Public Copy) <<http://archive.sclqld.org.au/qps-manuals/opm/current-issue/>> 6.3.12.

⁹¹ Sally Robinson, ‘Safe at home? Factors influencing the safety strategies used by people with intellectual disability’, *Scandinavian Journal of Disability Research* (2013) DOI:10.1080/15017419.2013.781958, 2.

⁹² Victorian Law Reform Committee, *Report of the Law Reform Committee for the Inquiry into Access to and Interaction with the Justice System by People with an Intellectual Disability and the Families and Carers*, Parliamentary paper No 216 (2013) , 283.

⁹³ *Ibid* 283.

⁹⁴ *Ibid* 283.

⁹⁵ *Ibid* 283.

Looking towards the future and the NDIS

The Public Advocate recently tendered a submission in response to the Consultation Paper that was distributed about a proposed Quality and Safeguarding Framework for the NDIS.

While this submission will not seek to detail the issues that were raised in the Public Advocate's response to the NDIS Quality and Safeguarding Framework, there are some key principles that are integral to promoting a culture of appropriate and responsive services and supports to people with disability.

In considering options by which to enable appropriate and responsive safeguards for people with disability, the minimum threshold for testing any such options should involve analysing the extent to which each option complies with the objectives and principles of the United Nations *Convention on the Rights of Persons with Disabilities*.

There is also a clear need to undertake a detailed and sophisticated risk analysis that considers the different NDIS participant populations and the potential for market failure in the NDIS against the heavy reliance on industry self-regulations that appears to be favoured in the proposed design of the NDIS Quality and Safeguarding Framework.

Furthermore, given that the circumstances of many people with disability increase their vulnerability, especially those who have impaired decision-making capacity, I believe that we need to adopt a balanced approach that recognises differing levels of risk and enables the highest possible safeguards to be applied where needed while still ensuring a simplified approach and enabling people with disability to have maximum autonomy within the new service system.

The focus of the NDIS must be on achieving outcomes for people with disability. This should be central to any model that is developed, recognising that this must be applied within the context of a consumer-driven market-based approach to service delivery.

The quality and safeguarding framework under the NDIS cannot rely solely on any one singular mechanism to effectively safeguard people with disability. The framework must work as a cohesive structure that draws upon a number of mechanisms working in a coordinated and integrated manner. The framework needs to be iterative in nature so that it can be progressively enhanced in accordance with the growing understanding that will be generated as the new disability service system evolves over time. Further to this, there may be instances where particular safeguards are not sufficient to adequately and appropriately protect people with disability and the framework must have capacity to apply corrective strategies to resolve such issues.

The framework must offer appropriate protections for people with disability, especially when responding to instances of abuse, neglect and exploitation, but that also reduces the burden of overly bureaucratic processes and enables a system that is easy to navigate and access.

Unfortunately it is still the case that people with disability are often not embraced as being part of the rich and diverse fabric of society. This needs to change. We need to educate the community of today in seeking to ensure a positive shift in the attitudes of those who will comprise the society of tomorrow.

Given the premises upon which the NDIS is being implemented, there should be a focus on the importance of the general community having a shared role in ensuring accessibility, reasonable accommodation and acceptance. There should be a sustained 'campaign' that seeks to convey the clear message that ensuring an inclusive community is everyone's responsibility, and not just a responsibility for Government. Such a campaign should also involve community safety messages that are inclusive of people with disability.

In accordance with this, central to any system of safeguarding is the need to ensure that it is accessible and applicable across all levels of community, to the extent that it is equally inclusive to people with disability as much as it is the general public, and to mainstream services as much as it is to specialist disability services. There should also be a particularly strong emphasis on the developmental and educational elements, while still providing for appropriate corrective responses when issues are identified.

There should be a focus on developing and maintaining appropriate natural safeguards that recognise the vulnerability that is often experienced by people with disability, particularly those with impaired decision-making capacity. However, it should also be acknowledged that many people with disability have few natural networks and/or experience limited social connectedness. Furthermore, many rely on formal supports to assist them in much of their everyday life, including their social engagement.

In recognising this, alongside the need to enhance and strengthen natural networks should be a range of intentional safeguards that are easy to identify and simple to access, while also being responsive and effective.

In designing an appropriate system of quality and safeguards, it is important to ensure that the system is not unduly onerous for either people with disability themselves or for those who offer support to people with disability. To this end, any system that seeks to ensure appropriate safeguards for people with disability also needs to ensure that people with disability are able to exercise choice and control without being bound by unnecessarily bureaucratic systems that may limit their ability to engage a provider of their choice and/or decide the way in which support is provided to them.

Recognising that some people with disability are likely to find any system of safeguarding to be complex to navigate, there is a clear need for advocacy. Building the capability of people with disability to self-advocate will be of significant benefit, however there also needs to exist advocacy in a variety of other forms to ensure that people with disability can get the support that they need to pursue their expressions of concern when they experience issues with the provision of supports and services.

There is also a need for independent safeguarding mechanisms such as the Community Visitor Program that can cast an independent eye over service arrangements and that have the potential to seek out issues of concern for people with disability, rather than requiring people with disability to independently navigate formal complaints management systems.

From a service provision perspective, the importance of generating a positive organisational culture should be central to the way in which any service seeks to establish and maintain its own internal approach to quality and safeguarding. This is as much about the attitudinal elements of the organisation itself and those who they employ, as it is about the systems and processes that underpin service delivery.

Service providers should seek to develop systems that prioritise the satisfaction of those who choose to access their services. They should seek to establish facilitative and inquisitorial approaches that proactively identify opportunities for service improvement by encouraging expressions of dissatisfaction and attending to these promptly and decisively.

Furthermore, there should be a clear delineation between those who respond to concerns raised by people with disability and those about whom the concerns have been raised. This independence is an important safeguard both for people with disability as well as for organisations themselves in seeking to ensure high quality service delivery that is both respectful and responsive to those who have chosen to use their service. Without this, service providers may find it difficult to retain a sufficient client base to maintain the viability of their organisation.

At the corrective end, the system needs to be simple. It needs to ensure that people can easily identify the appropriate agency to whom concerns should be directed while being assured that their concerns will be taken seriously and responded to appropriately. The system also needs to be appropriately responsive to people with disability who use a range of different communication methods.

Regardless of any internal systems that may be operated by a service organisation, there should also exist an independent oversight body that is independent of both the NDIS itself, and the National Disability Insurance Agency. Such a body should be given the statutory authority to not only investigate complaints but also to direct action in response to substantiated issues. Furthermore, an independent oversight body should play a central role in identifying and addressing systemic issues by using the information gathered through their work to guide and enhance education, training, skills development and systems improvement both within the disability service sector as well as in the general community.

Concluding comments

I commend the Australian Government for its focus on this important issue and the Committee for its review of violence, abuse and neglect against people with disability in institutional and residential settings. The investigations that have occurred in Queensland in response to allegations of abuse in institutional and residential settings is reflective of a pervasive issue that has been evidenced across time and across multiple jurisdictions, both nationally and internationally.

Mitigating the risk of abuse, assault, neglect and exploitation of people with disability is by no means an easy task. It requires not only a systemic solution targeted to those providing supports and services to people with disability but also a level of general community responsibility that says 'this is not right; we need to make sure that this doesn't happen'.

The importance of creating a culture of openness and transparency in institutional and residential settings must not be under-estimated. In accordance with this, there is a need to ensure that anyone who reports a concern in respect of the treatment of people with disability in these settings is taken seriously, and that appropriate and responsive mechanisms for doing so exist both within service organisations but also independent of these organisations.

I trust that this inquiry will lead to an improved understanding of issues relevant to preventing and responding to situations of violence, abuse and neglect of people with disability, and in doing so assist in generating solutions that are both effective and sustainable within the context of the National Disability Insurance Scheme.

I would be pleased to further discuss the issues that I have noted in this submission should the Committee require additional information. Additionally, I would be pleased to give evidence at a public hearing regarding this inquiry should the opportunity arise.

Yours sincerely,



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