

Annexure 1

Evaluation of the Independent Mental Health Advocacy Service (IMHA)

**Final Report
January 2019**



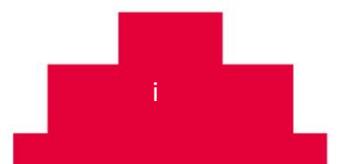
**Dr Chris Maylea, Susan Alvarez-Vasquez, Matthew Dale, Dr
Nicholas Hill, Brendan Johnson, Professor Jennifer Martin,
Professor Stuart Thomas, Professor Penelope Weller
Social and Global Studies Centre, RMIT University**



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Acknowledgments

The evaluation team would like to acknowledge the contribution of the consumers who provided feedback about their experience with Independent Mental Health Advocacy (IMHA), the Speaking from Experience Evaluation Subcommittee, IMHA's Senior Consumer Advisor and the consumer evaluators on the evaluation team for their invaluable contribution guiding and shaping this co-designed and co-produced evaluation. Vaanie Krishnan and Flick Grey were essential members of the evaluation team for the first stage of the evaluation. The evaluation team would also like to thank the mental health professionals and other participants who gave frank and fearless feedback, and Victoria Legal Aid (VLA) and IMHA for committing to an independent and transparent evaluation process. The evaluation team also acknowledges the work of previous consultants, VLA and IMHA staff who developed the program logic and objectives used as the basis of this evaluation.

The evaluation team recognises the lived experience of people who have received mental health services, and the good intentions and hard work of those who provide them in the context of contemporary and historical institutional and community settings.

This evaluation was conducted on Aboriginal land, which was never ceded. The Social and Global Studies Centre at RMIT University acknowledges the Australian Aboriginal and Torres Strait Islander peoples of the nations of Victoria, the custodians of this land. We pay our respects to ancestors and Elders, past and present. We are committed to honouring Australian Aboriginal and Torres Strait Islander peoples' unique cultural and spiritual relationships to the land, waters and seas and their rich contribution to society.

Abbreviations and Terms

A# – Advocate Quoted	MHDL – VLA's Mental Health and Disability Law team
C# – Consumer Quoted	MHHREC – Melbourne Health Human Research Ethics Committee
CATT – Crisis assessment and treatment team	MHLC – Mental Health Legal Centre, Victoria
CHEAN – College of Design and Social Context Human Ethics Advisory Network	MoU – Memorandum of Understanding
CRPD – <i>Convention on the Rights of Persons with Disabilities</i>	OCP – Victorian Office of the Chief Psychiatrist
DHHS – Department of Health and Human Services	OPA – Victorian Office of the Public Advocate
FG# – Focus Group Quoted	SDM – Supported decision-making
ECT – Electro-Convulsive Therapy	SH# – Stakeholder Representative Quoted
HREC – RMIT's Human Research Ethics Committee	SPOS – Second Psychiatric Opinion Service, Victoria
IMHA – Independent Mental Health Advocacy	SR# – Survey Respondent Quoted
KPI – Key Performance Indicator	The Act – <i>The Victorian Mental Health Act 2014</i>
MHP# – Mental Health Professional Quoted	The Charter – <i>the Victorian Charter of Human Rights and Responsibilities Act 2006</i>
Mental Health Services – refers to Designated Mental Health Services in s 3 of the Act	The Tribunal – Victorian Mental Health Tribunal
MHAS – Mental Health Advocacy Service of Western Australia	VLA – Victoria Legal Aid
MHCC – Victorian Mental Health Complain's Commissioner	VMIAC – Victorian Mental Illness Awareness Council
	YES Survey – Your Experience of Service Survey



Executive Summary

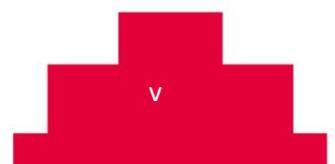
Overall findings

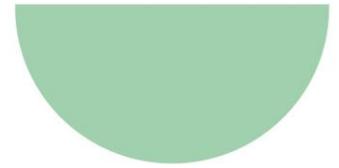
IMHA has proven to be very successful in a challenging context. After three years in operation, it has become an established part of the broader mental health service system. **Consumers highly valued IMHA** because it maintained their rights and because advocates treated them with dignity and respect. Irrespective of whether IMHA advocates achieved the outcome the consumer identified, consumers appreciated an advocate being present. Professionals who had worked with IMHA generally held it in high regard.

To successfully maintain the rights of people subject to compulsory mental health treatment IMHA **must be accessible** to everyone who is eligible for it. This requires the adoption of an **opt-out system** where every person made subject to compulsory treatment is offered advocacy. This will require **increased resourcing** for IMHA to be able to respond to increased demand.

With or without an opt-out system IMHA will require **significantly more resourcing** to ensure equitable access to advocacy via service promotion, and ensure referral pathways. Across the sector, but particularly in community mental health services, awareness of IMHA and understanding of the IMHA model is low. An opt-out system will reduce the need to address this and enable IMHA to focus on providing advocacy services instead of promoting the service.

Achieving IMHA's key objective of maintaining the rights of consumers will require a **whole of system approach** with political and public sector leadership. Oversight and funding bodies, led by DHHS and including VLA, the Office of the Public Advocate, the Second Psychiatric Opinion Service, the Mental Health Complaints Commissioner, the Mental Health Legal Centre, the Victorian Mental Illness Awareness Council, Tandem, the Office of the Chief Psychiatrist and the Mental Health Tribunal, must invest and coordinate with mental health services to ensure that services comply with legislation, are recovery-oriented and least-restrictive in practice, and people are provided with the support they need to make decisions. The evaluation identified an enormous amount of goodwill in the sector, but little in terms of tangible outcomes or improved experiences for consumers. IMHA is working towards this goal but is hindered by inaction and resistance in some parts of the sector. **Sector leadership will be required** to address these systemic issues going forward. The 2019 review of the *Mental Health Act 2014* and the proposed Royal Commission into Mental Health in Victoria provides an ideal opportunity for this.





Key recommendations

IMHA is instrumental to the maintenance of the rights of people who are subject to compulsory treatment. To ensure IMHA's continued success and address system-level issues, four main actions must be taken:

1. Referral to IMHA must be automatic for any person subject to compulsory treatment through an 'opt-out' system
2. IMHA must be adequately resourced to meet demand
3. IMHA must continue to improve sector awareness and understanding of advocacy
4. Oversight and funding bodies must coordinate and adequately invest to ensure that services comply with legislation, are recovery-oriented and least-restrictive, and that consumers are supported to make decisions

Detailed recommendations are included at the end of the report.

Evaluation Overview

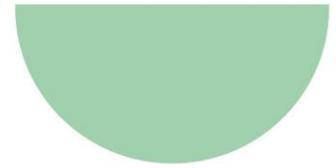
IMHA is a non-legal representational mental health advocacy service run by VLA and funded by DHHS. IMHA operates across Victoria, advocating with and for people who are subject to, or at risk of, compulsory treatment under the Victorian *Mental Health Act 2014*. IMHA was launched in August 2015. In 2017, VLA contracted RMIT's Social and Global Studies Centre to evaluate the service in two stages, a midterm review covering the first two years of operation, and a final evaluation covering the first three years of operation. This report details the findings from the final review.

IMHA is centred on realising the rights of consumers and ensuring their voices are heard. Measuring how well this has been achieved and the impact the service has had on the individual consumer has been central to the evaluation. This evaluation employed a mixed-methods approach, combining qualitative thematic analysis of primary and secondary data with descriptive statistical data to help address the evaluation questions.

The main evaluation questions were:

- ~ How is IMHA being implemented, and how does this compare with the logic model and other policy documentation?
- ~ Is IMHA effective?
- ~ Is IMHA efficient?
- ~ Is IMHA sustainable?

This evaluation was co-produced with consumers by an evaluation team comprised of experts in mental health law and service delivery. The evaluation consulted 69 consumers who had used IMHA, 40 consumers who were eligible for but hadn't used IMHA, 9 stakeholder body representatives, 292 mental health professionals, 31 mental health lawyers and 16 IMHA staff. Included in the analysis were consumer files, IMHA documentation and internal data.



Summary of Findings

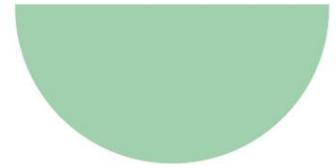
The IMHA Model

The IMHA model is unique in Australia. To maintain consumers' rights using a **supported decision-making** approach the IMHA model delivers **instruction based advocacy**. IMHA has no statutory powers to ensure access to people in services and in the community, unlike the equivalent services in Western Australia. Without legal powers to ensure access, IMHA relies on a **relational approach**, meaning advocates engage with services and staff to ensure access to and the support of advocacy. This model is informed by the principles of **self-determination** and **recovery** and is designed to improve a consumers' ability to **self-advocate**. While remaining focused on individual advocacy, IMHA also engages in **community education** and **sector reform** advocacy.

Representational advocacy means IMHA advocates listen to and communicate a person's preferences and wishes as expressed by them. They will not make an assessment as to whether a person's instructions might be influenced by mental illness. They also advocate irrespective of whether other people, including the advocate, clinicians, carers or family members agree with a consumer's particular preference. This is in opposition to the 'best-interests' model commonly adopted in mental health services, in which the professional takes responsibility for determining and acting in the best interests of the consumer. To carry out representational advocacy under IMHA's model, advocates use a supported decision-making approach, where people are provided with support to make their own decisions. This means advocates will provide people with information relevant to a decision, such as their legal rights, help them actually make the decision, help them implement the decision, and help them reflect on the decision-making process. This approach is in opposition to the 'best-interests' model commonly adopted in mental health services where the professional takes responsibility for determining and acting in the best interests of the consumer. While supported decision-making is consistent with a representational approach and the *Convention on the Rights of Persons with Disabilities*, its application in the best-interests substituted decision-making framework of the environment of contemporary compulsory mental treatment is the source of many of the tensions and barriers identified during the evaluation.

The IMHA model is **recovery-oriented** and incorporates empowerment principles to improve individual consumer's ability to self-advocate. IMHA is proving successful in building this capacity, however consumers were clear that help from an IMHA advocate may still be necessary for the future, particularly if they were in crisis or where self-advocacy had failed. IMHA has developed a self-advocacy toolkit and resources, which at the time of writing are being reviewed prior to implementation. The evaluation identified opportunities for providing support to family, friends and carers to act as advocates for people who use mental health services.

A third part of the IMHA model is its **relational** aspect. This requires advocates to develop relationships with consumers to enable supported decision-making, and with clinicians to ensure access and opportunities for advocacy. This was necessary for effective advocacy as the power to make treatment decisions lies with the treating team. Participants identified that this was largely successful, with advocates generally maintaining good relationships while advocating strongly for consumers. This was limited by the time advocates could spend building these relationships. IMHA was poorly perceived by mental health professionals when advocates did not have good relationships with services and staff. The adversarial approach adopted by some advocates



was reported to work well for individual consumers but resulted in strained relationships that were seen as having a negative impact on individual outcomes and future advocacy opportunities.

IMHA’s Performance

The **overall findings from the evaluation were overwhelmingly positive**. All participant groups gave positive feedback. The areas for further development that were identified related to systemic issues that were beyond IMHA’s control, such as the identification of new opportunities for increased effectiveness, resource constraints and the newness of the service. The evaluation identified that IMHA was being implemented as intended, and is consistent with the establishing documentation, policies and procedures, program theory and logic model. IMHA is **reaching a broadly representative population**, although it has focused on inpatient settings and is **not easily accessible in the community**. IMHA is exceeding key performance indicators by 357% for high-intensity contacts and 233% for low-intensity contacts.

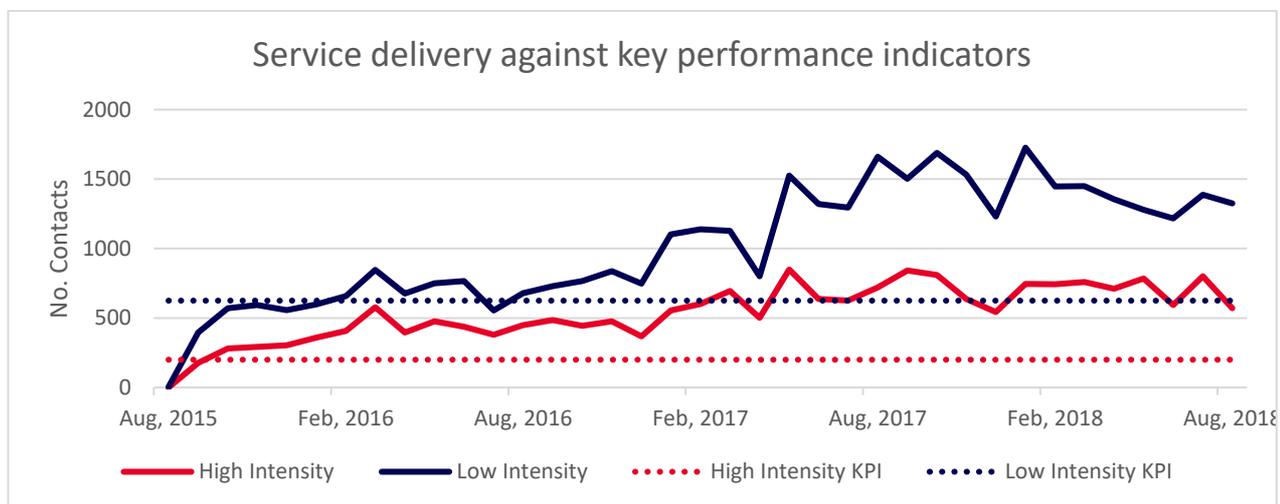


Figure 1 – IMHA Service Delivery KPIs Aug 2015 to Aug 2018

IMHA staff demonstrated consistency with IMHA’s values of integrity, respect, person-centred, curiosity and reflectiveness. The central tenet of IMHA’s service – rights based representational advocacy – was consistently portrayed by advocates and valued by consumers. IMHA advocates supported consumers in a range of areas, primarily around discharge, and participation in decisions around treatment and care. IMHA also provided information and referral to other services, most often legal services, SPOS and the MHCC.

Consumers highly valued IMHA. Consumers appreciated having an advocate present irrespective of whether they were able to achieve the desired outcomes. Mental health professionals who had interacted with IMHA held it in high regard, whereas those who had not had contact (particularly those in the community) held neutral views. The issues regarding IMHA that were raised by mental health professionals largely related to a misunderstanding of the model and occasional examples of IMHA advocates not adhering to the model.

Other Findings

In addition to assessing IMHA’s performance, the evaluation identified specific issues that arose from the data and during the evaluation process. These included challenges related to the mental health context, access issues, questions of IMHA’s scope, IMHA’s role in systemic reform and resourcing.



IMHA must be evaluated in relation to the context that it operates within. The evaluation team heard repeated reports of **breaches of consumers' rights** and **breaches of the Act** by clinical staff. This highlighted the need for an independent advocacy service but also suggested that IMHA is only one part of the solution. Tensions between IMHA's representational model of advocacy and the best-interests approach that dominates contemporary mental health treatment and care were also identified. The evaluation team sought to provide direction to address these by mapping mental health professionals' attitudes to advocacy, finding that while many did not understand representational advocacy, they had positive dispositions to it once it was explained. This suggests that education and promotion have the potential to successfully engage professionals in advocacy.

The evaluation highlighted problems in **accessing IMHA** in inpatient units and in the community. Demand for services is much higher than IMHA can currently provide meaning that service promotion and relationship building are unable to be prioritised. This can be resolved through the adoption of an opt-out system which would ensure that all people who are subject to compulsory treatment are referred to IMHA. A corresponding increase in resourcing would be required for IMHA to provide advocacy to all who require it. Although difficult to accurately determine based on limited data, the evaluation team assesses that twice as many advocates are needed to provide advocacy services within inpatient units, and as many again to ensure access in the community.

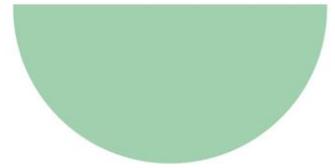
Issues related to **IMHA's scope** were identified. There was a lack of clarity in how the IMHA model could respond to advocacy needs that did not specifically relate to compulsory mental health treatment and care despite a need being identified by advocates and consumers. The evaluation also identified some difficulties with identifying consumers who are 'at risk' of compulsory treatment. The role of IMHA in relation to the Mental Health Tribunal was also raised by participants and should be considered by IMHA and VLA.

Linked to considerations of scope, IMHA's ability to **engage in systemic and cultural change** was a recurrent theme throughout the evaluation process. System-level reform is focused on reducing the use of restrictive practices, increasing self-advocacy and the reception of self-advocacy by decision makers, increasing the adoption of supported decision-making practices and improving the quality of mental health care and treatment. The sector level data does not indicate immediate success in this area, with rates of restrictive practices including compulsory treatment, seclusion and restraint all remaining static. Much of IMHA's impact at the systemic level has been made by the IMHA Manager, who met regularly with stakeholder bodies, clinical and non-clinical mental health agencies and DHHS. These networks should be formalised to galvanise sector leadership and ensure collaboration with other safeguarding institutions to identify and resolve systemic issues.

IMHA's ability to engage in **strategic reform** through individual advocacy is somewhat limited by the lack of statutory support. In Victoria, consumers have a right to communicate with IMHA advocates, but no other powers. In Western Australia, the advocates are led by a Chief Mental Health Advocate and table an annual report in Parliament. The establishment of a Victorian Chief Mental Health Advocate or other statutory systemic role would give IMHA a formal place amongst other oversight bodies. Granting other statutory powers, including the right for IMHA to access consumer files with consumer consent would improve IMHA's effectiveness.

Hindering IMHA's ability to operate effectively is the **lack of useful sector level data**. The poor quality of publicly available sector level data means that it is not possible to determine how many people are subject to



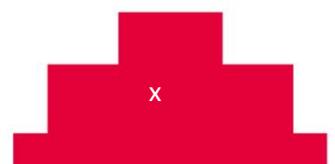


compulsory treatment and therefore eligible for IMHA in Victoria on any given day. To adequately assess service demand and allocate resources accordingly, accurate data on the number of people who are subject to compulsory treatment, including key characteristics such as age, background, gender, type and length of order, needs to be made available to IMHA. This data is already collected by mental health services but not reported or shared with IMHA. IMHA's own data collection processes are inconsistent and difficult to access. IMHA is introducing a new database that will address this issue.

Finally, the evaluation considered issues of **resourcing**. Without clear data on the numbers of people eligible for IMHA's service, the only indication of demand is the demand of consumers who have used IMHA's services. The consistent experience of IMHA advocates is that when they do have the capacity to take on more work, they spend time promoting the service, which leads to an influx in referrals and quickly absorbs their capacity. This process has resourcing implications for community education, capacity building and the system-level reform aspects of IMHA's role. The increase in incoming referrals has also restricted the type of service offered by advocates, with face-to-face advocacy being replaced by telephone advocacy out of necessity. While telephone advocacy has a role, this shift has ramifications for the quality of service IMHA provides. Both consumers and staff identified the importance of being in attendance for treating team meetings and the importance of face-to-face contact for building trust and rapport.

IMHA will only be able to adequately meet the advocacy needs of consumers if the number of advocates is increased. At a minimum, IMHA needs to be present in inpatient units on a weekly basis, which would require **twice as many advocates**. To ensure access in the community within the current opt-in system IMHA would require at least as many advocates again. If an opt-out system was adopted, advocates would be able to spend less time on ensuring access and service promotion. Adopting an opt-out system would require a significant increase in resourcing to meet increased demand. Limited sector data and the variability in opt-out system options mean that exact resourcing requirements will need further consideration.

Each of these issues are covered in detail in the body of the report.





1. Introduction

Independent Mental Health Advocacy (IMHA), run by Victoria Legal Aid (VLA) and funded by the Victorian Department of Health and Human Services (DHHS), provides independent, specialist mental health advocacy to people in Victoria who are subject to, or at risk of being subject to, compulsory treatment under the Victorian *Mental Health Act 2014* (the Act). IMHA was established in August 2015 and operates across Victoria.

In 2017, VLA conducted a formal competitive tendering process to evaluate IMHA. As a result, RMIT University's Social and Global Studies Centre (formerly Centre for Applied Social Research) was contracted to evaluate IMHA in two phases: a midterm review¹ covering the first two years of operation and a final review covering the first three years of operation. This report details the findings from the final review.

1.1. Background

In Victoria, the *Mental Health Act 2014* (the Act) allows for the compulsory treatment and detention of people with a diagnosis of mental illness. In conjunction with a number of other reforms that were inspired by the United Nations *Convention on the Rights of Persons with Disabilities 2008*, the Victorian government announced a new, statewide representational non-legal mental health advocacy service in 2014. After a public tender process, VLA was awarded the initial three-year contract. At the time of introduction it was the first of its kind in Australia, although Western Australia has subsequently introduced a similar service. IMHA services have existed in the UK since 2007.²

IMHA adopts a representational model of advocacy, which means that they attempt to directly represent the views, wishes and concerns of the person, without applying their own views or values. This is distinct from a best-interests approach which continues to dominate within mental health treatment and care practices, despite the Act requiring treating teams to be more inclusive of consumer preferences. In pursuing this approach, IMHA has adopted a supported decision-making model that upholds the right of consumers to be supported to make their own decisions. The Act includes a number of provisions that aim to actively promote consumer participation in treatment decisions and make decisions involving a degree of risk while providing for actual decisions about treatment to be made by authorised psychiatrists when a person is subject to a treatment order. In this context, the provision of representational advocacy recognises that consumers can participate in decision-making processes. Furthermore, it recognises that people may require assistance to articulate and represent their preferences. IMHA advocates provide information, assist in supported decision-making, build individual capacity for self-advocacy, link consumers to other services and provide individual advocacy. This model also aims to contribute to system-level advocacy and system reform.

IMHA is guided by the principles detailed in section 11 of the Act. These principles include a 'least-restrictive' approach, a recovery orientation with a view to full participation in community life, upholding the right of

¹ Chris Maylea et al, 'Mid-Term Review of the Independent Mental Health Advocacy Service (IMHA)' (Social and Global Studies Centre, RMIT University, 2018) <<https://sway.office.com/fgJtBnSrMFNTEZYw>>.

² For the report on the evaluation of IMHA in England, see: Karen Newbigging et al, 'Right to Be Heard, A Review of Independent Mental Health Advocacy Services in England' (Research Report, University of Central Lancashire, June 2012) <https://www.uclan.ac.uk/research/explore/projects/assets/mental_health_wellbeing_review_of_independent_mental_health_advocate_research_report_190612.pdf>.



people subject to compulsory treatment to participate in and make decisions about their assessment, treatment and recovery, and respect for their rights, dignity and autonomy. IMHA is informed by the following values: integrity, respect, person-centred, curiosity and reflectiveness. IMHA explicitly adopts a recovery focus. IMHA is also required to comply with the Victorian *Charter of Human Rights and Responsibilities Act 2006* (the Charter).

IMHA has a systemic reform role beyond individual advocacy and coexists with a group of other oversight and systemic advocacy bodies. In Victoria this includes:

- ~ Community Visitors and the Office of the Public Advocate (OPA)
- ~ Victoria Legal Aid (VLA) Mental Health and Disability Law (MHDL)
- ~ Second Psychiatric Opinion Service (SPOS)
- ~ Mental Health Complaints Commissioner (MHCC)
- ~ Department of Health and Human Services (DHHS)
- ~ Mental Health Legal Centre (MHLC)
- ~ Victorian Mental Illness Awareness Council (VMIAC)
- ~ Tandem
- ~ Office of the Chief Psychiatrist (OCP)
- ~ The Mental Health Tribunal (the Tribunal)

The development and implementation of IMHA have been guided by a logic model. This sets out short, midterm and long-term outcomes, in the areas of IMHA consumers, the IMHA service and the mental health system. This provides a guide for IMHA in implementation and a method for assessing performance. These documents are not made publicly available and are not included in this report.

IMHA operates from four VLA offices located across Victoria, in the Melbourne CBD, Dandenong, Geelong and Bendigo. IMHA services are delivered in-person and via the telephone, with ‘outposts’ established in inpatient mental health units. IMHA consists of 19 staff employed at 15 full-time equivalent, and 3 people employed on a casual basis. Each IMHA team consists of a Senior Advocate and Advocates: 2 in Bendigo, 1 in Geelong, 3 in Dandenong and 4 in Melbourne. The staff team includes a Manager, Administration Officer and Senior Consumer Consultant based in the Melbourne office. IMHA is guided by a consumer advisory group, *Speaking from Experience*.

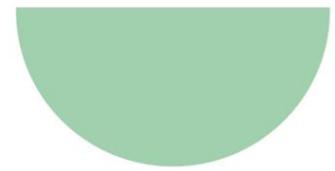
1.2. Evaluation Methodology

1.2.1. Aims and scope

The overarching aim of this evaluation was to detail the extent to which IMHA is providing effective, efficient, sustainable independent advocacy services to eligible consumers. The overall quality of the service delivered was then related to how well each of these factors were achieved, both separately and together. This aim has been achieved by understanding quality from a consumer perspective and engaging with a range of other stakeholders.

The evaluation adopted principles of participatory co-design and co-production, valuing and responding to the lived experience of the people who have previously, currently or may in the future use IMHA. This approach is based on principles of equality, diversity, accessibility, reciprocity and mutuality. Six of the members of the evaluation team have experience as consumers of mental health services and one is currently eligible for IMHA’s services. A subcommittee consisting of five members of *Speaking from Experience* provided guidance and direction at six key points over the course of the project.





For the duration of the evaluation Dr Maylea was located part-time on-site at IMHA. This embedded model facilitated a deeper level of engagement with the IMHA team while maintaining independence and impartiality. All stages of the evaluation were undertaken in close, ongoing consultation with VLA to ensure the evaluation proceeded in line with VLA expectations and the deliverables were appropriate.

All IMHA delivery sites were within the scope of this evaluation, covering the three-year period between 1st September 2015 and 31st August 2018. All IMHA consumers, staff and mental health professionals who work with them were within the scope of this evaluation.

1.2.1. The evaluation team

All members of the evaluation team are committed to the protection of rights of people experiencing mental distress. They bring a diverse blend of skills to the project, including law, criminal justice, sociological, consumer and social work perspectives. The evaluation team consists of Dr Chris Maylea (lead evaluator), Susan Alvarez-Vasquez, Matthew Dale, Professor Stuart Thomas, Professor Penelope Weller and Professor Jennifer Martin. Brendan Johnson and Dr Nicholas Hill joined the team for the final stage of the evaluation. Flick Grey and Vaanie Krishnan were members of the evaluation team for the midterm review.

1.2.2. Key evaluation questions

The questions outlined below were used to inform and guide the evaluation:

- ~ How is IMHA being implemented and how does this compare with the Logic Model, Hierarchy of Objectives and other policy documentation?
 - ≈ Is IMHA being implemented as intended?
 - ≈ For whom, in what ways and in what circumstances? What unintended outcomes (positive and negative) have been produced?
 - ≈ Are consumers being reached as intended?
 - ≈ To what extent is the program achieving the intended outcomes in the short, medium and long-term as outlined in the logic model?
- ~ Is IMHA effective?
 - ≈ How satisfied are consumers? For which consumers?
 - ≈ What were the particular features of the program and context that made a difference?
 - ≈ How has IMHA changed the Victorian mental health service context?
 - ≈ How has IMHA realised the rights of consumers and promoted their voices?
- ~ Is IMHA efficient?
 - ≈ What is currently being done that maintains IMHA's efficiency?
- ~ Is IMHA sustainable?
 - ≈ What, if anything, needs to be put in place to maintain the service benefits?

Over the course of the evaluation, the research team determined that the originating documentation, particularly the Logic Model and Hierarchy of Objectives, had been instrumental in establishing IMHA, but the service had outgrown aspects of these documents. Informed by the establishing documentation, and guided by the key evaluation questions, the team worked with IMHA to develop an assessment framework that incorporated these elements, and which evolved during the course of the evaluation. This report adopts a structure that is reflective of this process.



1.3. Data Collection

1.3.1. Methods

The evaluation employed a mixed-methods approach with a focus on qualitative data. The evaluation was undertaken in two stages: a midterm review from June to September 2017 and a final evaluation from April to September 2018. Data collection consisted of a review of IMHA documentation, an annotated bibliography of relevant literature, a legislative review of other jurisdictions with IMHA equivalents and a suite of participant consultation strategies, including focus groups, interviews and online surveys.

Interviews, focus group and survey questions were developed with reference to the Hierarchy of Objectives. All questions were developed by consumer evaluators and co-produced with the *Speaking from Experience* subcommittee.

Seven stakeholder bodies were consulted:

- ~ Second Psychiatric Opinion Service
- ~ Mental Health Complaints Commissioner
- ~ Office of the Public Advocate
- ~ Department of Health and Human Services
- ~ Victorian Mental Illness Awareness Council
- ~ Tandem
- ~ VLA Mental Health and Disability Law team

The evaluation team visited ten sites across Victoria to conduct interviews and focus groups with professionals and consumers (six metropolitan and four regional):

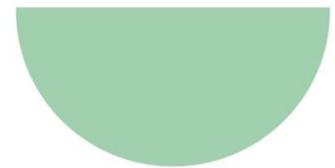
- ~ Ballarat Hospital (Ballarat Health Service)
- ~ Bendigo Hospital (Bendigo Health Service)
- ~ Bendigo VLA Office
- ~ Broadmeadows Adult (NorthWestern MH)
- ~ Broadmeadows Aged (NorthWestern MH)
- ~ Dandenong VLA Office
- ~ Geelong VLA Office
- ~ Melbourne VLA Office
- ~ Monash Clayton Medical Centre (Monash Health)
- ~ RMIT City Melbourne Campus
- ~ Thomas Embling Hospital (Forensicare)

Table 1 details the number and variety of participants engaged by the method of consultation:

	Interview	Focus Group	Online survey	Total
Consumers who had used IMHA	5	33	31	69
Eligible consumers who had not used IMHA	2	19	19	40
Stakeholder body representatives	9	-	-	9
Mental health professionals	44	21	227	292
Mental health lawyers	-	8	23	31
IMHA staff	16	-	-	16
Total	76	81	300	467

Table 1 – Participants by Method of Consultation

A roughly representative range of professions were consulted, shown in Table 2.



	Interview or Focus Group	Online survey	Total
Consultant psychiatrist	11	12	23
Manager	3	4	7
Mental health nurse	29	92	121
Occupational therapist	4	12	16
Peer worker or consumer consultant	1	17	18
Psychiatry Registrar or Intern	4	7	11
Psychologist	2	14	16
Social worker	7	22	29
Other	4	47	51
Total	65	227	292

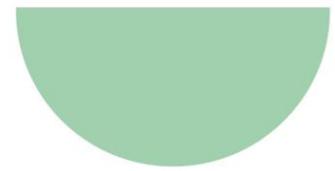
Table 2 – Breakdown of Mental Health Professionals by profession

All consumer focus groups were led by consumer evaluators. Individual interviews were conducted by both an academic evaluator and a consumer evaluator where possible. Interviews and focus groups were recorded and professionally transcribed. Surveys were distributed via IMHA’s professional networks, social media, and mental health services. Survey invites were also sent to 329 consumers who used IMHA and to all VMIAC members. Consumers who participated in the online survey were invited to leave their details to be contacted for a separate interview. Survey responses were anonymous and are not linked to interviews, IMHA files or any other source.

Recruitment for the consumer focus groups was undertaken by mail out to people who had used IMHA. People who were interested in participating contacted the research team and were directed to a focus group in their area. Consumers who participated in a focus group or an interview were compensated for their time at a rate of \$35 per hour and \$10 for travel in the form of a gift voucher. Consumers who participated in interviews and focus groups were asked if they would like to consent to the evaluation team reviewing their files. Twenty consumers consented to the evaluation team reviewing their files which were then included in the analysis. The experiences of three of these consumers were selected to be developed into de-identified vignettes which will be made available in a forthcoming publication. IMHA staff were also provided with fictional advocacy scenarios and asked to document their responses. Eight staff returned responses.

Quantitative data was provided by IMHA, including data on performance indicator activities, criteria groups, areas of assistance, demographics, referral details and client and caller locations. This data has been used where relevant. Due to difficulties related to IMHA’s database design, the data has been interpreted with caution and guidance from IMHA.

The evaluation team recorded and transcribed 62 hours of audio. Analysed transcripts, survey responses, policy documents and other documentation totalled 961,523 words. Prior to thematic analysis, the raw data was coded to prompting questions, allowing for cross-tabulation of the thematic data. Data was then thematically analysed, first by two consumer evaluators who independently defined the codes using open coding. Academic evaluators then independently coded across each of the groups of sources, axially coding across data sources, which was then combined with the coding conducted by the consumer evaluators. This co-produced process ensured a double handling of the data and thematic analysis led by people with a lived experience of using mental health services and supported by experienced qualitative researchers. Data sources generally triangulated with consistency, with no major inexplicable disagreements between data



sources. The data collected was mapped against the IMHA Logic Model and Hierarchy of Objectives. This informed the structure and focus of this report.

Participant quotes used in this report have been lightly edited for readability and to ensure confidentiality. Some content in this report is reproduced from the Midterm Evaluation Report.³

1.3.2. Limitations

Data collection generally proceeded as planned, although IMHA's priority groups are underrepresented due to a lack of response to invitations to participate in the evaluation. This issue was anticipated in the evaluation plan and mirrors the experience of evaluators on similar projects.⁴ The evaluation team consulted with one of VLA's Aboriginal Community Engagement officers, and IMHA advocates specifically invited consumers from underrepresented groups to participate, however, this was not entirely successful, and the evaluation was not able to fully capture the diversity of IMHA participants.

The evaluation process was consistently hindered by the lack of available sector level data, as discussed below in section 2.3.6. Both service level data provided by IMHA and sector level data was often incomplete, unreliable or inconsistently collected. IMHA and VLA have taken steps to address this issue, with plans for a new IMHA specific database (see Recommendation 14). Without reliable sector level data, it was not possible to accurately determine IMHA's quantitative performance.

1.3.3. Ethics

Ethics approval was obtained through RMIT's College of Design and Social Context Human Ethics Advisory Network (DSC CHEAN) (#A 20975-06/17), RMIT's Human Research Ethics Committee (RMIT HREC) (#20970) and Melbourne Health Human Research Ethics Committee (MH HREC) (#17/MH/394).

The findings of the evaluation are presented in three sections: the IMHA model in practice, IMHA's Performance and Other Specific Findings. Detailed recommendations are included at the end of the report.

³ Maylea et al, above n 1.

⁴ Daniel Van der Pluym, 'Consultation Report - Supported Decision Making under the Mental Health Act 2014 - What Consumers Want' (Consultation Report, Independent Mental Health Advocacy, Victoria Legal Aid, 2016); Newbigging et al, above n 2.



2. Evaluation Findings

2.1. The IMHA Model in Practice

To answer the key evaluation question regarding the implementation of IMHA, this section describes the IMHA model in practice and highlights key aspects and tensions.

The IMHA model is unique in Australia in that it provides specialist advocacy to people subject to, or at risk of, compulsory treatment under the Act. Unlike IMHA services in England, it is a state-wide service covering the entire jurisdiction. Unlike the West Australian Mental Health Advocacy Service (MHAS), it has no statutory powers and is not a statutory body.⁵ Distinct from the Community Visitors run by OPA, IMHA provides ongoing, instruction-based non-legal advocacy. IMHA advocates are specialists in both mental health and in the legislative frameworks which govern compulsory treatment, unlike generalist mental health or disability advocates. IMHA has had to develop a model specific to the Victorian context that does not rely on statutory powers. It delivers instruction-based advocacy using a supported decision-making paradigm and relies on a relational approach. This takes the form of individual advocacy, community education and system-level reform. The model applies a recovery approach and incorporates empowerment principles to support consumers' ability to self-advocate.

2.1.1. Instruction-based Representational Advocacy Using Supported Decision-making

Instruction-based Representational Advocacy

The key difference identified between IMHA and other advocacy provided within the sector was the adoption of a representational approach as a fundamental principle. Representational advocacy is defined by DHHS and adopted into IMHA policy as:

Representational (or instructed) advocacy ensures that people are supported to speak for themselves and have someone 'on their side' who can represent their views, wishes and concerns. Advocates take their instruction from the [Patient] and ensure that they do not take action without the [Patient's] express permission. Representational (or instructed) advocacy promotes what the [Patient] wants for his or herself not what other people think they should have or not have. This is also true in relation to information. Advocates do not keep secrets from [Patients] and will not accept unsolicited information about a person from a service provider or other external source.

In practice, this means that advocates will represent the person's wishes as expressed by them. They will not make an assessment that a person's preferences may be influenced by mental illness, and will advocate irrespective of whether other people, including the advocate, clinicians, carers or family, agree with these preferences. They will share any information they have with a person, without making a judgement about the impact that information might have on a person. Advocates will ask questions as necessary, negotiate and mediate, but will not make decisions on behalf of a person. Consumers may delegate minor decisions to their

⁵ Although consumers have a statutory right to communicate with IMHA. *Mental Health Act 2014* (Vic) s 16(2)(f), *Mental Health Regulations 2014* r 5A.



advocate, such as the drafting a document on their behalf but will have the final say over both the process and the document.

This is linked to and consistent with a rights-based approach, and is informed by the *Convention on the Rights of Persons with Disabilities* (CRPD) which seeks to ensure that people who use mental health services are not discriminated against on the basis of their diagnosis. This is in opposition to the ‘best-interests’ model commonly adopted in mental health services where the professional takes responsibility for determining and acting in the best interests of the consumer. The representational approach was highly valued by consumers, but caused significant tensions with clinical staff, as explored below.

Supported-decision making

IMHA do not apply a capacity test, instead adopting an approach informed by the CRPD. This requires people to be supported to make their own decisions, rather than having their rights to make decisions taken away from them.⁶ This is more sophisticated than simply repeating the consumer’s words, and explicitly incorporates a supported decision-making model. Supported decision-making includes at least three steps:

1. Support to formulate a person’s purposes, explore choices and make decisions
2. Support to engage in decision-making processes and to engage with other parties
3. Support to act on the decision⁷

If decision-making is described as a continuum, with substituted decision-making at one end, and independent decision-making at the other, IMHA occupies a middle position where people are able to make their own decisions and are provided with whatever support they require to do so. This is more structured and implies more support than assisted decision-making, which may simply be the provision of information. Contemporary Victorian compulsory mental health treatment is substituted or shared decision-making. In a supported decision-making approach, the consumer has the final say, both in the decision itself and in the process of deciding.⁸



Figure 2 – A Continuum of Decision-Making⁹

The Act requires, at a minimum, a shared decision-making approach, where consumers ‘should be involved in all decisions about their assessment, treatment and recovery’.¹⁰ It also requires that consumers ‘be supported to make, or participate in, those decisions, and their views and preferences should be respected’. In practice,

⁶ Wanda Bennetts et al, ‘The ‘Tricky Dance’ of Advocacy: A Study of Non-Legal Mental Health Advocacy’ (2018) 2018(24) *International Journal of Mental Health and Capacity Law* 12.

⁷ Gavin Davidson et al, ‘Supported Decision Making: A Review of the International Literature’ (2015) 38 *International Journal of Law and Psychiatry* 61.

⁸ MB Simmons and PM Gooding, ‘Spot the Difference: Shared Decision-Making and Supported Decision-Making in Mental Health’ [2017] *Irish Journal of Psychological Medicine* 1.

⁹ Adapted from Bennetts et al, above n 6.

¹⁰ *Mental Health Act 2014* (Vic) s 11(c).



the evaluation identified that within mental health services a substituted decision-making approach was most commonly experienced by consumers.

The presence of a supported decision-making approach in a shared or substituted decision-making framework is the source of many of the tensions and barriers identified by the evaluation. Examples of advocacy that caused tension included an advocate supporting a consumer to make a complaint about a nurse who they thought was poisoning their food, an advocate who refused to divulge the location of a person who had absconded and when an advocate asked for a change of psychiatrist based on the gender or ethnicity of the psychiatrist. In each of these cases, the advocate followed the instructions of the consumer. Tensions also emerged when advocates refused to divulge information to clinicians about a consumer without the explicit consent of the consumer. These tensions were less pronounced when there was a high degree of understanding of representational advocacy, and there were good relationships between advocates and staff.

Linking individual issues to systemic advocacy

IMHA’s advocacy is mainly at the individual level, but also has a strong focus on amplifying individual issues to contribute to system-level reform and systemic advocacy. The IMHA Manager provides feedback to service executives and some IMHA advocates provide ward level feedback to nurse unit managers or other mid-level managers. Another example of systemic reform is the relationship with VLA’s MHDL team, which has resulted in litigation to protect consumer’s rights under the Act in the Victorian Supreme Court. IMHA also runs supported decision-making training for mental health services. This training requires specific resourcing (Recommendation 4). IMHA is also in the process of developing a self-advocacy toolkit for consumers. This focus on increasing individual self-advocacy skills is key to understanding IMHA’s approach to advocacy and is explored in further detail in the following section.

2.1.2. Building Capacity

An important aspect of the IMHA model is the focus on equipping individual consumers with the skills to engage in self-advocacy and improve their ability and confidence to advocate for themselves. This is based on an emphasis on recovery and empowerment principles and underpinned by an awareness of the problems caused by creating unnecessary dependency on services. Consumers identified that their capacity to self-advocate was improved through working with IMHA. This is shown in the quantitative data in Figure 3. IMHA’s own continuous improvement data supports this, with the majority of consumers strongly agreeing that ‘they had a greater understanding of their rights and were more confident expressing their views and

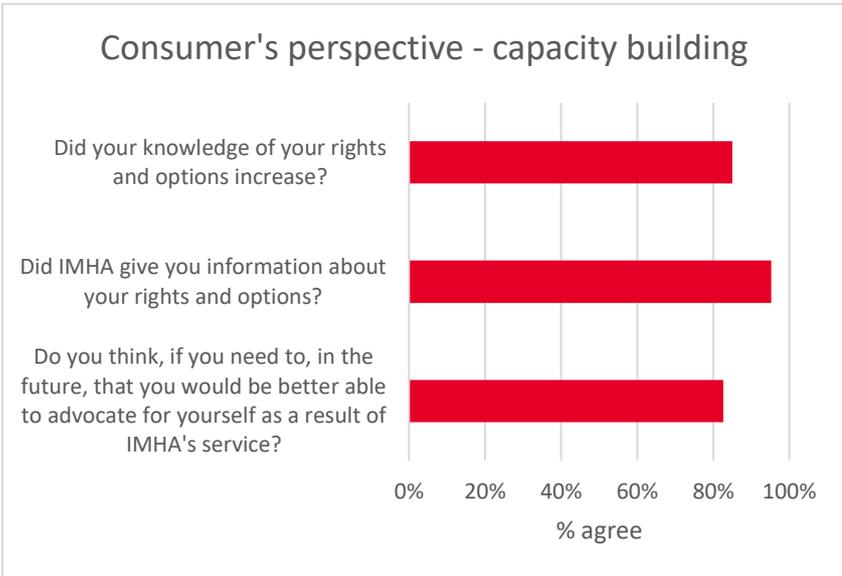


Figure 3 – Consumer's perspective – capacity building (online survey (n=22))



preferences'.¹¹ Qualitative responses offered a more complex story, as some consumers noted that their ability and confidence to self-advocate can vary over time. Others pointed out that it was not just about advocacy skills, but the openness of treating teams to the accommodation of individual preferences. Power and status were important factors in an individual's ability to express their preferences and have those heard by mental health professionals.

This points to a tension between the instruction-based model, supported decision-making and improving self-advocacy skills. In one case it was observed that an advocate had encouraged a consumer to make a complaint on his own, to ensure that it was 'his words' and not those of the advocate. However, this consumer could not undertake this task at that time. Eventually, the complaint was completed using a combination of the consumer's words and the advocate's interpretation of the consumer's preference. This illustrates IMHA's attempt to follow instructions while ensuring it is not encouraging dependence on the advocate. This is consistent with a supported decision-making model that mandates that only as much support as is necessary is provided. Consumers recognised the value of self-advocacy but expressed a preference for representational advocacy in times of crisis and/or distress.

Mental health professionals did occasionally identify IMHA's ability to improve consumers' ability to self-advocate, although this was often difficult for them to assess because of the generally short periods they worked with people. IMHA has developed a self-advocacy model and resources which, at the time of writing, are being reviewed prior to implementation. This has the potential to support self-advocacy beyond IMHA's current reach and should be evaluated following implementation (Recommendation 13.1).

There are opportunities to support family, friends and carers to be advocates for people who are engaged with mental health services. This may give rise to conflicts of interest, as the preferences of carers and family members can often differ to those of the person receiving treatment and care. There is potential value to be found, however, in IMHA promoting the adoption of a rights-based model and supported decision-making by carers and family members. Stakeholder bodies consulted in the evaluation expressed support for extending the focus on self-advocacy to include family and carers. This presents an opportunity for IMHA to build capacity for advocacy within consumers' support networks in circumstances where independent advocacy is unavailable, such as in crisis situations (Recommendation 13.2), and improve awareness of IMHA in the community.

In spite of attempts to improve self-advocacy skills and the ability of interpersonal networks to provide support, it must be noted that independent face-to-face advocacy will remain necessary for many people given the complexities of the current mental health system and the often challenging circumstances they experience.

2.1.3. A relational model of advocacy

The IMHA model is further defined by a strong relational aspect. This requires advocates to develop relationships with consumers to enable supported decision-making, and with clinicians to ensure access and opportunities for advocacy. Advocates indicated that this model was required because the power to make treatment decisions continues to reside with the treating team. There was a tension identified by advocates

¹¹ Independent Mental Health Advocacy, *We're Listening – What Users of Our Services Have Told Us* (6 September 2017) <<http://www.imha.vic.gov.au/about-us/news/were-listening-what-users-of-our-services-have-told-us>>. Ibid.

between the importance of relationships with treating teams and the need to challenge their decisions based on the preferences of the consumer they were advocating on behalf of. There was a concern that this real or perceived conflict with clinicians might limit their ability to advocate for consumers in the future. Advocates indicated that they would generally sacrifice relationships with clinicians to resolve this tension,

which can work both ways, with consumers generally preferring an advocate who has a close working relationship with the treating team. Focus groups were asked about this issue and strongly identified a preference for an advocate who was independent but who had good relationships with the treating team.

The need for advocates to work closely with the treating team was recognised by consumers, who did not identify issues of perceived bias by their advocates. This suggests that, from the consumer perspective at least, advocates have been resolving this tension successfully by clearly advocating on behalf of consumers while maintaining positive relationships with decision makers. This relationship building requires time and consistency of contact and is something that is challenged by the high turnover of staff within services.

For the most part, mental health professionals appreciated the relational model. Both advocates and mental health professionals indicated that within this relational model, advocacy could become quite heated without damaging relationships. Poor relationships, however, appeared to limit the potential for the provision of advocacy because access is dependent on these relationships. The evaluation did identify a number of situations where the relational model had broken down and the advocacy relationship had become adversarial, but it is important to note that while relational advocacy was appreciated by the clinical staff, consumers did not identify negative outcomes as a result of adversarial relationships. In some cases, the opposite was observed, with adversarial advocacy getting results that relation advocacy had not been able to achieve.

One area that the relational model did not extend to was relationships with families and carers. As noted above, the evaluation team identified the potential for IMHA to work with families and carers to facilitate the adoption of supported decision-making practices. This does not indicate a role for IMHA in directly supporting carers but indicates that IMHA might be well-placed to equip carers with tools or approaches. IMHA already has a strong relationship with Tandem, and further opportunities for collaboration exist (Recommendation 13.2).



2.2. IMHA’s Performance

The overall findings from the evaluation are overwhelmingly positive. All participant groups gave positive feedback and where areas for further development exist, they predominately relate to systemic issues which are beyond IMHA’s control, new opportunities for increased effectiveness, and resourcing limitations.

The evaluation found that IMHA was being implemented as intended, consistent with the establishing documentation, policies and procedures, program theory and logic model. IMHA staff demonstrated consistency with IMHA’s values of integrity, respect, person-centred, curiosity and reflectiveness. The central tenet of IMHA’s service – rights based representational advocacy – was consistently portrayed by advocates and valued by consumers. The IMHA model is generally consistently applied in practice across the IMHA regions by staff, with some variance that might be attributable to the professional backgrounds of advocates in those regions. Staff expressed a desire for more opportunities for integration, such as shadow shifts with advocates from different regions (see Recommendation 15.3).

Consumers received advocacy from IMHA around a broad range of issues, as detailed in Table 3. Assistance with discharge, participation in decisions, medication and treatment were most common, with a high demand for support for consumers before the Tribunal. Table 3 also highlights opportunities to increase assistance for consumers to link in with other services and other aspects of the Act, such as advance statements (see Recommendation 13.3).

Discharge	15%
Participation in Decisions	13%
Medication	13%
Treatment	12%
Mental Health Tribunal	9%
Second Opinion	6%
Leave	6%
Complaints	5%
Diagnosis	4%
Nominated Person	1%
Restrictive Intervention	2%
Advance Statement	2%
Change of Clinician	2%
Other	10%

Table 3 – Areas of Assistance – % of consumers

2.2.1. Program Theory and Logic Model

The evaluation process included a mapping of emergent findings against IMHA’s program theory, logic model and hierarchy of objectives, divided between system, service and consumer level objectives. These documents are not publicly available and are not included in this report.

In general, IMHA is performing consistently with this model, although many of the system level objectives are not able to be determined based on currently available data. The evaluation did not identify any areas where IMHA had not meaningfully attempted to achieve an objective, however, these attempts were not universally successful. Some objectives are clearly long-term and would not be expected to be measurable at this time. This was anticipated in the planning and establishment phase of IMHA, as the IMHA Hierarchy of Objectives states that:

The long-term objectives are aspirational and are not the lone responsibility of IMHA. IMHA will be making a contribution to enabling the long-term objectives related to mental health system change.

IMHA is clearly working towards these long-term objectives, but no discernible change in mental health system practice or culture, or a reduction in restrictive practices, or application of recovery-oriented practice could be identified by the evaluation team. IMHA’s objective of contributing to increased consumer satisfaction with public mental health care and treatment was assessed as not achieved on the basis that IMHA often had the



opposite effect, as increasing consumer’s awareness of their rights would decrease their satisfaction with the restrictions imposed as part of their treatment. The barriers to achieving these systemic objectives are central to IMHA’s performance, and as such within the scope of the evaluation and are detailed in this report.

IMHA’s objectives were generally achieved across the service level with key performance indicators exceeded, the development of strong relationships with other services and the successful demonstration of the value and effectiveness of the IMHA model. There is still work to be done in making other services aware of IMHA and ensuring that mental health professionals understand the IMHA model, and IMHA is resolving issues related to data collection.

As a result of contact with IMHA, consumers identified an improvement in their self-advocacy skills, an increased sense of having their views and preferences respected, a greater sense of control over treatment and recovery, and generally felt they had received less restrictive treatment. Where this had not occurred, consumers were quick to locate responsibility with the mental health services and rarely blamed IMHA.

IMHA’s ongoing performance monitoring framework should include the development of an ongoing *Hierarchy of Objectives* and revised logic model (see Recommendation 16.3), and regular transparent reporting to DHHS on performance against those objectives (see Recommendation 16.1).

2.2.2. Key Performance Indicators

As Table 4 shows, IMHA has exceeded key performance indicators for service delivery to date.

Service Type	Key performance indicator	Total Services 1 Sep 2015 to 31 Aug 2018	Total Services 1 Sep 2016 to 31 Aug 2017	Total Services 1 Sep 2017 to 31 Aug 2018
High Intensity <i>(advocacy/Coaching for self-advocacy, debriefing)</i>	2400	4534	6958	8565
Low Intensity <i>(information, referrals)</i>	7500	7647	13048	17486

Table 4 – IMHA Service Delivery by Service Type, 1 Sep 2015 to 31 Aug 2018

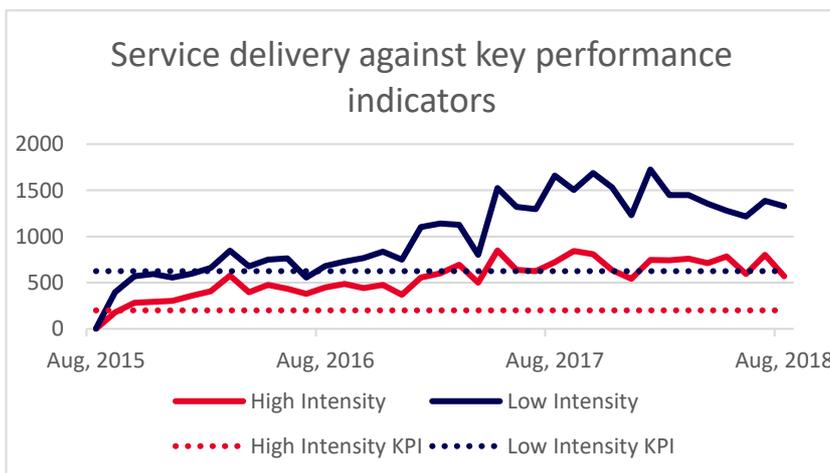


Figure 4 - IMHA Service Delivery KPIs Aug 2015 to Aug 2018

As Figure 4 illustrates, IMHA began to meet these targets in its first few months of operation and has continued to exceed them over time. These targets may have been appropriate for a new service, but now may now be more usefully recalibrated to reflect strategic targets, such as increasing support in the community (see Recommendations 16.1 & 18.1).



With IMHA clearly exceeding its agreed performance indicators, this evaluation has focused on service quality and distribution rather than quantity.

2.2.3. Demographics and representation

What data was available indicated that IMHA has been reaching a demographically representative population. Binary genders were evenly represented, although data was not consistently collected for gender diverse communities.

Figure 5 suggests that IMHA has been reaching adults aged under 65 more successfully than younger or older people. This is likely to be a function of the lower rates of compulsory treatment in those groups. Professionals who worked with older or younger people reiterated the need for advocacy for these groups, and anecdotally it appears that IMHA is responding to this need. Aboriginal and Torres Strait Islander consumers were roughly representative, consisting of 2.3% of mental health services

consumers and 3% of IMHA's consumers, although 35% of IMHA consumers were not asked or did not state if they identified as Aboriginal or Torres Strait Islander. Aboriginal and Torres Strait Islander people constitute 0.8% of the population of Victoria.

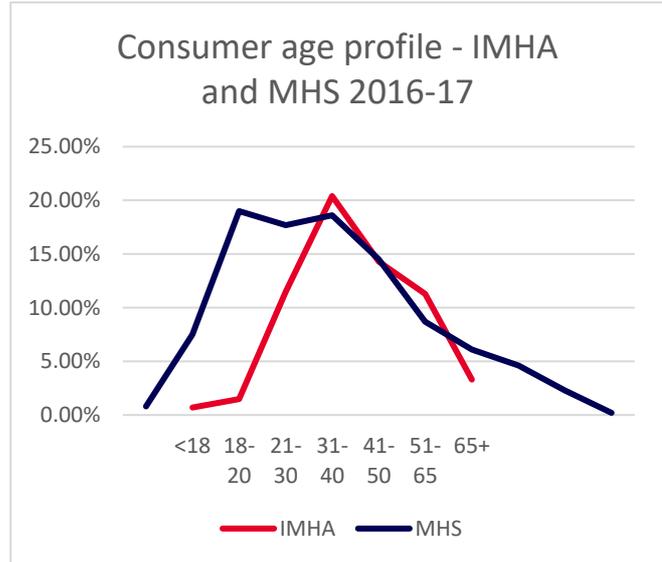


Figure 5 – Consumer age profile – IMHA and MHS 2016-17

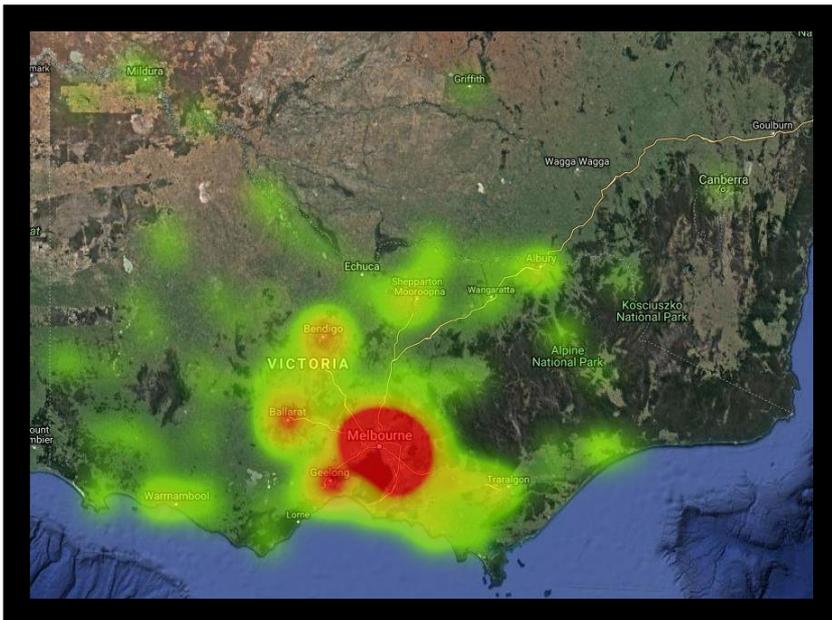


Figure 6 – Geographical spread of people using IMHA (heatmap)

Geographically, IMHA was distributed as expected, clustered around major population centres but with reach across the state, as illustrated in Figure 6. For other specific groups, including people who are homeless, receiving Electro-Convulsive Therapy (ECT), are at risk of family violence or people subject to seclusion and restraint comparative data were not available.

What limited quantitative data was available indicates that IMHA is providing more services than originally expected to a roughly representative consumer population.



2.2.4. Satisfaction with IMHA

All participant groups who had encountered and interacted with IMHA gave overwhelmingly positive feedback to the evaluation team. Consumers gave the most praise of IMHA, with more than one person telling the evaluation team that ‘IMHA saved my life’. One consumer noted:

IMHA, yes, I think in a way they represent some hope. Especially when you’re isolated. And I think that is in itself a good thing. If you have that, you know, that spark there of someone’s listening to me in a rational way. And seems to be wanting to help. Then that’s a big thing. And then of course, if they follow it up and they can help it’s even better. (FG2 C4)

This experience was nearly universal, but there were a few exceptions. One consumer, who was extremely happy with one advocate, was unimpressed by another advocate she had originally been assigned:

The second one, he listened. He tried to understand. I believe that the first advocate dismissed what I was even saying. She just, ‘Oh, you must be crazy. You’re in here’ sort of a situation. That’s what it made me feel like. (C3)

This quote highlights how the representational advocacy model requires unfiltered respect for the person’s perspective. This was only part of what people valued about IMHA’s approach. This consumer shared what made her IMHA experience positive:

Their honesty. Their reflective listening skills. They didn’t just listen, they actually listened. And reflected back to you what I’d, back to me what I’d said. But they also sought solutions and suggested a number of different ways and checked in with me which way do you want to go. So, they put me in control of what happened next. ... she didn’t make assumptions about what I needed and tell me what I needed. She asked me. ... So, she did the right thing there, but she never took any of the power and control away from me. So, she heard, she gave me options, she asked what options, and she didn’t make assumptions about what I needed. And she followed through. (C2)

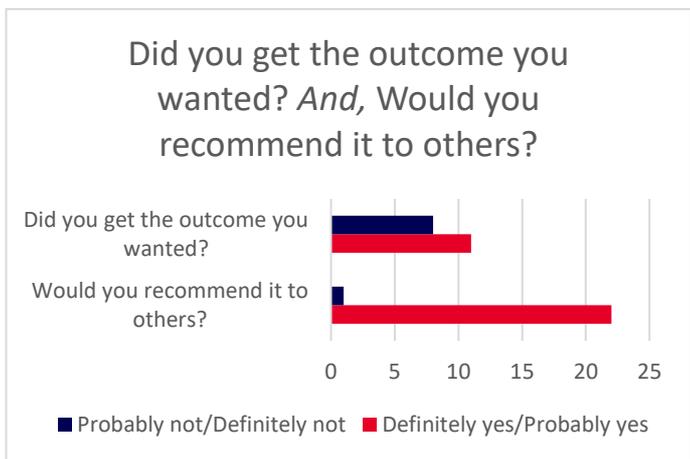


Figure 7 - Did you get the outcome you wanted? And, Would you recommend it to others? (online survey (n=22))

The praise consumers heaped on IMHA seemed unrelated to any actual change in their treatment. This is not to suggest that IMHA did not achieve changes in treatment for consumers, but even when they were unsuccessful their presence was still highly valued by consumers. Irrespective of the outcome, consumers appreciated having an advocate present. Figure 7 illustrates that consumers overwhelmingly would recommend IMHA to others, despite not always getting the outcome they wanted.



The value of IMHA for consumers was also frequently identified by mental health professionals. This overall positive view of IMHA was reflected in the quantitative survey data, shown in Figure 8, although only for mental health professionals who had worked directly with IMHA either by referring someone to IMHA or having direct experience of IMHA’s advocacy. This indicates that IMHA is held in high regard by those who had contact with it, but this reputation does not extend far beyond those individuals.

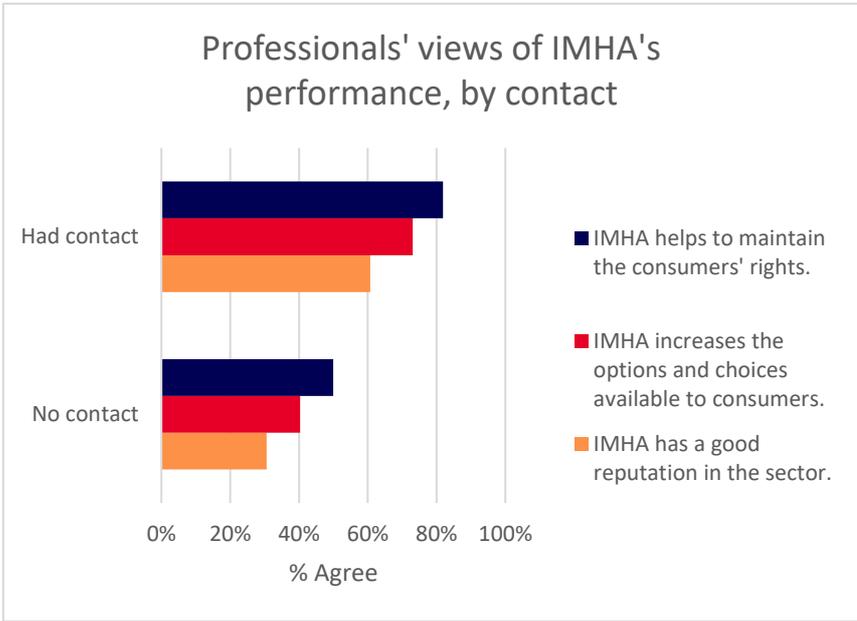


Figure 8 – Professionals' experience, by contact (online survey (n=188))

IMHA cannot be said to have a good reputation amongst professionals in the sector who had not had direct contact with an advocate. Those who had contact with IMHA were twice as likely to agree that IMHA had a good reputation. This is a positive sign, indicating that an encounter with IMHA leads to a positive impression.

Also of note is that while IMHA is recognised as successfully maintaining consumers’ rights, it is viewed as less successful at increasing options and choices.

There were some areas where mental health professionals did not reinforce the positive image outlined by consumers. This includes IMHA’s work to build capacity to self-advocate, as shown in Figure 9, or in the work IMHA does at the systemic level, as discussed below. Ambiguity around capacity building is largely attributable to the viewpoint of mental health professionals, who often did not work with people for long enough to see a change in their self-advocacy skills.

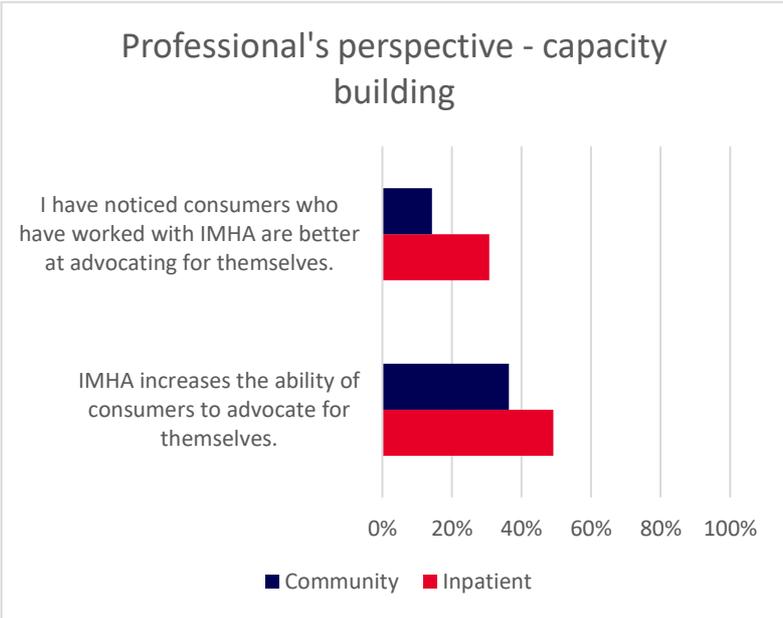


Figure 9 – Professional's perspective – capacity building (online survey (n=188))

Where mental health professionals did raise issues with IMHA, they were mostly related to a misunderstanding of the model or rare examples of the IMHA advocates not complying with the model. For instance, one junior doctor, who strongly supported instruction-based advocacy and had worked well with advocates in other services, reported that one advocate did not allow the consumer to speak, which prevented an assessment of the person’s mental state. This appears inconsistent with the IMHA model, which is focused on

promoting the consumer voice. Alternatively, it may be that the consumer requested the advocate speak on their behalf, which would be consistent with the representational model, and highlight the importance of communicating the nuance of the model so that the doctor had understood this.

A consultant psychiatrist told the evaluation team that when the relational model broke down and the advocate adopted an adversarial stance this caused problems for consumers:

Overall it has been favourable to see consumers being supported with advocacy, and some helping the consumer to better re-frame their difficulties. Unfortunately, on occasion, there has been an adversarial stance taken by consumers on the instigation of an advocate – to the detriment of the therapeutic relationship with the treating team and the mistrust with the support being offered for the recovery journey. Fortunately, these have been isolated events. It will be uniquely enriching for the consumer when advocacy through IMHA support can work collaboratively with the treating team on a consumer’s recovery journey and not take up an adversarial stance. (SR147)

This quotation draws attention to a fundamental difference between the best-interests approaches taken by treating staff and the instructions based approach taken by IMHA. This is the most significant barrier to IMHA’s success and the most important reason for it to be accessible to all who require advocacy. Without IMHA to intervene, many consumers will continue to experience disempowering and discriminatory treatment and care. The reform agenda initiated by the introduction of the Act in 2014 is, as yet, incomplete. Building on and expanding this understanding, the evaluation team considered other specific issues which require action for IMHA to be successful in supporting this reform agenda.



2.3. Other Specific Findings

In addition to assessing IMHA's performance, the evaluation team identified key issues regarding IMHA's ability to succeed and for ensuring the success of IMHA into the future. These issues arose in response to the key evaluation questions of effectiveness, efficiency and sustainability. These include the challenges inherent in the context of the mental health sector, ensuring access to IMHA, IMHA's scope, systemic reform, data and documentation and resourcing constraints.

2.3.1. Challenges of Context

The IMHA model must be considered in the context it operates within. A number of issues were identified in the spaces IMHA is working in, including a disregard for rights, the tension of representational advocacy in best interest services, professionals' attitudes towards advocacy, sector knowledge and understanding of IMHA.

Disregard for rights

The evaluation team identified persistent and consistent breaches of peoples' rights and breaches of the Act, from failure to provide people with Statements of Rights,¹² to failure to involve people in decision-making processes,¹³ and the unlawful detention of consumers who were not subject to an order. The detention of people who were voluntary was commonly acknowledged by mental health professionals and, at times, identified as an issue. Mental health services are required to provide consumers with information about their rights and to explain that information to them.¹⁴ Consumers consistently identified that this was not occurring and when pressed were consistently not able to articulate their rights of appeal or to be involve in decisions. This supports the need for IMHA in this context.

Having established that consumers felt advocacy was necessary, the evaluation team sought to determine attitudes to advocacy amongst mental health professionals.

Situating representational advocacy in best-interests mental health treatment

The evaluation identified the main barrier to the acceptance and success of IMHA was a disconnect between the representational model adopted by IMHA and the best-interests approach dominant in contemporary mental health treatment in Victoria. Many mental health professionals did not see the value in repeating what consumers were saying, as they had already heard what the consumer was saying, sometimes many times. These professionals viewed advocacy as potentially degrading the therapeutic relationship and creating unnecessary work for clinicians. This was central to the issues mental health professionals raised with IMHA. They wanted IMHA to take a 'common sense' approach, and act in the best interests of the consumers. Professionals who raised opposition to IMHA generally did not appreciate how important it was to consumers to have someone to listen to them and act for them without judgement. Even consumers who later agreed that what the advocate supported them with was not in their best interests still preferred the representational model.

IMHA cannot solely be responsible for providing education on the value of representational advocacy and the importance of autonomy as central to the recovery model. Mental health services are responsible for the

¹² *Mental Health Act 2014* (Vic) ss 12-13.

¹³ *Mental Health Act 2014* (Vic) ss 11(c).

¹⁴ *Mental Health Act 2014* (Vic) ss 12, 13.



training and development of staff and must work with IMHA to create environments in which advocacy can flourish with a view to creating environments where it is not required at all (Recommendation 8).

Mental health professionals’ attitudes toward advocacy

The evaluation team sought to chart the cultural and attitudinal barriers of professional mental health staff to IMHA. This was done by mapping understanding and attitudes to advocacy using a model developed through the evaluation of IMHA in England, shown in Figure 10.

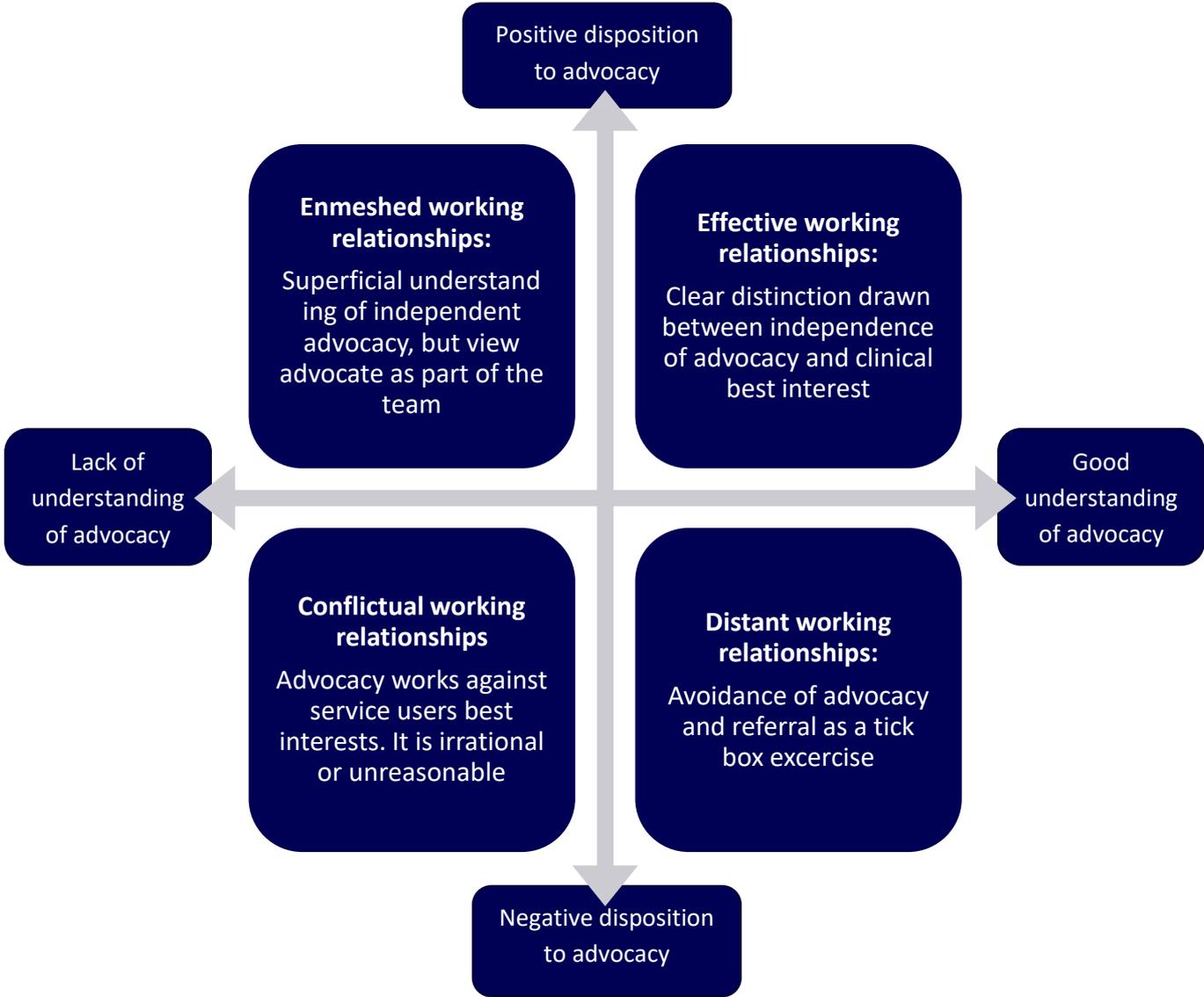
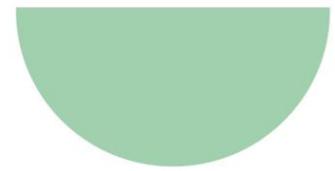


Figure 10 – Understandings of and Dispositions to Advocacy¹⁵

In general, the evaluation team found that advocacy was more successful when clinicians had a good understanding of the representational model. Of the 65 mental health professionals interviewed, there was a significant degree of variability in understandings of advocacy, with the majority of clinicians not comprehending the representational model. Despite this, clinicians overwhelmingly expressed positive

¹⁵ Newbigging et al, above n 2.



dispositions to advocacy. This suggests that change is possible and illustrates the need to provide education about advocacy rather than the more difficult task of changing attitudes. Consistently, the evaluation team found that clinicians were much more positive towards IMHA when they had the model explained to them. Altering attitudes to advocacy will require a cultural and systems-level change, which requires both an increase in advocacy and sector leadership. Compulsory training, particularly around supported decision-making, will address this to some extent (Recommendations 2 & 8).

Some mental health professionals readily accepted IMHA and opted to work with advocates to achieve reform. These staff valued IMHA because they felt they did not have the power to achieve change from within the service. This was particularly the case for allied health professionals who disagreed with the decision of the medical team or legal decision-making body. Nurses, social workers and peer workers all consistently identified using IMHA strategically to support and supplement their own advocacy. A peer worker noted that IMHA had more confidence to 'push back' where they would not be able to:

I have a good working relationship with everybody on the ward no matter what level, but I still don't have the confidence to sort of push back onto huge, big things. ... When someone comes in who does not work on the ward and has those difficult conversations with the doctors and then can walk away again, I think in terms of my professional relationship, I don't know if mine would maintain that. (MHP65)

Other mental health professionals did not share this view of advocacy, such as a psychiatry registrar who felt dealing with IMHA was an imposition on their limited time:

... from the frontline clinician perspective the IMHA appears to be another drain on clinical time, requiring a lot of liaising, and extending the length of interviews. This raises the problem of equitable access – those who have not accessed the IMHA (and carers) are then affected by the increased time I have spent with people who have IMHA involvement. (SR258)

Similarly, a consultant psychiatrist complained about the 'verbatim' nature of representational advocacy, suggesting that an advocate's role was to convince the consumer of the benefits of the proposed treatment. A different consultant psychiatrist told the evaluation team that 'advocacy doesn't add value' as he already knew what the consumer wanted, and that 'advocacy needs to challenge the patient'. This psychiatrist also believed that consumers were well aware of their rights and did not need IMHA to explain them. This opposition or indifference to advocacy was in the minority, although the evaluation team heard this repeated at all services, and from all professional groups.

In general, the evaluation team found that where IMHA was well known and well understood, it was well used and well appreciated. Much more work remains to be done in this area (Recommendation 19). Unfortunately, the evaluation team also found that awareness and understanding of IMHA was uneven across the sector, as shown in the following two sections.



Sector knowledge of IMHA

The evaluation identified that awareness of IMHA across the sector was low. Service promotion in the Victorian mental health sector faces significant barriers, including high rates of staff turnover, fractured and decentralised service provision and a diverse and regularly changing array of similar services. In England, IMHA services were still experiencing promotion issues many years after implementation,¹⁶ therefore this finding was not unexpected. The issue has been compounded by IMHA’s decision to focus on the inpatient setting rather than the community setting. This focus has resulted in much better awareness of IMHA in inpatient units, as detailed below.

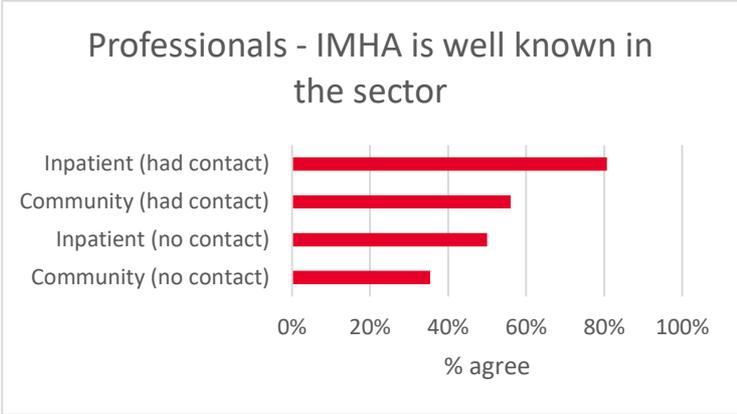


Figure 11 – How well known is IMHA, by contact (online survey (n=188))

Figure 11 indicates that amongst professionals who had interacted with IMHA, it was well known in the sector. The opposite was true of professionals who had not. Knowledge of IMHA is higher in inpatient settings than in the community. This was reflected in the qualitative data, particularly amongst nurses and administration workers who had the most contact with consumers but who would rarely be the target of IMHA advocacy. This appears to be a missed opportunity to increase access (Recommendation 19.2).

This advocate’s assessment correlates with the data in Figure 11, illustrating that this is an important issue for IMHA to address:

Well, I think outpatient you’re looking at probably 30% knowledge, I think it’s lacking. I mean I call people and they say yes I know, but I’m probably calling the same people. Like there are probably clinics out there that don’t know much about IMHA. Inpatient I think would be a lot higher. (A3)

The high turnover in the sector exacerbates this issue, and IMHA is not sufficiently well promoted to ensure that new staff are aware of the advocacy available. The turnover of staff within the sector is a difficult issue for IMHA to address, as it is an unavoidable aspect of the mental health system. IMHA can address this by working with services to ensure that all new staff are briefed on IMHA’s role, and mental health services can ensure IMHA is featured in training for new staff (Recommendation 2). IMHA are included in staff orientation in some, but not all, mental health services.

Sector understanding of the IMHA model

Consumers had an immediate comprehension of the representational model, with all consumers who were asked being able to articulate this, usually as being ‘on my side’. For consumers, it was a very straightforward arrangement. This consumer said:

My expectations were that the advocate would listen to my concerns, and liaise with my treatment team and present my concerns in a cogent manner. They did so, and I was of the

¹⁶ Ibid.

opinion that the treating team was much more receptive to my concerns when they were relayed by the advocate. They also treated me in a more civil and respectful manner when the advocate was present. (SR45)

Despite an understanding that the advocate was on their side, people were not always clear what an advocate was, or what they could actually do. One advocate noted:

Some people might not even know what the word, like what does it mean to have an advocate, you know. I get that question a fair bit. (A3)

Many consumers identified that processing any information while in extreme mental distress was very difficult. This consumer, who had worked with IMHA but had no recollection of it, noted:

I could imagine when I was in the [Unit], if my nurse opened the door – if I was involuntary, which I expect I was at the start – but, like I said, I don't remember – I wouldn't understand what IMHA is. If they told me that, I wouldn't understand whether I needed them or not. (FG1 C1)

When the distress subsided and the effects of medication did not interfere with comprehension, consumers were better able to understand IMHA's role. This comprehension did not extend to clinical staff and other stakeholders, many of whom had passing familiarity but only limited understanding of IMHA's role. One administration worker who had been referring consumers to IMHA for over a year was unable to clearly articulate IMHA's role:

... they're advocates. I don't know that much about IMHA to be completely honest with you. ... I know they're not legal representation. They're an advocate. I do know they help with explaining their rights and give them a lot of resources in relation to that ... I sort of know what to go to an IMHA person for if I need something, but I don't know her exact role, no. I don't know exactly what she does, what she can and can't do. That's a no. (MHP45)

Having someone 'on my side' was consistently identified as vital and important to consumers, but was overlooked by many professionals who would have preferred people to comply with their treatment. Significantly, the evaluation team often found that when professionals' understanding of the model was increased, either by IMHA or through explanation by the evaluation team, their apprehension and opposition to IMHA decreased. Advocates told the evaluation team they had worked hard to improve sector understanding of the model, yet there was still work to do (Recommendations 8 & 19).

2.3.2. Access to IMHA

Currently, consumers can get access to IMHA in three main ways: through inpatient unit ‘outposts’, referrals from mental health professionals or IMHA promotional materials. These three pathways often overlap, such as when services provide promotional material.

IMHA has made significant inroads into the inpatient setting, but in both inpatient and community settings there remains a concern that consumers who are

already best able to advocate for themselves are more likely to come into contact with IMHA, while those who have less developed advocacy skills may not. As Figure 12 illustrates, IMHA is providing support to people who require advocacy. Significantly, there remains a group of people eligible for advocacy who might not be aware of IMHA, may not be able to use the phone to call IMHA, could have a clinician, carer or other person discouraging or preventing access, or are experiencing significant barriers to effective communication. One psychiatrist noted:

... interestingly, a lot of the consumers who ask for IMHA, are also people who are already advocating for themselves. (MHP52)

This means IMHA must continue to work to ensure access, and should be adequately funded to reach those who find accessing support more difficult (Recommendation 3). An opt-out approach would also ensure access for many who are currently not able to do so (Recommendation 1.2).

Access in inpatient units

Advocates and consumers raised issues around the accessibility of IMHA within inpatient units. Advocates conduct outposts in all inpatient units across the state, usually once a fortnight but less often in regional areas. With the average stay in a general mental health inpatient unit being 8-9 days,¹⁷ a large number of consumers will not be present or may be on leave for the duration of the outpost. Advocates frequently reported issues with ensuring continued inpatient access, despite all mental health services signing a MoU or letter of agreement. Advocates and consumers identified issues with access to phones to call IMHA or access to interpreters.¹⁸ Consumers also identified that they often required advocacy out of business hours, or more urgently than is currently possible.

Increasing face-to-face access in inpatient units requires more advocates. Participants suggested that advocates should visit at least once every week, which would require doubling the current number of

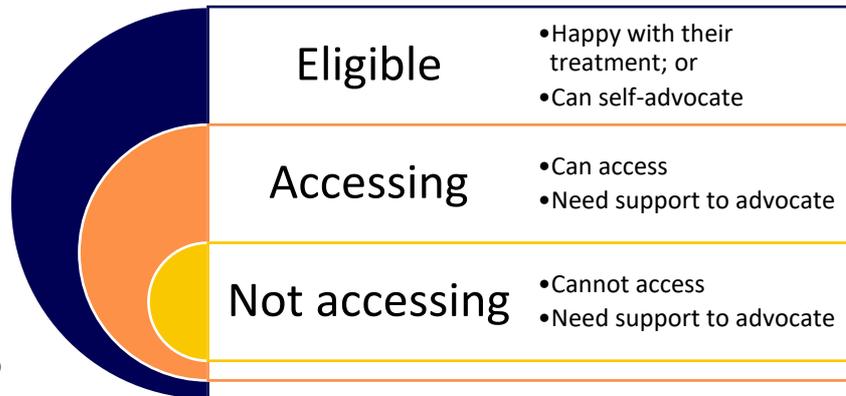


Figure 12 – Three levels of access

¹⁷ DHHS, ‘Victoria’s Mental Health Services Annual Report 2016-17’ (Department of Health and Human Services, October 2017) <<https://www2.health.vic.gov.au/mental-health/priorities-and-transformation/mental-health-annual-report>>.

¹⁸ This has been confirmed by other oversight bodies. See e.g.: OPA, ‘Community Visitors Annual Report 2016-2017’ (Office of the Public Advocate, 2017) <<http://www.publicadvocate.vic.gov.au/our-services/publications-forms/strategic-plans-and-annual-reports/community-visitors-annual-reports/442-community-visitors-annual-report-2016-2017>>.



advocates (Recommendation 3). An after-hours crisis line would require the allocation of further resources. (Recommendation 17.3). Access in inpatient units is also facilitated outside of the outpost by referrals from mental health professionals.

Referring to IMHA

Many mental health professionals interviewed regularly referred consumers to the service. The methods of, and reasons for, directly referring and recommending consumers to IMHA varied across sites and amongst professionals. Referring usually involved making IMHA materials available on request, but sometimes extended to warm referrals. Mental health services are commonly displaying IMHA materials, however, consumers reported not being aware of IMHA or IMHA materials until specifically directed to them. Many professionals encouraged consumers to contact IMHA themselves and helped to facilitate that contact. One nurse said:

We really encourage them to take that responsibility to contact [IMHA], [their] number is up on the wall everywhere and we facilitate it if we need to. (MHP1)

Other mental health professionals described contacting IMHA on behalf of consumers or would recommend that the IMHA advocate contact particular patients during an outpost. Some professionals shifted between both methods depending on the needs and concerns of the individual consumer at the time.

Table 5 illustrates that referrals to IMHA are largely self-referrals, with only a limited number of referrals coming from key bodies, such as the MHCC, OPA Community Visitors and the OCP. These figures suggest there is an opportunity for IMHA to work with these organisations to increase referrals. IMHA encourages consumers to self-refer but does not collect data on where consumers first hear about IMHA. It could be that many of the self-referring consumers may be coming from these organisations. This would account for the absence in the data of organisations such as VMIAC and Tandem, who told the evaluation team they regularly refer consumers to IMHA.

Referral source	No. referrals
Self-referred	4087
Public health services	580
VLA	485
Mental Health Complaints Commissioner	31
Office of the Public Advocate	13
Office of the Chief Psychiatrist	1
Other	66

Table 5 – Incoming Referrals 1 Sep 2015 to 31 Aug 2018

Figure 13 indicates that incoming referrals from mental health services vary significantly over time. It is unclear why this is the case.

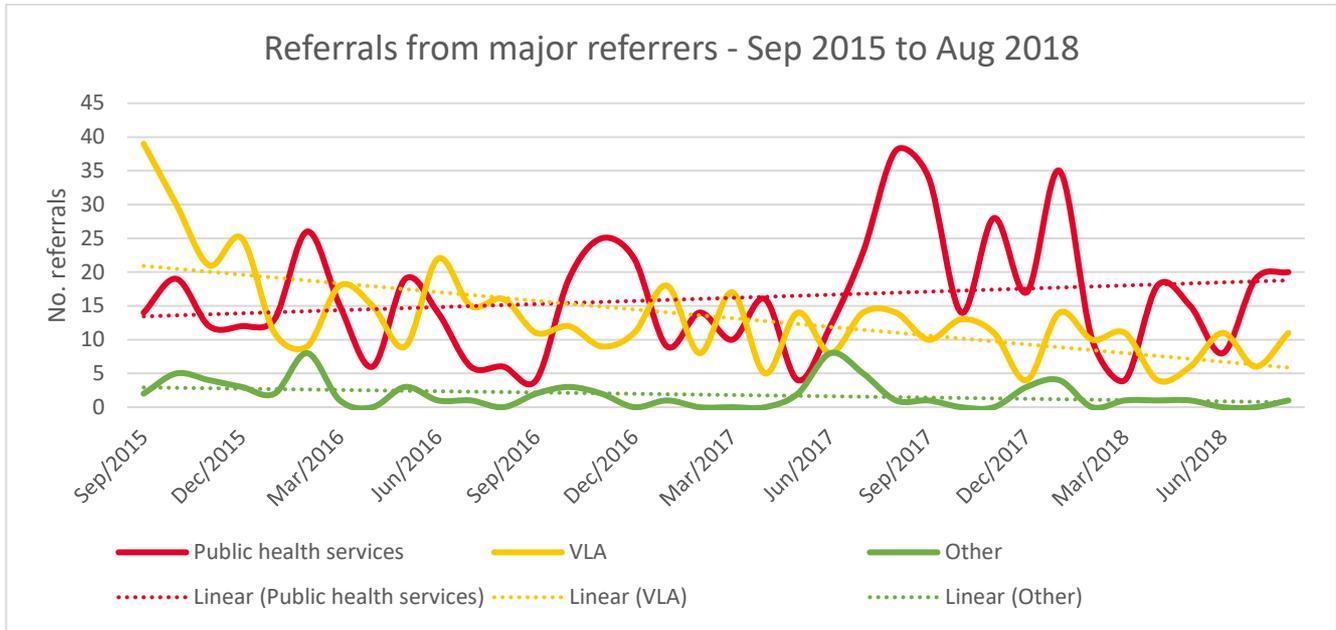


Figure 13 – Referrals from Major Referrers – Sep 2015 to Aug 2018 (excluding self-referrals)

The reasons for recommending and referring consumers to IMHA varied. The most common reason was consumer unhappiness with and concerns about compulsory treatment, wanting to be discharged, distress, lodging a complaint and the need for further support. Consumer concerns and anxiety about forthcoming reviews, Tribunal hearings and discharge also triggered referrals to IMHA.

It was clear that when mental health professionals were aware of and understood IMHA, they actively recommended and referred people. It is reasonable to suggest that raising awareness of IMHA and fostering good working relationships with staff will increase referral pathways and recommendations to IMHA (Recommendations 8 & 19).

Access in the community

Ensuring access to IMHA for people outside of the inpatient setting has proven difficult for IMHA and is a key area for further development. Consumers subject to Community Treatment Orders are less entwined with the system and may only have irregular contact with a case manager. In addition, the MHDL team, who are responsible for many incoming referrals, tend not to represent people at Community Treatment Order hearings due to resourcing limitations. This has created an environment where those who are most in need of advocacy in the community – those who are isolated, unsupported and who lack positive relationships with their treating teams – are those who are least likely to have access.¹⁹ Advocacy also has the potential to achieve more long-term goals post-crisis, when a person is living in the community.

The demand for advocacy within community-based settings was difficult for the evaluation team to measure, however, IMHA advocates identified this as a gap in their service provision. This gap was also evident in IMHA’s internal data. Figure 14 indicates that IMHA has consistently provided more services in inpatient settings, while the provision of advocacy within community-based settings has remained largely static.

¹⁹ This has also been identified as an issue for IMHAs in the UK. See: Newbigging et al, above n 2.

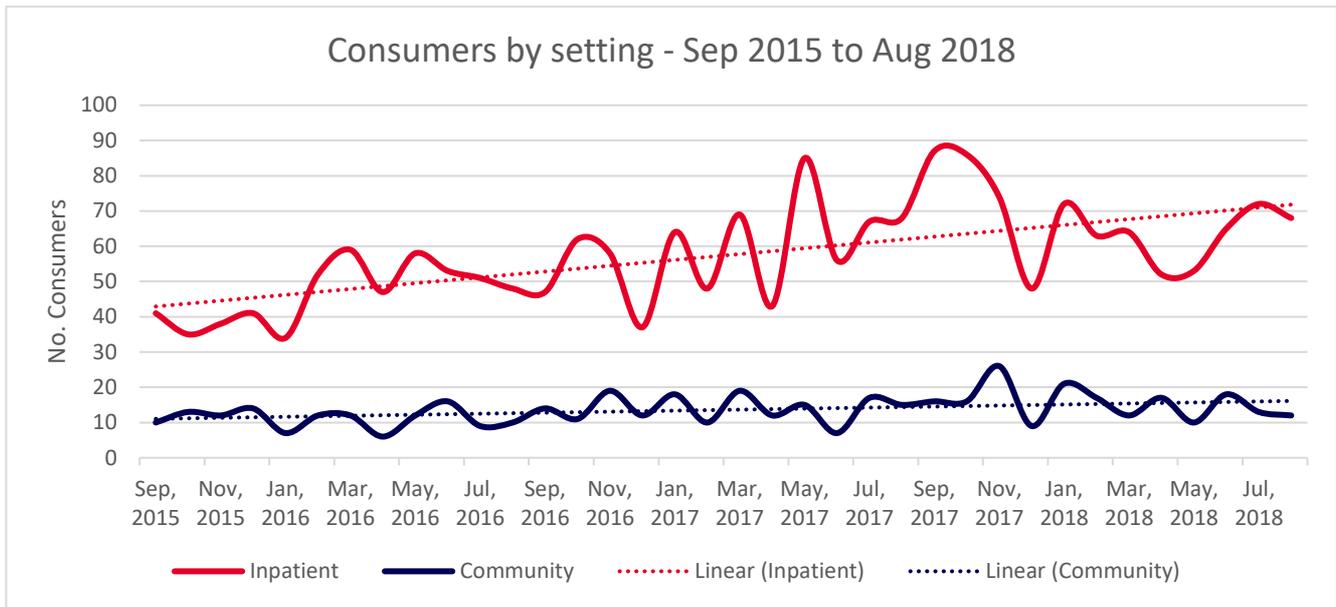


Figure 14 – Consumers by Setting – Sep 2015 to Aug 2018

Without being able to ascertain the number of people on Community Treatment Orders at any one time, it is difficult to assess the extent to which IMHA is meeting demand. Even if this data were available, advocacy needs are different in inpatient units, and providing advocacy in the community is more resource intensive. To determine what level of resources IMHA requires to meet community needs requires the identification and consideration of a number of unknown factors. To address this, the evaluation team employed a *Collaborative Outcomes Reporting* model and assembled a panel of experts,²⁰ including academic experts, a service provider, consumers, and IMHA staff to identify the potential need for advocacy in the community and how IMHA might identify and overcome barriers. It was noted by the panel that Community Treatment Orders are often experienced by consumers as disempowering and limiting choice and agency. The panel identified that people on Community Treatment Orders are in some senses hidden from view, in that they are subject to a level of coercion which is difficult to ascertain and has no physical structure. The experience of Community Treatment Orders as restrictive and disempowering is consistent with the literature examining the lived experience of those subject to such orders.²¹ A representative of a stakeholder body confirmed this:

I think, having worked with people who are on CTOs, they need advocacy... But I think the community sector don't know enough about IMHA because they just – they don't associate IMHA with somebody who is on a CTO. (S7)

²⁰ Jessica Dart and Megan Roberts, *Collaborative Outcomes Reporting* (2014) Better Evaluation <<http://www.betterevaluation.org/plan/approach/cort>>; Alice Roughley and Jessica Dart, 'Developing a Performance Story Report: User Guide' (Department of the Environment, Water, Heritage and the Arts, 2009) <<http://nrmonline.nrm.gov.au/catalog/mql:2162>>.

²¹ Lisa Brophy and David Ring, 'The Efficacy of Involuntary Treatment in the Community' (2004) 2(2–3) *Social Work in Mental Health* 157; K Canvin, A Bartlett and V Pinfeld, 'Acceptability of Compulsory Powers in the Community: The Ethical Considerations of Mental Health Service Users on Supervised Discharge and Guardianship' (2005) 31(8) *Journal of Medical Ethics* 457.



The evaluation team consistently heard that advocacy is experienced positively by consumers because they feel heard and are provided with options. The few consumers who participated who were on Community Treatment Orders indicated that advocacy in the community would have similar benefits, although not necessarily outcomes:

I was in the community treadmill, so I'm still in. If they [IMHA] turned up at every meeting that I have with the psychiatrist ... I don't know whether it would be of benefit but I wouldn't mind them being there, to be honest with you, because, as I've said, it's part of witnessing what is occurring. (C3)

Based on the findings of the evaluation, existing literature and the expert panel, it is clear that advocacy for people on Community Treatment Orders would be effective and appreciated. IMHA are aware of this issue and have taken diverse and creative steps to address it. These strategies have included outposts at community clinics, education and information sessions for support workers and clinicians, and agreements with mental health services to include IMHA publications in notifications of Tribunal hearing letters. In the first three years of operation, IMHA completed 550 information sessions to 6692 staff and consumers, including many to senior teams by the IMHA Manager. Many of these have been in the community, or for community clinicians. IMHA have invested heavily in addressing this issue, although ongoing work is needed.

Similarly, IMHA has strong relationships with non-clinical mental health support services such as Neami, Mind Australia and VMIAC, consumer and carer support groups and peer worker networks. Increased engagement with these groups has the potential to increase referrals and knowledge of the service within the sector more generally (Recommendation 18.1). Stakeholder bodies expressed an eagerness to collaborate with IMHA to promote advocacy and increase referral pathways. It is also possible that consumers in the community may be better placed to participate in advocacy training sessions, including advance statement workshops, which could increase IMHA's presence in the community (Recommendation 18.1).

With demand high in inpatient settings and a perceived lower return on investment in the community, there is a strong argument for continuing to focus on inpatient settings, particularly given the potential human rights issues associated with deprivation of liberty. The only response that will maintain IMHA's current work in inpatient settings and improve access in the community is an increase in the number of advocates employed. Regional based staff indicated that additional advocates need to be more widely dispersed than the current IMHA regions, as consumers on Community Treatment Orders are not located in major centres in the way that inpatient units are. These could take the form of fractional appointments in existing VLA offices in Mildura, Shepparton, Horsham, Ararat, Warrnambool, Bairnsdale, Morwell, Ballarat and Sale, as well as existing IMHA offices (Recommendation 3).

Promotion

Despite many clinicians being supportive of and referring consumers to IMHA, there is a concern that clinicians who are least likely to engage in supported decision-making are also those who are least likely to engage with IMHA. Relationships with clinicians are fundamental to IMHA's ability to provide advocacy, but they cannot be relied on as the primary or sole avenue for access.

Current promotional materials such as posters and postcards are not working effectively for IMHA. As one consumer interviewed within an inpatient unit noted:

... it requires to have heard of it and go, 'Oh there's the poster'. 'Great, there's the phone number'. The poster itself isn't sufficient. ... when you're acutely mentally ill, poster on the wall's not enough. You need someone to be able to come to you and say, 'Hey, it looks like you're struggling with this. These are just some services. Here's some phone numbers you can call. Do you want me to get you a phone'? (C1)

Posters are also not guaranteed to stay in place. Four advocates suspected that IMHA posters were being removed by clinical staff, and clinical staff indicated that consumers sometimes remove them. In some services, posters were not permitted for policy reasons. Some consumers who had used IMHA did report that they had found out about IMHA from posters and flyers, so it is clear that this strategy is working for some consumers.

The importance of the timing of the delivery of information about IMHA and the packaging of information are central issues that need to be considered. Participants suggested that information needed to be delivered in different formats and at multiple points within a consumer's journey through the mental health system (Recommendation 18). The existence of multiple services adds to the complexity of the system and can be confusing, particularly when in combination with consumer distress, the effects of medication and possible competing priorities.

In person approaches were viewed as the most effective vehicles for promoting IMHA. Within inpatient units, running workshops with staff and consumers was one way of increasing awareness of IMHA. This strategy would need to be ongoing given the high turnover of consumers and mental health professionals.

Digital resources were another possible avenue for the promotion IMHA. The IMHA website had 34,343 hits in the first three years since launch. Visitors to the site mainly accessed pages outlining consumer rights, or how to access an IMHA advocate. Two-thirds of these visits have been from a computer with the remainder via smartphones and tablets, indicating the potential access in inpatient units. IMHA also has a social media presence and a newsletter, all of which are well positioned to promote the advocacy service further. This digital presence and the largely positive consumer experience of IMHA are significant resources that can be drawn on and should be harnessed in any future promotion of IMHA. Both consumers and mental health professionals felt that testimonials from consumers who had used IMHA would be powerful. Mental health services indicated they would be open to installing a digital display and collaborating with IMHA to produce content.

IMHA has begun developing digital resources, although consumers and advocates both identified further opportunities. Since the midterm review, IMHA has begun to develop videos to help mental health services promote IMHA to consumers, and has created an online referral form to facilitated web access (Recommendations 18.2 & 18.3). Web-based services are still developing an evidence base regarding their ability to facilitate help-seeking. There is some evidence that digital services appeal to people who are experiencing high levels of mental distress and who are in earlier stages of experiencing symptoms.²² These approaches should be viewed as supplementary, rather than replacing effective face-to-face and telephone

²² Debra Rickwood et al, 'Who Are the Young People Choosing Web-Based Mental Health Support? Findings From the Implementation of Australia's National Web-Based Youth Mental Health Service, Eheadspace' (2016) 3(3) *JMIR Mental Health* <<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5016625/>>; Sylvia Deidre Kauer, Cheryl Mangan and Lena Sanci, 'Do Online Mental Health Services Improve Help-Seeking for Young People? A Systematic Review' (2014) 16(3) *Journal of Medical Internet Research* <<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3961801/>>.

strategies. These approaches are not a substitute for an opt-out system and would be required to supplement it.

As noted above, IMHA is currently developing and implementing a self-advocacy resource which will assist in the promotion of IMHA (Recommendation 13.1). This was not able to be included in the scope of this evaluation and should be assessed after implementation.

The responsibility for promoting the advocacy service is one that is shared between IMHA and the mental health services. The evaluation team visited some services where nearly every person was offered IMHA, and others where promotion was largely left to advocates when they arrived for outposts. IMHA must continue to work with services and there are opportunities for closer collaboration. One potential avenue is to formalise the way in which written material is provided by mental health services and the Tribunal (Recommendation 12). Another option would be to encourage services to include a question on access to advocacy in the *Your Experience of Service (YES) Survey* (Recommendation 9).

Compulsory notification

The most direct way to ensure people who are eligible for IMHA are provided with access is through the adoption of an 'opt-out' system, similarly to the model operating in Western Australia. In this model, all people who are subject to compulsory treatment must be contacted by an advocate within a specified timeframe of a treatment order being made. Consumers then have access to an advocate who outlines their rights under the Act and explains the available options to them. After speaking with an advocate, consumers are able to accept or refuse advocacy.

Consumers supported this model and identified access to independent advocacy as more important than privacy concerns. This model has significant resourcing implications. While the exact number of people subject to compulsory treatment at any one time is not made public, the adoption of an opt-out system would increase referrals and would quickly exceed IMHA's current capacity to provide advocacy. It is recommended that an 'opt-out' model be adopted, either legislatively or via the *Mental Health Regulations 2014*, and that IMHA be sufficiently resourced to provide advocacy for all who are eligible for and require it (Recommendations 1.1 & 1.2).

It is important to note that this would significantly increase access to IMHA, but would not capture consumers who are at risk of compulsory treatment or are detained unlawfully, or those who are on very short-term orders. A compulsory notification system would need to balance the importance of providing access to IMHA with pragmatic concerns. This balance would need to determine whether notifications should be made on the basis of Assessment Orders, when orders are varied to inpatient, or when they are renewed.

The most effective strategy would be to provide IMHA advocates with powers similar to Western Australian mental health advocates or Community Visitors in Victoria. These powers include the right to visit persons, inspect any part of a mental health service, make inquiries and copy documents and provide for criminal offences for people who interfere with the exercise of these powers (Recommendation 1.3, 1.4 & 1.5). This should be considered in reference to powers held by Community Visitors and enhance IMHA's current individual representational advocacy approach. IMHA should not replace the Community Visitors nor duplicate their role.

2.3.3. IMHA's Scope

Three key issues relating to IMHA's scope emerged through the consultation process: the ability to engage in non-mental health advocacy, advocacy for voluntary consumers, and the ability for advocates to support consumers at the Tribunal.

Non-mental health advocacy

IMHA currently focuses on advocacy within the clinical mental health system. This is consistent with the *Advertised Call for Submissions*, which stated that a feature of IMHA is that it relates to mental health treatment and care, not general advocacy. IMHA's policy states:

4.1 In addition, IMHA can only provide services where the assistance sought falls within IMHA's scope of service provision, principally being the provision of information, assistance to self-advocate or advocacy in respect of issues relating to a person's assessment, treatment and recovery.

The inclusion of recovery has been used within IMHA to broaden the areas around which advocacy support is provided. The policy also states:

(e) Recovery support services – While IMHA makes referrals to other services that support recovery, IMHA does not deliver recovery support services to Clients. For instance, Advocates will not directly contact landlords on behalf of Clients and will not assist Clients to complete forms to apply for housing or government benefits. Note: Advocates may provide advocacy for a recovery support service, such as a public housing agency, to support a Client to access their service and to actively assist them with a housing issue.

To some degree, this is at odds with consumer-directed representational advocacy that suggests that advocacy should be provided in whatever area consumers require, including housing or other areas. In practice, advocates generally did not advocate outside of the area of mental health when there was another professional able to provide that support. This meant that IMHA advocates would refer consumers to an NDIS advocate or contact a hospital social worker to encourage them to advocate on behalf of a consumer. If IMHA already has a relationship with a person, this process of external referral or indirect advocacy may not be the consumer's preferred option. Expanding the scope of IMHA, however, has negative implications for resourcing and role definition. Ideally IMHA would provide advocacy in line with consumer's needs, rather than being restricted to the mental health sector, however, IMHA's strengths lie in being a *specialist* mental health advocacy service. Any changes to the advocates' role should be considered with a view to increasing IMHA's presence in the community (Recommendation 18.1). This should not be to the extent that IMHA would be supplementing service delivery gaps that should be addressed by other services but may include more integrated relationships with those services to facilitate advocacy.

Advocacy for voluntary consumers

IMHA does provide support to consumers who are 'at risk' of being made compulsory. This is consistent with the evaluation's identification of a large cohort of people who are not subject to a treatment order but are restricted from leaving the inpatient setting. Consumers are presently reliant on mental health professionals identifying the issue, who then contact or recommend IMHA. These consumers are clearly eligible for IMHA's service but are not easy to identify, and would not be picked up by an opt-out system.



In addition to consumers who are 'at risk' of being made compulsory, there is also a clear need for advocacy for those who are voluntary and who simply want a better quality of treatment. The *Advertised Call for Submissions* excludes this group:

The majority of mental health Consumers ... are not in the target group for the IMHAS and will continue to access general support services.

The evaluation did not include the broader mental health consumer population in scope, as they are not eligible for IMHA. VMIAC has recently employed a number of advocates, however, it remains to be seen if they are resourced sufficiently to fill this service gap. Peer workers also provide advocacy to this group and are becoming increasingly common, although the latest available figures indicate only 18 employed in public mental health services across the state.²³ An expansion for IMHA to include voluntary consumers of public mental health services was raised in earlier studies of IMHA,²⁴ however, this is a service gap that should be filled by VMIAC, peer workers and other advocates.

2.3.4. Non-legal advocacy at the Mental Health Tribunal

The third question relating to IMHA's scope relates to the current policy position of IMHA staff not attending the Tribunal other than in exceptional circumstances. IMHA advocates are not lawyers and are not trained in interpreting the Act. Representation at the Tribunal is already very low in this jurisdiction at 15% in 2016/17, down from 19% the previous year.²⁵ IMHA advocates should not be used to fill this gap or replace lawyers at hearings where they are providing representation. This is consistent with the *Advertised Call for Submissions*, which states that:

It is anticipated that advocates would provide support to Patients at the Mental Health Tribunal only in exceptional circumstances. Advocate support should occur earlier with an emphasis on assisting the Patient to self-advocate. Alternatively, the advocate can refer the Patient to Victorian Legal Aid for legal advice and representation.

Despite this, consumers overwhelmingly indicated that they would prefer their IMHA advocate be able to attend hearings with them if they wanted them to. No distinction was made as to whether they would prefer non-legal advocacy to legal advocacy. In general, the responses indicated that consumers wanted more support at the Tribunal. This was reflected in consumer focus groups and in areas of assistance recorded by IMHA staff (Table 3). IMHA advocates, mental health professionals and stakeholder bodies were also generally supportive of IMHA advocates attending Tribunal hearings.

The evaluation identified that people before the Tribunal needed support and that IMHA advocates are well positioned to provide this. Neither the Tribunal nor the Act require advocates at the Tribunal to be legally trained. Staff and consumers suggested that the type and length of contact advocates had with consumers would mean that were well placed to provide advocacy and support at the Tribunal. Furthermore, the Tribunal environment provides opportunities for advocacy that might not be otherwise available, such as the

²³ DHHS, above n 17.

²⁴ Bennetts et al, above n 6.

²⁵ Mental Health Tribunal, '2015/ 2016 Annual Report' (Victorian Mental Health Tribunal, 19 August 2016) <<http://www.mht.vic.gov.au/wp-content/uploads/2016/10/MHT-2015-2016-Annual-Report.pdf>>.



opportunity to have a constructive, facilitated discussion with the treating team and to hold the treating team to account on behalf of the consumer.

Other participants raised concerns regarding the strategic implications of such a move. Replacing lawyers with IMHA advocates gives the impression of minimising the need for legal representation and reduces the strategic attempts by mental health lawyers to enforce legal rigour in Tribunal processes. There are also resource implications, issues around delineation of roles and the risk of engaging in unqualified legal practice. There are also lessons to be learned from the UK context, where the role of IMHA advocates at Tribunal hearings has been explored in depth.²⁶ As the main provider of legal advocacy at the Tribunal, MHDL is central to these considerations and should be included in any review.

An approach that sought to accommodate the widest range of consumer needs and preferences would be that each person appearing before the Tribunal have the option of having both an IMHA advocate and legal representative. Currently, levels of resourcing do not allow for this. Given the overwhelming support from consumers for IMHA advocates to be able to attend Tribunal hearings as standard practice, it is recommended that IMHA consider reviewing this policy and its implications (Recommendation 17.2). Any review of this policy should ensure that IMHA is not simply filling resource gaps left by other parts of the system.

2.3.5. Systemic Reform

A key tension in the IMHA model is the objective of system-level change and reform in the context of individual advocacy. This objective is focused on reducing restrictive practices, increasing self-advocacy skills and the reception of self-advocacy by decision makers, implementing supported decision-making practices and improving the quality of mental health care and treatment. In general, sector level data does not reflect immediate success in this area, with rates of restrictive practices including compulsory treatment, seclusion and restraint all fairly static. Despite this, IMHA is working hard for cultural change and sector reform.

Mental health professionals were asked whether IMHA had achieved systemic change within their three years of operation. Responses varied across inpatient units and professions, with many respondents noting that it was difficult to quantify or find specific examples of IMHA's impact. This difficulty was linked to issues and constraints within the mental health system as a whole. Many respondents highlighted the potential of IMHA to achieve systemic change and appreciated their independence. Raising awareness and education was an area where respondents felt that IMHA could have a positive impact.

This supported decision-making training is a key aspect of IMHA's systemic reform agenda. All executive directors of mental health services have agreed for IMHA to do this training in their services, but IMHA must be properly resourced to continue this work (Recommendation 2).

Many respondents felt that the presence of IMHA had a positive impact on workplace culture and practices, fostering greater accountability, reflexivity and transparency on the part of treating teams. One senior social worker felt that IMHA had made treating teams more accountable:

²⁶ Mental Health Law Online, *Practice Note: Role of the Independent Mental Health Advocate in First-Tier Tribunal (Mental Health) Hearings* (May 2011)

<[http://www.mentalhealthlaw.co.uk/Practice_Note:_Role_of_the_Independent_Mental_Health_Advocate_in_First-tier_Tribunal_\(Mental_Health\)_Hearings](http://www.mentalhealthlaw.co.uk/Practice_Note:_Role_of_the_Independent_Mental_Health_Advocate_in_First-tier_Tribunal_(Mental_Health)_Hearings)>; Mental Health Lawyers Association, 'MHLA Response to Draft Guidance on IMHAs' (11 November 2010) <<http://www.mhla.co.uk/news/mhla-response-to-draft-guidance-on-imhas/>>.

Holding us accountable through an external service. And there's not too much accountability here overall. We can have a patient here who isn't getting any active progress for years, and all of a sudden, once they decide, actually, 'No, I'm sick of this, I'm going to call a lawyer or whatever,' things can start moving pretty quickly. So it's important, I think. (MHP11)

Some professionals noted that IMHA helped improve the decision-making processes of services and treating teams. IMHA advocates were increasingly used by care teams to negotiate between consumers, care teams and management.

There was also evidence that IMHA was tipping the balance of power towards the consumer in some situations, which can be viewed as systemic change. Allied health staff often said they used IMHA's independent status strategically to challenge decisions made by management and consultants. One social worker viewed IMHA as a balancing force:

I certainly do see them as like a balance, like an external check I guess, checks and balances. Sometimes we can get in, working in the system, we can get frustrated with the way the upper management views our patients and the sort of stumbling blocks we get put in our way. I certainly see IMHA as potentially a good way to get around that. (MHP9)

Much of IMHA's impact at a systemic level is made by the IMHA Manager, who meets regularly with senior representatives from stakeholder bodies, clinical and non-clinical mental health agencies and DHHS, raising issues which require escalation by individual advocates. Building on this, there remain opportunities for VLA to engage in collaborative systemic advocacy with other organisations, particularly other oversight bodies. VLA has previously advocated for a group of representatives from each oversight body to be convened by DHHS to collaborate on systemic issues and provide feedback to the department. Other stakeholder bodies were in favour of this proposal (see Recommendation 3). Advocates provided a number of examples where working closely with other oversight bodies such as MHDL or MHCC had led to significant positive outcomes for consumers and changes within the broader system. IMHA has also participated in a range of projects and committees working to address systemic issues in the mental health system and provided advice on the use of supported decision-making, including membership of the SPOS Advisory Group.

Some Nurse Unit Managers identified a missed opportunity to provide feedback at the ward level. They indicated that they would appreciate regular written feedback on issues identified by the advocate during their outposts, similar to the way Community Visitors provide feedback. This feedback is currently provided by IMHA to mental health service executive management but does not appear to be reaching service level managers. A more direct method of feedback at the service level may be more appropriate (Recommendation 11).

IMHA's ability to engage in strategic reform through individual advocacy is limited by the limited legislative recognition of the program. In Victoria, consumers have a right to communicate with IMHA advocates but have no other statutory powers.²⁷ This is in contrast to the system in Western Australia, where the advocates are led by a Chief Mental Health Advocate and an annual report is tabled in Parliament.²⁸ The establishment of a Victorian Chief Mental Health Advocate or other statutory systemic advocacy role would give IMHA a formal place amongst other oversight bodies and increase IMHA's stature when dealing with the media and

²⁷ *Mental Health Act 2014 (Vic) s 16, Mental Health Regulations 2014 (Vic) reg 5A.*

²⁸ *Mental Health Act 2014 (WA) ss 348-378.*



stakeholders in advocating for systemic reform (see Recommendation 1.6). This does not automatically require a separate statutory body; much as the Community Visitors Program sits within OPA, IMHA can remain within VLA.

Statutory mechanisms for system reform

There are some missed opportunities for advocates to provide support to consumers so they are better able to use aspects of the Act that are meant to support systemic change, such as the making of advance statements, second opinions or complaints. The uptake of advance statements across the state is very low, at 2-3% of adult consumers of public mental health services having an advance statement.²⁹ There are also many reasons why a person would not complete an advance statement, such as disagreement about the presence of a diagnosis, levels of distress or the fact that they are not binding.³⁰ Consumers also reported being told by other consumers that advance statements are of no value.

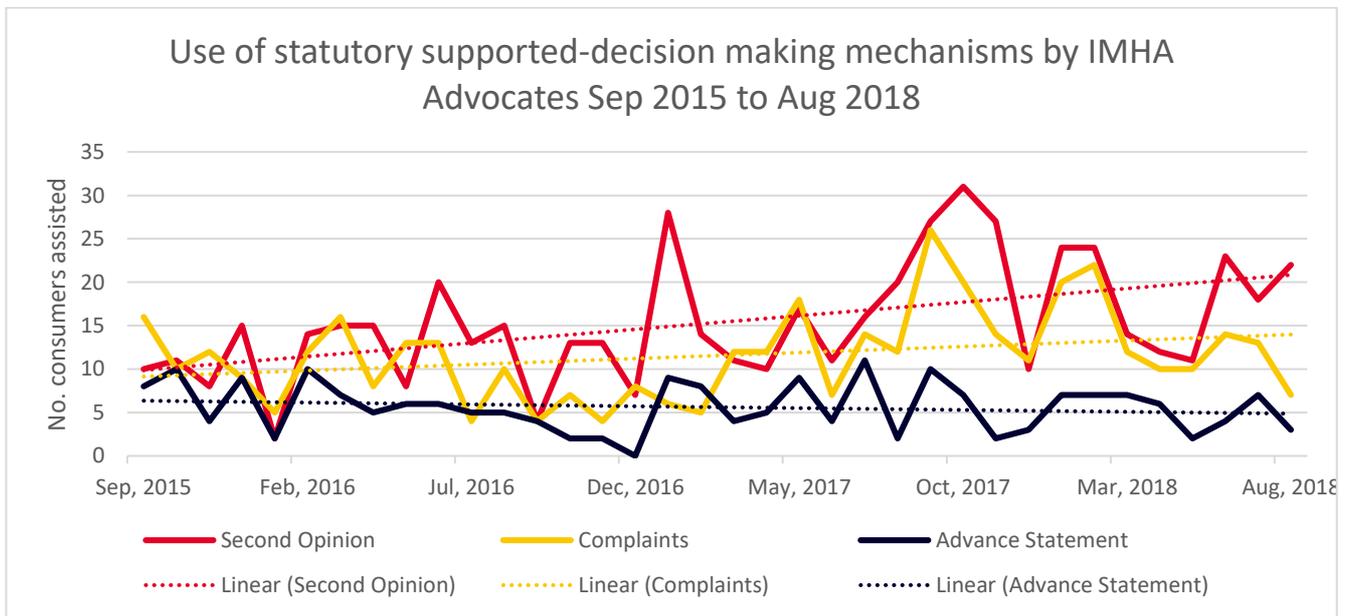


Figure 15 – Use of Statutory Supported Decision-Making Mechanisms Sep 2015 to Aug 2018

Figure 15 shows that while referrals to SPOS and the MHCC have increased over time, assistance with advance statements has decreased. SPOS was not available in all regions for much of the first three-year period, by the end of which 50-60% of referrals to SPOS were from IMHA, indicating good linkages in that area. The missed opportunities in supporting the development of advance statements were also identified in the qualitative data and IMHA files. IMHA consistently passed on information to consumers about advance statements and has developed resources for people to use, but often did not actually provide support to make one. A key aspect of the supported decision-making model is ensuring that people are provided with the supports that are required when they need them. IMHA is well positioned to increase uptake of advance statements if adequately resourced to do so (Recommendations 3 & 13.3).

²⁹ DHHS, above n 17.

³⁰ Maylea, C.; Jorgensen, A.; Matta, S.; Ogilvie, K.; Wallin, P., ‘Consumers’ Experiences of Mental Health Advance Statements.’ (2018) 7, 22 *Laws*; DHHS, above n 17.



Sector contribution to system reform

This evaluation focused on IMHA, however, all participant groups consulted during the evaluation reported that the rights of consumers are not consistently upheld. An experienced consultant psychiatrist, who had practised interstate and overseas, said that he had not received any training about the Victorian Act or been provided with information. This lack of understanding was not limited to decision makers, and included allied health professionals who would be expected to be able to communicate rights information to consumers. This lack of training and subsequent lack of understanding of the rights of consumers may in part explain the apparent disregard for consumers' rights outlined above (see 4.1.1). Addressing or influencing many of these issues is beyond IMHA's control or influence and responsibility must reside with the mental health sector more broadly. For example, in England, all decision makers must complete training on mental health legislation before they can subject a person to compulsory treatment.³¹ It cannot be IMHA's responsibility to provide basic rights and legal education to mental health services staff, yet that is what is currently occurring (Recommendation 2).

As above, the evaluation incidentally identified that the reform agenda of the Act is inconsistently applied in practice. This made assessing IMHA's contribution to that systemic reform difficult. It appeared that the sector was functioning in direct opposition to IMHA's goals. For example, sector reporting against the Mental Health Outcomes Framework requires that 'Services are recovery-oriented, trauma-informed and family-inclusive'.³² The reporting under this outcome has no relevance to recovery as it is defined by policy,³³ and instead focused on clinical recovery outcomes. This means that it is not possible to assess IMHA's objective to contribute to an increase in recovery-oriented practice (Recommendation 6). This not only contributes to the tensions outlined in 4.1.2 and 4.1.3 but means IMHA's attempts to engage in cultural change are stymied while the sector moves in a different direction. It is beyond the scope of this evaluation to map out a strategy for whole of sector leadership, although that is what is required.

2.3.6. Data and Documentation

Sector level data

Sector level data is so poor that it is not possible, using publicly available data, to determine how many people are subject to compulsory treatment in Victoria, and therefore eligible for IMHA on any given day. Previous studies have suggested that Victoria has the highest Community Treatment Order use in the country.³⁴ The IMHA Advertised Call for Submissions indicates that in 2012-13 there were 10,055 compulsory patients in

³¹ *Mental Health Act 1983 (Eng) s 12(2)*.

³² DHHS, above n 17, 48.

³³ Department of Health, 'A National Framework for Recovery-Oriented Mental Health Services: Guide for Practitioners and Providers' (Commonwealth of Australia, 2013) <<http://www.health.gov.au/internet/main/publishing.nsf/content/mental-pubs-n-recovgde>>; Department of Health, 'Framework for Recovery Oriented Practice' (Mental Health, Drugs and Regions Division, Victorian Government Department of Health, 2011) 34 <<https://www2.health.vic.gov.au/Api/downloadmedia/%7B62D4CFBB-6854-4652-ACDC-273D024B7A60%7D>>.

³⁴ Edwina Light et al, 'Community Treatment Orders in Australia: Rates and Patterns of Use' (2012) 20(6) *Australasian Psychiatry* 478.

Victoria, but not how many of them were inpatients and how many were in the community. The Tribunal releases detailed data on orders it makes, however, neither Temporary Treatment Orders nor Assessment Orders are included in this data and no data are available which illustrate how long orders made by the Tribunal stay in force before they are revoked by authorised psychiatrists.³⁵ Departmental data indicates that in the 2016-17 financial year 11% of consumers receiving community mental health services were on a treatment order and 51.5% of inpatient admissions were compulsory, without specifying how many people this percentage relates to.³⁶ Reporting from health services indicates that 14% of adult consumers in the community were on Community Treatment Orders, with a lower percentage for aged consumers and a higher percentage for extended treatment settings, but still no total numbers and no data at all on other types of orders.³⁷ Figures also vary across the state without explanation, with the percentage of people on Community Treatment Orders ranging from 6% to 29%.³⁸ In addition, 2015–16 and 2016–17 public mental health services data collection was affected by industrial activity, specifically impacting community mental health data.³⁹ This makes evidence-based service planning and resourcing recommendations for IMHA very difficult.

Ideally, data would be readily available on the number of people who are subject to compulsory treatment and would include key characteristics such as age, gender, type and length of order etc. This data is collected by mental health services but not reported (Recommendation 7). In addition to reporting already collected data, it would be useful to include a question about access to advocacy on the *YES Survey* to track the commitment of services to ensuring access to IMHA (Recommendation 9).

IMHA internal data collection

As a new, non-legal service located within a legal organisation, IMHA has had to develop bespoke data collection and documentation processes. The new IMHA database promises to address many of the issues related to data collection, although some processes require further review, such as the data is collected inconsistently. For example, mental health services publish data in youth age ranges 0–4, 5–14, 15–24 and IMHA collects data in youth age ranges <18, 18-20, 21-30, making comparisons between demographic groups difficult. Mental health services report the percentage of consumers on an order for more than 12 months, whereas IMHA collects data on people continuously subject to compulsory treatment for more than three orders over the last two or more years. Other data collected by IMHA, such as the list of 1086 client outcomes by location or the list of 179 systemic issues raised with services, have insufficient detail to be usefully analysed (Recommendation 14).

There are also issues in the way data is collected by IMHA. For instance, many consumers do not have their Aboriginal or Torres Strait Islander status recorded. This is not simply a data collection issue. Aboriginal people have extra rights under the Act and under the Charter that IMHA is obligated to uphold. Similarly, gender diverse groups may require specific responses (Recommendation 14).

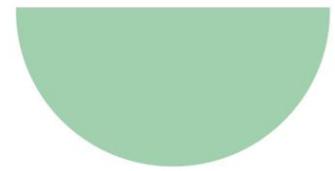
³⁵ Mental Health Tribunal, above n 25.

³⁶ DHHS, above n 17.

³⁷ DHHS, 'Adult Mental Health Performance Indicator Report 2017-18 - Quarter 4' (Department of Health & Human Services, 2018).

³⁸ Ibid.

³⁹ DHHS, above n 17.



IMHA reports quarterly to DHHS as part of its funding agreement and publishes these on its website. It is recommended that these reports are required to be tabled in Parliament, as is the case in Western Australia (Recommendation 1.6), and they are made more easily accessible on the IMHA website.

2.3.7. Resourcing

Without clear and accurate data on the numbers of people eligible for IMHA's service, the only indication of demand is the demand of consumers who have used IMHA's services. IMHA is doubling key performance indicator targets and some advocates are at capacity, yet this does not offer a complete picture of demand. The consistent experience of IMHA advocates is that when they do have the capacity to take on more work, they spend time promoting the service, which then leads to an influx of referrals that quickly absorbs their capacity. This has resourcing implications for community education, capacity building and other system reform aspects of IMHA's role. Another factor is that as IMHA has increased incoming referrals, advocates have by necessity resorted to more telephone advocacy. While telephone advocacy has an important role, relying on it to compensate for an increase in demand has ramifications for the quality of service IMHA provides. Both consumers and staff identified the importance of advocates attending treating team meetings and the value of face-to-face contact for building trust and rapport. Staff identified that providing face-to-face contact was difficult in areas distant from the IMHA offices, due to travel time and other resourcing constraints.

IMHA will only be able to meet the advocacy needs of consumers if the number of advocates is increased (Recommendation 3). At a minimum, IMHA needs to be present in inpatient units on a weekly basis, which would require twice as many advocates. To ensure access requirements in the community IMHA would require at least as many advocates again. If an opt-out system was adopted, advocates could spend less time ensuring access and service promotion. An opt-out system would require a significant increase in resourcing to meet increased demand.

A small number of consumers identified the need for advocacy outside of usual business hours, particularly in the evening and on weekends. This was usually in the context of admissions to emergency departments or attendance from the crisis assessment and treatment team (CATT). A crisis advocacy hotline would be valuable in providing on-demand advocacy to address this issue.

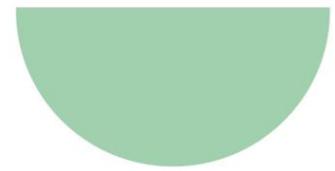
2.3.8. Other Specific Issues

Throughout the course of the evaluation numerous miscellaneous issues were raised by staff and consumers and have been fed back to IMHA management.

Consumers in focus groups indicated that they would have appreciated advocacy around basic items such as clothing and toiletries in inpatient units. This has also been raised as an issue by Community Visitors and offers an opportunity for joint advocacy, oversight and follow-up.⁴⁰

During the midterm review, the MHDL team raised a number of issues specific to their interactions with IMHA. Both MHDL lawyers and IMHA advocates noted excellent outcomes for consumers when they had worked well together. Both teams identified that these relationships were not consistently maintained across all IMHA sites, due to staffing changes and other organisational processes. VLA has implemented processes to ensure that this is addressed.

⁴⁰ OPA, above n 18.



Finally, IMHA's priority groups are too numerous and too unwieldy to provide an effective means of prioritisation and should be reviewed to ensure IMHA is focusing on consumers who are most in need of advocacy. This may require reforming priority allocation mechanisms around actual assessed need, rather than 'vulnerabilities' associated with population demographics (see Recommendation 16.2).

3. Conclusion

In conclusion, IMHA has proven very successful in an extremely challenging context. The evaluation consistently identified that mental health services are not operating in compliance with the Act, and IMHA has proven to be extremely effective at assisting them to do so. Consumers highly valued IMHA in the way it maintained their rights and also in the way advocates treated them with dignity and respect. Stakeholder bodies and mental health professionals who had worked with IMHA generally held it in high regard. For a service in existence for only three years, this is a significant achievement.

For IMHA to continue to be successful in maintaining the rights of people subject to compulsory mental health treatment it needs to be accessible to all who require it. This requires an opt-out system where every person who is eligible is offered advocacy, and an increase in funding to be able to provide services to all those who are eligible for IMHA.

This evaluation has shown that IMHA is essential to the maintenance of the rights of people who use mental health services. This is not IMHA's responsibility alone. In order to ensure that the rights of consumers are maintained, the sector must also take action. The various oversight bodies will need to coordinate and invest to ensure that services are operating in compliance with legislation that mandates recovery-oriented, least-restrictive treatment and care where people are supported to make their own decisions. The evaluation identified an enormous amount of goodwill in this regard, but little in terms of tangible outcomes or an improved experience for consumers beyond those directly supported by IMHA. IMHA is demonstrably working towards this goal but is hindered by inaction in some parts of the sector.



4. Recommendations

These recommendations have been developed in ongoing dialogue with IMHA. They represent the professional opinions of the evaluation team, based on rigorous analysis of evaluation data against the key evaluation questions and program logic model. IMHA is already making progress towards a number of these recommendations following the midterm evaluation report.

Each recommendation is referenced in the text of the report.

Recommendations for the 2019 Review of the Act

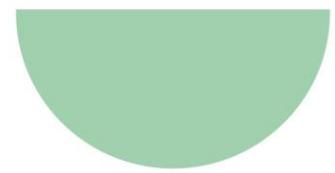
1. The role of IMHA should be legislated, including
 - 1.1. Responsibility for IMHA to contact every person on a Treatment Order (opt-out system)
 - 1.2. Responsibility for mental health services to provide details of every person on a Treatment Order to IMHA (opt-out system)
 - 1.3. Right for IMHA to access individuals
 - 1.4. Right for IMHA to access inpatient units
 - 1.5. Consequences for obstruction of IMHA advocates
 - 1.6. IMHA should have a statutory function for systemic advocacy including a responsibility to table an annual report in Parliament
2. Decision makers under the Act and all designated mental health services staff should be required to undertake regular training to ensure they understand the principles of the Act and their obligations to comply with them, particularly in regard to least-restrictive practice, supported decision-making and supporting recovery.

Recommendations for DHHS

3. Increase IMHA funding to increase the number of advocates to ensure all people who are eligible are able to access IMHA
4. Resource IMHA to provide supported decision-making training to mental health services
5. DHHS to form a formal collaborative network of oversight bodies, led by DHHS and including VLA, OPA, SPOS, MHCC, MHLC, VMIAC, Tandem, OCP and the Tribunal
6. Designated mental health services should be required to report on progress towards a recovery-oriented model of service using a definition of recovery consistent with DHHS policy and the Act
7. Designated mental health services should be required to include reporting of the number of people being compulsorily treated by setting and service including demographic data
8. Designated mental health services should be required to work with IMHA to identify opportunities for cultural change to improve an understanding of the value of representational advocacy
9. The *Your Experience of Service* (YES) Survey should include a question about consumer access to advocacy

Partnership Recommendations

10. Partner organisations and professionals who are not currently regularly referring to IMHA should be encouraged to do so
11. Review the process of IMHA feeding back directly to ward management at the service level
12. Mental health services and other stakeholder bodies should increase efforts to promote IMHA



Recommendations for IMHA policy and practice

Opportunities to increase effectiveness

13. Increase focus on leveraging supported decision-making elements of the Act
 - 13.1. Enhance self-advocacy training for consumers using the advocacy toolkit*
 - 13.2. Continue to explore opportunities to support family and carers to advocate using supported decision-making*
 - 13.3. Directly support consumers to create advance statements
14. Improve internal data collection
 - 14.1. IMHA's data collection categories should mirror those published by DHHS
 - 14.2. Ensure data collected by IMHA is consistent, reliable and complete*
 - 14.3. Collect data on where word of mouth referrals are originating from*
15. Target identified training areas
 - 15.1. Self-advocacy capacity building training for IMHA advocates*
 - 15.2. Training in linking systemic change to individual advocacy*
 - 15.3. Staff to undertake shadow shifts with other staff across regions

Strengthening a new service

16. Review reporting and performance frameworks
 - 16.1. Review number and appropriateness of Key Performance Indicators
 - 16.2. Review number and appropriateness of priority groups
 - 16.3. Develop an ongoing, long-term Program Logic Model and Hierarchy of Objectives
17. Review IMHA's scope and resourcing regarding
 - 17.1. Consistency across sites for advocacy for non-mental health issues
 - 17.2. Non-legal representation before the Mental Health Tribunal
 - 17.3. Demand for an out of hours crisis hotline
18. Increase consumer awareness of IMHA
 - 18.1. Develop strategies for increasing consumer engagement in the community*
 - 18.2. Continue to develop explanatory videos detailing IMHA's services*
 - 18.3. Work with services to provide inpatient access to IMHA videos*
19. Increase mental health professionals' understanding and awareness of IMHA
 - 19.1. Work with mental health services to educate staff on the value of representational advocacy*
 - 19.2. Continue to target and increase focus on mental health service staff who have high contact with consumers, including peer workers, nurses and ward clerks*

*In progress

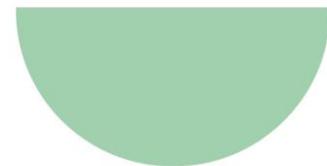
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<<http://www.mht.vic.gov.au/wp-content/uploads/2016/04/Performance-against-KPIs-January-to-March-2016.pdf>>

Annexure 2



CARE NOT CUSTODY

A new approach to keep kids in residential care out of the criminal justice system

 Victoria Legal Aid

#CareNotCustody
www.legalaid.vic.gov.au/carenotcustody

Victoria Legal Aid

Access to justice for all Victorians

VLA is the biggest legal service in Victoria, providing legal information, education and advice for all Victorians.

We fund legal representation for people who meet eligibility criteria based on their financial situation, the nature and seriousness of their problem and their individual circumstances. We provide lawyers on duty in most courts and tribunals in Victoria.

Our clients are often people who are socially and economically isolated from society; people with a disability or mental illness, children, the elderly, people from culturally and linguistically diverse backgrounds and those who live in remote areas.

VLA helps people with legal problems about criminal matters, family breakdown, child protection, family violence, child support, immigration, social security, mental health, discrimination, guardianship and administration, tenancy and debt.

We provide:

- free legal information through our website, our Legal Help line, community legal education, publications and other resources
- legal advice through our Legal Help line and free clinics on specific issues
- minor assistance to help clients negotiate, write letters, draft documents or prepare to represent yourself in court
- grants of legal aid to pay for legal representation by a lawyer in private practice or VLA staff lawyer
- a family dispute resolution service for disadvantaged separated families.

In addition to helping individuals resolve their legal problems, VLA works to address the barriers that prevent people from accessing the justice system by participating in law reform, influencing the efficient running of the justice system and ensuring the actions of government agencies are held to account. We take on important cases and campaigns that aim to improve the law and make it fairer for all Victorians.

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Executive summary

Children living in out-of-home care are some of the most vulnerable and disadvantaged in our community. Many have been exposed to multiple traumas from a young age resulting from family violence, substance abuse, neglect or abandonment and/or sexual or physical abuse.

Unfortunately, as numerous studies have demonstrated, too many of these children are still ending up involved from a young age – often unnecessarily – in our criminal justice system.

The over-representation of children from out-of-home care in our criminal justice system is a matter of long-standing concern to Victoria Legal Aid. A recent review of our child protection client data found that:

- **Almost one in three young people we assist with child protection matters who are placed in out-of-home care later returns to us for assistance with criminal charges;**
- **Young people we assist placed in out-of-home care are almost twice as likely to face criminal charges as those who remain with their families;**
- **Young people we assist placed in out-of-home care are more likely than other children to be charged with criminal damage for property-related offending;**

Our practice experience suggests that this problem is particularly acute with respect to children placed in residential care. This is due at least in part to the continued practice in many residential facilities of relying on police to manage incidents of challenging behaviour by young people.

While serious offending by young people may warrant a police response, we also see cases where police have been called to a residential facility to deal with behaviour by a young person that would be unlikely to come to police attention had it occurred in a family home. We have represented children from residential care who have received criminal charges for smashing a cup, throwing a sink plug or spreading food around a unit's kitchen. As the case studies in this report demonstrate, frequently children who may never have had a criminal charge prior to entering care, quickly accrue a lengthy criminal history due to a cycle of "acting out" followed by police responses which develops in a residential unit.

"We have represented children from residential care who have received criminal charges for smashing a cup, throwing a sink plug or spreading food around a unit's kitchen."

The broader reforms to the residential care system being introduced by the Victorian Government provide an important opportunity to address this criminalisation of vulnerable young people. Plans already underway to significantly reduce the number of children placed in long-term residential care and introduce mandatory qualification and training requirements for staff represent big steps forward, but do not do enough to address this specific problem. The present expectation that care providers develop their own guidelines about responding to challenging behaviour and when police should be called leads inevitably to variable and inconsistent responses in the way children are treated.

Further guidance, support and training for care providers are clearly needed about more therapeutic ways to manage challenging behaviour so as to minimise the need for police involvement in cases where there is no immediate danger to staff or other young people.

In New South Wales and parts of the UK, this has been done through the adoption of protocols that apply across all residential care facilities and explicitly aim to reduce young peoples' contact with the criminal justice system. Such protocols, which have been developed in partnership with care providers and police, provide a clear and consistent structure for decision-making in residential units when a child exhibits challenging behaviour. Together with appropriate training for staff, they have been highly effective in reducing the numbers of offences recorded against children in residential care – in one UK county by as much as 66%.

The adoption of a similar Protocol in Victoria would have clear benefits for both staff and young people living in residential care.

It would provide staff with a structured process for responding to incidents which distinguishes between behaviour which is merely disruptive or confrontational versus situations that are dangerous for staff and other young people.

It would ensure a consistent process across the 240 residential care units in Victoria so that all young people, regardless of geography, are treated equally.

Finally, it would provide children and young people with a response that is therapeutic and based on principles of care, rather than one which entrenches them in a cycle of involvement with the criminal justice system.

Recommendation

As part of its reforms to the residential care system, the Victorian Government work with relevant stakeholders to develop and implement an inter-agency Protocol to reduce the contact of young people in residential care with police and the criminal justice system, akin to that recently implemented in New South Wales (see Appendix).

Introduction

The past five years have seen unprecedented scrutiny of the problems with Victoria's out of home care system. The 2012 *Protecting Victoria's Vulnerable Children Inquiry*,¹ the 2014 Auditor-General's *Report on Residential Care Services for Children*² and the 2015 Commissioner for Children and Young People's Report "...As a good parent would..."³ all identified serious systemic failures in the out-of-home care system that have contributed to widespread problems of sexual exploitation and violence, poor health and educational outcomes, disconnection from family and culture and disproportionate rates of trauma among children in state care.

The Victorian Government's Roadmap for Reform,⁴ announced in April 2016, lays out ambitious plans for addressing many of these problems, with initiatives to improve monitoring and oversight frameworks, strengthen home-based care options and introduce minimum qualifications and additional training for staff working with children in care.

Many of these initiatives are already underway, with announcements in June 2016 of the move of 140 young people out of residential care into kinship placements⁵ and in August of a \$5.44 million funding package to assist Aboriginal⁶ young people in out-of-home care to remain connected to their culture and heritage.⁷

One critical issue not currently addressed by the Roadmap, however, is the disproportionate number of children and young people in care who end up in our criminal justice system.

Every year, Victoria Legal Aid assists thousands of the state's most vulnerable children and young people with child protection matters, many of who end up in state care. Unfortunately, too frequently we see these same children return to us, many within months of their placement, facing criminal charges for minor offending which would be unlikely to come to the attention of police had it occurred in a traditional family home.

This is particularly true of young people placed in residential care. Our client data and practice experience suggests that the current practice in many residential care facilities of relying on police to manage disputes over behavioural incidents is leading to an excessive criminalisation of children in residential care - propelling them into the very criminal justice system they should be protected from.

"The current practice in many residential care facilities of relying on police to manage challenging behaviour... is propelling children into the very criminal justice system they should be protected from."

¹ Victorian State Government (2012) Report of the Protecting Victoria's Vulnerable Children Inquiry, Victorian State Government, Melbourne. Accessed 4 November 2016 at <<http://www.childprotectioninquiry.vic.gov.au/>>

² Victorian Auditor-General (2014) Residential Care Services for Children, Victorian Auditor-General's Office, Melbourne. Accessed 4 November 2016 at <http://www.audit.vic.gov.au/reports_and_publications/latest_reports/2013-14/20140326-residential-care.aspx>

³ Commission for Children and Young People (2015), "...as a good parent would..."", Commission for Children and Young People, Melbourne. Accessed 4 November 2016 at <<http://ccyp.vic.gov.au/downloads/inquiry/final-report-as-a-good-parent-would.pdf>>

⁴ Department of Health and Human Services (2016) Roadmap for Reform: strong families, safe children - the first steps. Department of Health and Human Services, Melbourne. Accessed 4 November 2016 at <http://www.dhs.vic.gov.au/__data/assets/pdf_file/0006/964455/Roadmap-for-Reform--strong-families,-safe-children-3.pdf>

⁵ Minister for Families and Children (2016) Auditor General Praises Residential Care Reforms [Press Release]. Accessed 4 October 2016 at <<http://www.premier.vic.gov.au/auditor-general-praises-residential-care-reform/>>

⁶ Throughout this report, the term Aboriginal is used to refer to young people of Aboriginal or Torres Strait Islander background.

⁷ Minister for Families and Children (2016) Keeping Aboriginal Children Connected with their Culture [Press Release]. Accessed 4 October 2016 at <<http://www.jennymikakos.com.au/media-releases/keeping-aboriginal-children-connected-with-their-culture/>>

This report aims to draw attention to this problem and highlight the need for urgent policy responses to address it.

Part one of the report gives a brief overview of the residential care system in Victoria and the backgrounds of the children placed in residential care.

Part two discusses the results of recent academic studies on the links between out-of-home care and criminal justice outcomes and the reasons why children in care more frequently end up in our juvenile detention systems.

Part three examines the experiences of VLA's clients placed in residential care and the reasons why their interactions with the criminal justice system tend to escalate upon entry into care.

Finally, part four discusses possible policy responses, including approaches currently being trialed in NSW and the UK, where inter-agency protocols and restorative justice processes have been developed to try to protect young people in residential care from needless involvement in the criminal justice system.

Children in out-of-home care in Victoria

The numbers of children in out of home care in Victoria have grown substantially over the past decade.⁸ Currently, over 8,000 children in Victoria live in out of home care.⁹ This includes children living in foster care, those placed with relatives or kin other than their parents, and those who live in residential care.

Residential care is out-of-home care provided by paid staff, usually in a “group home” unit accommodating up to six children. As at January 2016, there were 240 such facilities operating in Victoria, accommodating 442 children and young people.¹⁰ The Department of Health and Human Services (DHHS) funds a variety of community service organisations (CSOs) to run these facilities on its behalf.

Aboriginal children are heavily over-represented both in residential care and out-of-home care more generally. As at April 2015, 1,400 children in out-of-home care in Victoria were Aboriginal – a ratio of one-in-12.¹¹ Likewise 90 of the children then in residential care – nearly one in five – were Aboriginal.¹²

Across Australia in recent years there has been a policy emphasis on keeping children with their families wherever possible. Out-of-home care is generally considered to be the placement of “last resort”, and is only used where the Children’s Court deems that children are at significant risk of harm, abuse or neglect from their own families and cannot remain in the home.

Children in out-of-home care are thus some of the most vulnerable in the State. This is particularly true of children in residential care, many of who have complex needs that mean that they have been unable to be placed within a kinship or foster-care option, or such options have broken down. The 2014 Victorian Auditor-General’s report observed that:

“Children in residential care have generally been exposed to multiple traumas in the form of family violence, alcohol and drug abuse, or sexual, physical and emotional abuse since they were very young. They may have a parent who is in prison or a struggle single parent with mental health issues. Some have been born to mothers who were very young, often with a violent partner. They usually have other siblings in care, and one of their parents may also have been in care as a child. They are usually known to child protection at an early age. They come to residential care typically as a young adolescent, having experienced a number of placements in home-based care that have since broken down or were only available for short periods of time....”¹³

These comments echo the results of studies on children in out-of-home care across Australia. A 2006 Australia-wide survey of children with high support needs in out-of-home care found that of such children, almost 75% came from households with a history of domestic violence or physical abuse; 66% had parents with substance abuse problems; and 58% had suffered neglect. Half the sample had parents with mental health problems, significant financial problems, homelessness or who had themselves been victims of sexual abuse.¹⁴

⁸ Over the 10 years to June 2011, the number of children living in out-of-home care placements increased from 3,882 to 5,678 – a growth of 46 percent. Victorian State Government (2012) Report of the Protecting Victoria’s Vulnerable Children Inquiry, p. 233. Accessed 4 November 2016 at <<http://www.childprotectioninquiry.vic.gov.au>>

⁹ DHHS, Roadmap for Reform, above n 4, p. 7.

¹⁰ Victorian Auditor General (2016) Follow Up of Residential Care Services for Children, Victorian Auditor-General’s Office, Melbourne, pp. 1 & 15. Accessed 4 November 2016 at <<http://www.audit.vic.gov.au/publications/20160608-Resi-Care/20160608-Resi-Care.pdf>>

¹¹ DHHS, Roadmap for Reform, above n 5, p. 7.

¹² CCYP, “...as a good parent would...”, above n 3, p. 27.

¹³ Victorian Auditor General, Residential Care Services for Children, above n 2, p. ix.

¹⁴ Osborn, A. & Delfabbro, P.(2006) National Comparative Study of Children and Young People with High Support Needs in Australian Out of Home Care, University of Adelaide, Adelaide, p. 40.

The links between out-of-home care and the criminal justice system

Studies on children in out-of-home care in Victoria and elsewhere have also consistently highlighted their significant over-representation in the juvenile justice system.

A 2005 survey of care leavers in Victoria found that nearly half those interviewed had had some type of involvement with the police or justice system and 12% had spent time in detention in the year after leaving care.¹⁵ Another 2007 study found that 21% of 11-17 year olds living in out-of-home care in Victoria had been cautioned or charged by police in the previous six months.¹⁶ National surveys of care-leavers undertaken by the CREATE Foundation in 2008 and 2009 also found that disproportionate numbers of care leavers become involved in the youth justice system.¹⁷ This was particularly true of young Aboriginal people leaving care.¹⁸

“You think about your own family – if my child smashed a window or nicked something from me, I wouldn’t call the police...we go to that criminal response a lot more quickly for young people in care.”

- Former CP worker

Studies of youth justice populations have shown similar results. A 2010 review of the NSW justice system estimated that 28% of male and 39% of female youth detainees had a history of out-of-home care.¹⁹ Another recent report by the Australian Institute of Health and Welfare noted that in 2014-15, young people who were the subject of a care and protection order were 20 times as likely to be under youth justice supervision in the same year as the general population.²⁰ Studies on young people in custody in the UK and US have shown similar results.²¹

Statistics kept by the Victorian Youth Parole and Youth Residential Boards do not specifically monitor out-of-home care status, but do indicate that almost half of young people currently in custody in Victoria have had previous child protection involvement.²²

Research that has sought to explain the links between out-of-home-care and criminal justice outcomes has traditionally focused on the backgrounds of the children in out-of-home care and the greater exposure of this group to various factors that increase the risk of offending behavior, such as exposure to domestic violence or abuse, parental abandonment, substance abuse and traumatic experiences such as the death of family members.

¹⁵ Raman, S., Inder, B. & Forbes, C. (2005) Investing for Success: the economics of supporting young people leaving care' Centre for Excellence in Child and Family Welfare, Melbourne.

¹⁶ Wise, S. & Egger, S. (2007) The Looking After Children Outcomes Data Project: Final Report, Australian Institute of Family Studies, p. 15.

¹⁷ McDowall, J. (2008) Report Card: Transitioning from Care, CREATE Foundation, Sydney.

¹⁸ McDowall, J. (2009) Report Card: Transitioning from Care: Tracking Progress, CREATE Foundation, Sydney.

¹⁹ Murphy, P., McGinness, A., Balmaks, A., McDermott, T. & Corriea, M. (2010) A Strategic Review of the New South Wales Juvenile Justice System, Noetic Solutions Pty. Ltd., Canberra.

²⁰ Australian Institute of Health and Welfare (2016) Young People in Child Protection and Under Youth Justice Supervision 2014-15, Data linkage series no. 22. Cat. No. CSI 24, Canberra, p. 10.

²¹ A 2011 survey of over 1,000 young people in custody in the UK found that over a quarter of young men and half young women in custody had previously spent time in out-of-home care. Summerfield, A. (2011) Children and Young People in Custody 2010-11: An analysis of the experiences of 15-18 year olds in prison, HM Inspectorate of Prisons & the Youth Justice Board, London. See also Cusick, G., Coutney, M., Havelicek, J., & Hess, N. (2010) Crime during transition to adulthood: How youth fare as they leave out-of-home care, National Institute of Justice, Washington D.C.

²² The 2015 Annual Report of the Youth Parole Board, for example, showed 43% of young people in youth justice centres had previous child protection involvement. Youth Parole Board (Vic) (2015) Annual Report 2014-15, Victorian Government Printer, Melbourne, p. 26.

It is by now well-established, for instance, that young people with a history of severe maltreatment are more likely to engage in offending behaviours,²³ particularly where the maltreatment has occurred or extended into adolescence.²⁴ In the case of Aboriginal children in care, there are also other complex contributing factors arising from the legacy of racist policies of past forcible removal, intergenerational trauma and disconnection from culture.²⁵

More recently, however, there has also been growing awareness of the role that aspects of the child protection system itself can play in exacerbating the risk factors that precipitate children's entry into the criminal justice system.

A recent 3-year study conducted by researchers at Monash University, which interviewed over 70 former care workers and young people with experiences of out-of-home care in Victoria, found that in addition to traumatic childhood experiences, out-of-home care placement type and stability and the levels of support available to young people during and in transition from state care were important factors contributing to the risk of offending. Specific features of the out-of-home care system that were noted to contribute to the risk of offending included:

- Placement breakdowns, preventing the formation of relationships necessary to address trauma and other risks;
- Difficulty accessing specialist support services in care to address trauma, mental health issues or learning difficulties;
- Further traumatic exposure in care, whether due to adverse exposure during reunification attempts, abuse and neglect by caregivers, or abuse by other young people in care or from people outside the system;
- Co-location of "high risk" young people in congregate accommodation, raising exposure to behaviour and attitudes which increase the likelihood of offending behavior;
- The legislated age of leaving care (currently 18) and limited support structures for young people post-care, which make it difficult for many young people to cope on their own after leaving state care.²⁶

In relation to children placed in *residential* care units, the study found that the practice of adopting formal legal responses to behavioural issues was also a contributor to children's over-exposure to the criminal justice system.

"Some interviewees viewed the adoption of a legal response to behavioural issues, such as property destruction, theft and assaults (specifically in residential care) as criminalizing. As a former CP worker pointed out "...you think about your own family – if my child smashed a window or nicked something from me, I wouldn't call the police...we go to that criminal response a lot more quickly for young people in care." Participants also stated that there were circumstances where system responses, even when engaged for the protection of young people, exposed them to an excessive level of involvement with statutory bodies, authorities and the justice system: "If a young person...is taken into care, or put on a court order, often police are involved to investigate a crime that's been committed against a young person. Young people need to go to court, they need to have lawyers. If they run away, warrants can be issued and executed, often by plain clothes policemen".²⁷

Other studies on the links between residential care facilities and children's offending have reached similar conclusions. A 2010 UK study by Carol Hayden of 10 children's homes across the UK found that the high levels of offending behaviour in residential care facilities can be explained by two main factors: first, the "last resort" status of residential care facilities, which concentrates risk by caring for the children who are hard to place elsewhere; and second, the way the residential care system operates and is utilised. In particular,

²³ Stewart, A., Dennison, S., & Waterson, E. (2002) "Pathways from child maltreatment to juvenile offending" Trends and Issues in Crime and Criminal Justice 241; Ryan, J.P, Williams, A.B. & Courtney, M.E. (2013) "Adolescent neglect, juvenile delinquency, and the risk of recidivism", Journal of Youth and Adolescence 42, pp. 454-465.

²⁴ Smith, C.A., Ireland, T.O. & Thornbury, T.P. (2005) "Adolescent maltreatment and its impact on young adult antisocial behaviour", Child Abuse and Neglect, 29(10), pp. 1099-1119.

²⁵ Mendes, P., Saunders, B. and Baidawi, S. (2016) Indigenous Care Leavers in Victoria: Final Report, Monash University, Melbourne.

²⁶ Mendes, P., Snow, P & Baidawi, S (2014) Good Practice in Reducing the Over-Representation of Care Leavers in the Youth Justice System, Monash University, pp. 24-5.

²⁷ Mendes, P., Snow, P. & Baidawi, S (2012) Young People Transitioning from Out-of-Home Care in Victoria: Strengthening support services for dual clients of Child Protection and Youth Justice, Monash University, Melbourne, pp. 22-23.

Hayden noted that how staff manage children and young people's behaviour is central to how, and whether, a situation turns into a major conflict that could involve the police and (potentially) a criminal record.²⁸

“Over-reliance on police may indicate that some staff are not adequately equipped or supported to respond to trauma-related behaviours of vulnerable children”.

- Commission for Children and Young People

Another 2010 study by Kath McFarlane of criminal files in the New South Wales Children's Court of children in out-of-home care identified that half of those charged were before the Court for property-related offences, usually relating to damage to the group home or other 'specialist' facility in which they lived. She concluded that the practice by care home staff of relying on the police and justice system to manage and control children's behaviour in situations of conflict remains prevalent, despite the fact that many homes are engaged by the state to provide professionalist behavioural techniques to mitigate children's behaviour.²⁹

The over-use of police to manage children's behaviour in residential care facilities is also a theme also picked up on by the Commission for Children and Young People (CCYP) in its recent Report “...as a *good parent would...*”. The CCYP observed that:

“in some situations, there is an over-reliance on police being called to attend residential care units to respond to children's behavior that is not of a criminal nature. Such reliance on police may indicate that some staff are not adequately equipped or supported to respond to trauma-related behaviours of vulnerable children”.³⁰

The CCYP attributed this problem largely to a lack of qualifications, support and adequate supervision of staff within many CSOs and the highly casualised nature of the workforce (currently 55% of staff at CSOs are casual).³¹ It recommended the minimization of the use of labour-hire staff, improved training and the introduction of a minimum Diploma-level qualification in Child, Youth and Family Intervention for all direct-care staff, as well as funding and accreditation of CSOs that are linked to demonstrated outcomes for children, including a demonstrated reduction in police attendance to residential care units for behavior management issues that are not criminal.

²⁸ Hayden, C, (2010) “Offending behaviour in care: is children's residential care a 'criminogenic' environment?” Child & Family Social Work 15(4), pp. 461-472.

²⁹ McFarlane, K (2010) “From Care to Custody: Young Women in Out-of-Home Care in the Criminal Justice System”, 22(2), Current Issues in Criminal Justice, pp 345-353.

³⁰ CCYP “...as a good parent would...”, above n 3, p. 14.

³¹ Victorian Auditor-General, Follow Up of Residential Care Services for Children, above n 10, p. 9.

The experience of VLA's clients

The criminalisation of children and young people in residential care facilities described in the studies above is also a pattern that has been noted with concern by VLA's lawyers working in the crime and child protection jurisdictions.

VLA is in many ways uniquely positioned to observe this trend because we are the only legal organisation in Victoria with specialised child protection and youth crime units that operate across the state. Every year, VLA lawyers and private practitioners on grants of legal aid assistance assist over 1,800 children who are the subject of child protection proceedings. We also assist over 3,000 young people each year with criminal matters, including providing legal advice and representation in court.

Despite the fact that only around a third of children we represent in child protection proceedings are placed in out-of-home care, a disproportionate number of these young people return to us for assistance with subsequent youth crime matters.

In 2014, we conducted a longitudinal review of high-contact users of legal aid services over a 10-year period. This research found that people who became high-contact users were three times more likely than standard users to have been involved in a child protection or family violence matter while they were still children.³²

We recently undertook a further review of our internal data to assess the extent of "cross-over" between our child protection and youth crime clients and whether this cross-over was greater for children placed in out-of-home care.

We analysed the data of all children aged 11-17 seen for a child protection matter over the past five years that resulted in their placement in out-of-home care (1,318 children in total) and looked at how many reverted for assistance with a criminal charge. We then compared this with our data for clients in the same age range who had child protection matters which did not result in their placement in out-of-home care (3,845 clients in total).

The results of this review highlighted the stark contrast in the levels of contact with the criminal justice system by our clients who are placed in out-of-home care.

As set out in Figure 1 below, 30% of children we assisted who were placed in out-of-home care later went on to seek our assistance for a criminal matter, compared with 18% of those who were not placed in care. In other words, children placed in out-of-home care were almost twice as likely as those not placed in care to become involved with the criminal justice system.



Figure 1: Child protection clients aged 11-17 who go on to seek our assistance for criminal charges

³² Jolic, R. (2014) Victoria Legal Aid Client Profiles: high contact users of legal aid services, Victoria Legal Aid <http://www.legalaid.vic.gov.au/about-us/what-we-do/research-and-analysis/client-profiles>.

For the vast majority of those who were charged (83%), the first charge occurred within 12 months of their placement, suggesting most children are charged while still in care.

This pattern was fairly uniform across the state. Boys placed in out-of-home care were significantly more likely to revert to us with criminal charges than girls (38% vs 22%), particularly those in the 13-14 year- old age bracket. Sixty-nine percent of the “cross-over” children were aged 14 or under.

Consistent with their over-representation in the out-of-home care system more generally, indigenous children were also over-represented among those from this group who went on to have a criminal matter – 9% of the “cross-over” children identified as Aboriginal or Torres Strait Islander.

When we looked at the type of criminal charges laid, there were also some clear differences in the patterns of charging against children placed in care.

For those not placed in out-of-home care, the most common criminal charge was theft, consistent with youth crime statistics statewide.³³

Those in care, by contrast, were most frequently charged with criminal damage – 30% sought our assistance for a charge of criminal damage compared with 21% of those who were not placed in care. Overall, 77% of children who sought our assistance for criminal charges did so for property offences.³⁴

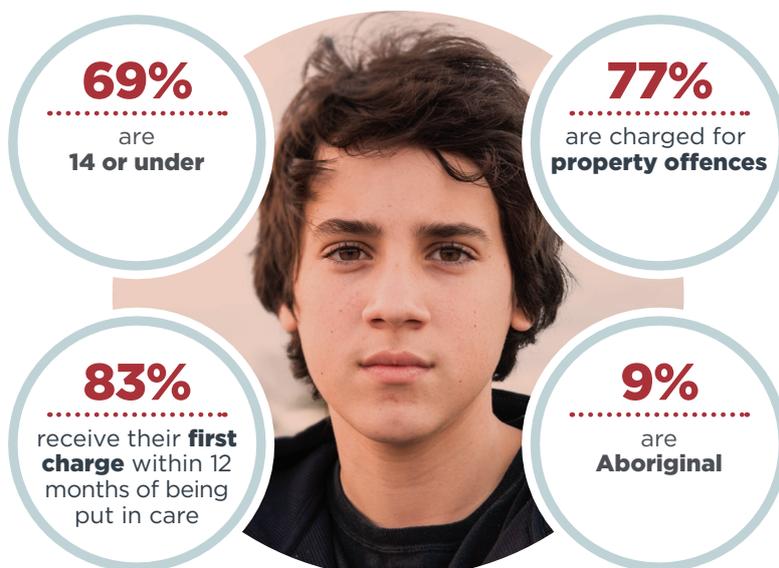


Figure 2: From care to custody: children in out of home care who go on to seek our assistance for criminal charges

The child protection data kept by VLA did not until very recently indicate the *type* of out-of-home care placement given to children we assist. It was therefore not possible to confirm from the review of this data whether children we see who are placed in residential care units are charged more often, or for different types of matters, than children placed in foster homes or with kin.

The anecdotal experience of our child protection and youth crime lawyers, however, suggests that children placed in residential care are charged more frequently than children in other types of out-of-home care – particularly with respect to behaviour that occurs within the units themselves.

³³ The most recent report by the Sentencing Advisory Council of Victoria shows that of the 20 most frequently sentenced offences in the Children’s Court for 2015, theft was the most common offence sentenced, accounting for 10% of all sentenced offences, followed by criminal damage which accounted for 7.5% of sentenced offences. Sentencing Advisory Council of Victoria (2016) Sentencing Children in Victoria: Data Update Report, Sentencing Advisory Council of Victoria, Melbourne, p. 21. Accessed 4 November 2016 at < <https://www.sentencingcouncil.vic.gov.au/sites/default/files/publication-documents/Sentencing%20Children%20in%20Victoria%20Data%20Update%20Report.pdf> >

³⁴ Within this 77%, some children sought our assistance for several offences involving both property and non-property related offences. Overall, 58% of the total criminal charges related to property offences.

Most commonly, we see children from residential units who have been reported to police by staff in the units for property damage or assaults associated with altercations with staff over “boundary setting”. The stories of “Jess” and “Luke” highlighted below are typical of the experience of many of our clients placed in residential care.³⁵

Jess' Story

Jess grew up exposed to domestic violence. Notifications to DHHS were made from when Jess was a few months old, and DHHS was involved at various stages through her childhood. When Jess was 10, her stepfather started to abuse her, physically and mentally. “He used to smash things over my head [...] He also used to take everything out of my room that could entertain me. I was just told to sit there. I was only allowed out for dinner. I was then told to go to bed. This happened for about a year”.

Jess was eventually placed in out-of-home care aged 13 when her school found out what was happening to her. After being moved through multiple foster homes, she was placed in residential care. She describes being in residential care as initially feeling like she was in jail. She was a “scared little kid” and “didn’t talk to anyone”. She was surprised to find cupboards were locked and she wasn’t allowed to use the phone.

In the next unit she was moved to, Jess had her first contact with drugs and was assaulted by another resident. Feeling no-one cared about her, she went into a downward spiral. She began smoking a lot of marijuana and skipping school. “I went really out of control at that unit...Life was nothing. Workers in that unit didn’t care about the kids taking drugs. They would just sit in their office”. At the next unit she was moved to, she had a scuffle with a worker and got her first criminal charge. This charge was subsequently withdrawn.

Jess moved unit again, and this time it was a positive change. Staff turnover was lower, and workers at the residence would drive her to visits with her mother. One night, however, she came home late and was grounded for a month. This meant the workers would no longer drive her to see her mother (despite contact being court-ordered), and it was too far for Jess to go on public transport. Jess was trying to improve her relationship with her mother and this upset her considerably.

During that month, Jess got into a dispute with a worker in the unit about using the phone to call her mother. The unit had a policy limiting phone calls to 10 minutes in length. At the end of the 10 minutes, Jess walked off with the cordless phone, and the worker disconnected it. Angry that she couldn’t get to see her mother or even talk with her on the phone, Jess threw the phone at the wall. The phone broke, the workers called police, and Jess was charged with criminal damage and discharging a missile. Despite offering to pay for the cost of replacing the phone, Jess now has a criminal record relating to this incident.

Often, as in the case of Jess, our clients have had no history of involvement with the criminal justice system prior to their placement in residential care. They do often have a significant history of behavioural problems that pre-date and are in many cases the reason for their placement in care. These are usually closely linked to previous trauma and/or other protective issues such as mental health problems, intellectual disability, autism-spectrum disorders or substance abuse problems. Predictably, these behavioural issues continue when they are placed in care – with the important difference that they begin to attract criminal sanctions.

Typically, a minor confrontation over, for example, a failure to obey an instruction by a staff member triggers an outburst by the young person and a display of challenging behavior. Unit staff call police and the young person is charged with assault, criminal damage or other related offences. In many instances, the attendance of the police further escalates the situation, with the young person then sometimes accruing additional charges for resisting arrest or assaulting police.

³⁵ All client names in this report have been changed and some details of cases changed to ensure de-identification.



Luke's Story

Luke is one of several siblings. He loves music and drama. His father is not involved in his life. When his mother's health deteriorated, her children were put into care. When she died shortly afterwards, Luke, aged 12, was devastated and began using alcohol and cannabis to help him cope.

Luke had received cautions and a couple of criminal charges prior to entering care, but once in residential care, the number of charges he received escalated substantially.

One charge arose when Luke was told he couldn't use the internet because of the offensive language he had used when asking to do so. Luke, then 14, was angry. He threw a cup at the wall and yelled at and threatened the care worker.

About six months later, aged 15, Luke was again charged in relation to his behaviour at the residential unit. He returned to the unit drunk and staff told him he was grounded. Luke was frustrated and threw a plate across the room and overturned a coffee table and stomped on it. Police were called and Luke was again charged with criminal damage.

When this pattern repeats itself, it quickly leads to the young person accumulating a lengthy criminal history. Even where these charges do not ultimately result in the imposition of a custodial sentence (whether because the court finds the child lacks capacity, the charges are withdrawn by the prosecutor once we put the child's history before the court or because the court finds the behaviour simply does not warrant a custodial sentence), they often result in children from residential care spending significant periods in custody on remand.

They also increase the likelihood of the child's future re-arrest and establish a precedent of interaction with the criminal justice system. "Bella's" story below is a good example of a case where an entrenched pattern of confrontations with carers, resulting in criminal charges, has developed.



Bella's Story

Bella's father is not involved in her life and her mother has serious mental health problems. She was placed in residential care aged 12 when her mother's illness deteriorated. Bella has very low IQ and has been moved around multiple schools and residential units.

By the time she was 15, Bella was regularly getting into trouble with the police and courts for her behaviour in the residential unit. On one occasion, she broke into the internal office of the unit and damaged a cabinet and some papers. She was charged with aggravated burglary and criminal damage. In the car on the way home from court, she had an argument with another child and threw a pen at the car door. She was charged with criminal damage.

Another day, after some of her possessions were stolen, she got into an argument with a carer and broke a coffee mug belonging to the unit in addition to smashing some of her own possessions. She was charged with criminal damage. The charges relating to the damage to her own possessions were later withdrawn.

Clearly more serious conduct by young people such as physical assaults or other behaviour that endangers or harms carers or other residents may require a police response. However, as can be seen from the case studies, police are also often called to manage behavior which, had it occurred in a family home, might result in a young person being grounded or otherwise disciplined, but not charged and detained.

While “criminal damage” is the most common charge we see against young people in residential care, the offences which give rise to it often fall well below the threshold for behaviour that one might consider criminal. As shown in the case studies, we have had clients who have been charged with criminal damage for matters such as throwing a pen at an air conditioning unit, breaking a coffee mug, breaking their own possessions, throwing a sink plug, spreading food around the unit, stuffing pasta into the keyhole of their bedroom door to stop a staff member spying on them and even breaking into a cupboard to get food because the cupboards in the unit were kept locked and they were hungry.

It is also clear that in many instances, had a different approach been adopted to the young person’s behaviour at the outset, the matter might never have escalated to the point of requiring police involvement. “Tamara’s” story below is a good example of how choices around the management of behavior can contribute to the unnecessary criminalisation of a child in residential care. The end result in this case, an assault on a staff member, is clearly more serious than the instances of minor property damage referenced above, but it is equally clear that this is a confrontation that could have been avoided.

Tamara’s Story

Tamara’s parents separated when she was very young, following a history of family violence and substance abuse. She originally lived with her mother and younger sister, but was eventually removed from her mother’s care following multiple instances of neglect and verbal abuse. Her mother would often disappear for prolonged periods leaving the children to fend for themselves. Tamara would wake up to find her gone and have to skip school to look after her little sister. When her school notified DHS, she was eventually placed in residential care, aged 12.

Not long after her placement in care, Tamara was charged in relation to a scuffle with workers in the unit. She had gone to sleep in her bedroom mid-morning feeling unwell. Around 11am, one of the residential care workers came into her room and woke her up to tell her lunch would be ready soon. Tamara was upset at being woken up and swore at the worker. The worker then returned with the shift manager, who told Tamara she would have to get up for lunch. Tamara refused and swore and told them to leave her alone.

Rather than leaving Tamara in her room, the manager removed her computer from her room as punishment for swearing and she and the worker then attempted to physically pull her out of the bed. When Tamara continued to resist and swear, she was informed money would be deducted from her allowance for aggressive behaviour. At this point, Tamara hit the worker across the face and stormed out into the yard, overturning a pot-plant. Police were called and she was charged with assault on the worker.

This is not to suggest that the criminalisation of children in residential care boils down to poor decision-making by individual staff, many of who have to deal with very challenging situations on a regular basis. As highlighted by the Commission for Children and Young People, the highly casualised nature of the CSO workforce as a whole and insufficient training and support for staff in dealing with young peoples’ behaviour are clearly two important systemic factors underpinning this problem.³⁶

A lack of access to proper therapeutic and psychiatric services, particularly for children in residential care in regional areas, often compounds the problem. Jon’s story below clearly highlights the way in which, in the absence of the provision of more appropriate therapeutic interventions, staff may fall back on reliance on police to deal with behavioural issues.

³⁶ CCYP, “...as a good parent would...”, above n 3, p. 14.





Jon's Story

Jon was born with multiple difficulties, including autism, an intellectual disability and ADHD. From an early age, he displayed a range of challenging behaviours. His mother on occasion had to seek help from neighbours and local police to help calm him down, but the local community understood his problems and he had never been detained or received a criminal charge.

When Jon was 11, his mother was obliged to put him in care on a temporary basis due to doctors' concerns about his escalating behaviour. Due to his special needs, he was placed in a residential care unit over an hour's drive from where his family lived and case managed from the department's regional office over 200km away. Workers in the unit were ill-equipped to deal with his behavioural problems and constantly called police when he acted out.

In one occasion during his time in residential care, his mother was dropping him off at school after a weekend visit. When she tried to leave, Jon clung on and refused to move. Teachers tried to disengage him but were unsuccessful. Despite his mother's protests that she was happy to stay with him until he calmed down, the care worker called police to have him removed. They pulled him off his mother, kicking and screaming throughout. He was charged with assaulting police and resisting arrest.

On another occasion, Jon was playing monopoly with an 18-year old staff member from the unit. When the staff member won the game, Jon became very distressed about losing and took off one of his thongs and threw it at her, hitting her in the arm. He then followed her into the next room and picked up the nearest objects, a sink plug and a whisk and threw them at the wall. Jon then went back to his bedroom.

Police were called and Jon was charged with assault on the worker, discharging a missile and criminal damage. Police sought to remand him into custody, but the magistrate refused and decided to take a case management approach, including ordering a Children's Court Clinic assessment – in particular to have Jon's medication reviewed because a doctor had said this might be contributing to his behavioural problems. Because Jon was in a rural area, the process of arranging an assessment took months. In the meantime, the residential unit continued to report him when he misbehaved and police continued to charge him.

Jon ended up receiving twenty-five charges during the few months he was in care. He was ultimately returned to his family and has not received any charges since.

There may also be a need for further guidance at a Departmental level, however. The current DHS Program Requirements for Residential Care in Victoria require the formulation of written policies and practices that outline appropriate trauma-informed intervention and support in response to challenging behaviour (including employing therapeutic and trauma-informed responses and utilising de-escalation strategies).³⁷ However, they leave the details of the policies, and how they are implemented and enforced, to the discretion of individual CSOs.

The expectation that CSOs develop their own practice guidelines in this area leads inevitably to variable and inconsistent responses. When our lawyers have queried staff about why police were called in particular situations, they have often been told that the staff member in question was just following their agency's protocol, or that police had to be called so that an insurance claim could be made for the damaged property or for Work Cover purposes.

³⁷ Department of Health and Human Services (2016) Program Requirements for Residential Care Services in Victoria, Department of Health and Human Services, Melbourne (Requirement 2.3.3), p. 19.

Towards a new approach

The broader overhaul of the residential care system currently proposed under the government's Roadmap for Reform will undoubtedly go some way towards addressing the problems outlined above.

One of the aims of the Roadmap is to reduce reliance on residential care and to transform it from a long-term placement option into a short-term "intensive trauma-informed behaviour support service". It is unclear at this stage exactly what this new model will look like in practice, but presumably it will at least in part be based on current therapeutic models of residential care, which have been found to have better outcomes for children in terms of stability, continuity of care and support.³⁸

The Roadmap also identifies the need to improve support and training for care workers, in both the foster and residential care systems. The government has set aside \$8 million to provide mandated minimum qualification training for residential care workers and has also increased staffing levels in residential care facilities.

There is no indication at this stage, however, that the Roadmap will introduce any specific training around dealing challenging behaviour by young people, or additional policy guidance concerning when it is appropriate to call on police and the criminal justice system to manage that behaviour.

Given the clear evidence that some residential facilities, at least, are still frequently relying on police in lieu of employing de-escalation and conflict resolution procedures, additional guidance is clearly needed from the Department about more therapeutic ways to manage challenging behaviour, as well as an investment in specific training for care providers with respect to this issue.

In New South Wales, such guidance has been provided through the development of a state-wide Protocol to Reduce the Criminalisation of Young People in Residential Out of Home Care (see Appendix), implemented in August 2016.

The Protocol, developed by the NSW Ombudsman's office and endorsed by the NSW Police, Family and Community Services (FACS) and the Association of Child Welfare Agencies, is based on principles of trauma-informed care and has two key objectives. The first is to reduce the frequency of police involvement by ensuring police are called by workers only in appropriate circumstances, and not in cases of minor offending. It commits care providers to a range of measures, including:

- Developing tailored behavioural support plans where young people exhibit behaviour that exceeds what is normally expected;
- Giving consideration to how routines in the unit and environmental factors (such as sufficient privacy for young people and quiet spaces) can be improved to help prevent situations from escalating;
- Ensuring comprehensive handovers at the beginning of staff shifts;
- Applying de-escalation strategies according to the young person's behavioural support plans;
- Only calling police where there is an immediate threat or danger to staff or other residents or, if not, with the authorization of senior residential service staff.
- Appointing a senior member of staff as a police liaison officer to monitor all contact between staff in the unit and police.
- Ensuring that police, when called, are properly briefed on the young person's life circumstances so that these can be factored into any decision as to whether to pursue charges.

"The adoption of a protocol... would provide young people with a response based on principles of care, rather than one which entrenches them in a cycle of involvement with the criminal justice system."

³⁸ Stockley, C. (2013) "The Role of Out-of-Home Care in Criminal Justice Outcomes", Crime and Justice, Issue 8, Victorian Council of Social Service, Melbourne, p. 41.

The second objective of the Protocol is to promote the principle that criminal charges against a young person in residential care will not be pursued if there is an alternative and appropriate means of dealing with the matter. Under the Protocol, police are encouraged when called to respond to incidents in residential units to view arrest as a last resort, and to first consider other options such as cautions, warnings and diversion or a Youth Justice Conference – or indeed whether it is necessary to take any further formal action against the young person.

“In Leicestershire (UK), a program which aimed to encourage and enable staff to manage low level behaviour without recourse to police led to a 66% reduction in the number of offences recorded against young people.”

The development of the Protocol followed a successful pilot in Western Sydney under which Legal Aid NSW, police, Juvenile Justice, FACS and a number of CSOs worked collaboratively through case conferences and the development of a local protocol to try to minimize the need for call-outs to police for children in residential facilities in that area.

Similar protocols and restorative justice programs have also been implemented in various parts of the UK with significant rates of success.

In Leicestershire, for example, a restorative justice program run in residential children’s homes from 2007-2010 and which aimed to encourage and enable staff to manage low level behaviour without recourse to police, led to a 66% reduction in the number of offences recorded against the young people resident in the project homes over that period.³⁹

In Norfolk, the number of young people in care who became involved in the criminal justice system likewise dropped by 52% two years after the implementation of a county-wide restorative practice in children’s homes which involved inter-agency collaboration and the training of staff in restorative practice. The scheme was introduced in 2009 and involved the training of over 100 staff in children’s homes. The number of young people charged with criminal offences over the next two years fell from 7.2% in 2009 to 3.4% in 2011.⁴⁰ Comparable programs and protocols have been implemented in Leeds, Surrey, Staffordshire, Gwent, Hertfordshire and Waltham Forest, London.⁴¹

The success of these projects indicates that it is possible to reduce excessive involvement of young people in residential care in the criminal justice system while at the same time protecting the safety and welfare of staff and young people living in the facilities.

The adoption of a similar Protocol in Victoria would have clear benefits for both staff and young people living in residential care. It would provide staff with a shared understanding of how to best respond to challenging behaviour by young people and a structured process for responding which distinguishes between behaviour which is merely disruptive or confrontational versus situations that are dangerous for staff or other young people. It would ensure a consistent process across the 240 residential care units in Victoria so that all young people, regardless of geography, are treated equally. Finally, it would provide children and young people with a response that is therapeutic and based on principles of care, rather than one which entrenches them in a cycle of involvement with the criminal justice system.

³⁹ Knight, V., Hine, J., Patel, K., & Wilson, K. (2011) Evaluation of the Restorative Approaches Project in Children’s Residential Homes Across Leicestershire: Final Report 2011, De Monfort University, Leicester, p. 4.

⁴⁰ Restorative Justice Council (2015) Keeping Children in Care out of Trouble – an Independent Review, London, p. 1.

⁴¹ Lord Laming (2016) In Care, Out of Trouble, Prison Reform Trust, London, p. 28. Accessed 4 November 2016 at <http://www.prisonreformtrust.org.uk/Portals/0/Documents/In%20care%20out%20of%20trouble%20summary.pdf>

Conclusion

As the academic literature and our own case studies demonstrate, the reasons why children placed in state residential care end up over-represented in the criminal justice system are complex. One clear factor currently pushing children from care into custody, however, is an over-reliance by at least some residential care facilities on call-outs to police to manage young peoples' behaviour. Cumulatively, these practices are entrenching children, often from a very young age, in a cycle of involvement with police and the courts.

The current reform agenda for residential care provides a key opportunity for the Victorian government to come up with proactive policy responses to address this problem. Based on our significant experience assisting young people in residential care, we recommend the development of an inter-agency protocol to minimise children's contact with police and the criminal justice system, as exists in other comparable jurisdictions.

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Appendix

Joint Protocol to reduce the contact of young people in residential out-of-home care with the criminal justice system (NSW)



Joint Protocol to
reduce the contact of
young people in
residential out-of-
home-care with the
criminal justice
system

2016

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- NSW Police Force, Quakers Hill Local Area Command
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1. PURPOSE

This Protocol applies to young people under 18 years of age living in residential out-of-home care¹ (OOHC) in NSW. The implementation of this Protocol will be supported by Annexure A: Procedures for OOHC service staff and Annexure B: Policing responses to incidents in residential OOHC services.

The Protocol aims to:

- i. Reduce the frequency of police involvement in responding to behaviour by young people² living in residential services, which would be better managed solely within the service.
- ii. Promote the principle that criminal charges will not be pursued against a young person if there is an alternative and appropriate means of dealing with the matter.
- iii. Promote the safety, welfare and wellbeing of young people living in residential services, by improving relationships, communication and information sharing both at a corporate level and between local police and residential services.
- iv. Facilitate a shared commitment by police and residential services to a collaborative early intervention approach.
- v. Enhance police efforts to divert young people from the criminal justice system by improving the information residential services provide police about the circumstances of the young person to inform the exercise of their discretion.
- vi. Ensure that appropriate responses are provided to young people living in residential services who are victims.

The Protocol (and procedures) emphasise the importance of flexibility and proportionality in determining the most appropriate response to a young person's behaviour on a case by case basis. The procedures for residential staff stress that contact with police should only be made when the circumstances warrant it.

While the central purpose of the Protocol is to reduce unnecessary police contact with young people, it is equally important that residential service staff respond to the needs of any victim(s). In this regard, the Protocol also emphasises the importance of ensuring residential services promptly contact police when necessary – especially when there are immediate safety risks which require a police response. When police are called in these circumstances they will attend the service and take appropriate action to secure the safety of any alleged victim(s), the involved young person and service staff.

The Protocol makes clear that serious incidents fall outside its scope. Such incidents generally warrant a sensitive and comprehensive response from a number of agencies.

¹ OOHC is one of a range of services provided to children who are in need of care and protection. This can include a variety of care arrangements other than with their parents, such as foster care, placements with relatives or kin, and residential care.

² In this Protocol 'young person' means any person under the age of 18 who resides in a residential OOHC service. Generally children in residential services are at least 12 years of age, however younger children are sometimes also placed in residential care.

1.1. Guiding Principles

This Protocol is underpinned by the following guiding principles:

- i. Young people living in residential services have a range of complex needs arising from their traumatic backgrounds of abuse and neglect.
- ii. These young people may exhibit a wide range of behaviours associated with their experiences of trauma and neglect. These behaviours are best managed using trauma-informed approaches consistent with principles of therapeutic care.³
- iii. A multiagency commitment is necessary to divert young people in residential services from unnecessary contact with the criminal justice system.
- iv. Police should be called as a last resort in response to incidents arising from challenging behaviours by young people in residential services unless it is to prevent a significant breach of the peace.⁴
- v. Services should always call police to respond to incidents involving young people where there is a safety risk. For example, services have discretion not to call police for minor offences where no one is hurt and the victim wants no police action; or for minor breaches of house rules.
- vi. Young people living in residential services have the same rights as other young people to seek assistance from police. Residential service staff will provide appropriate support and assistance to young people who choose to report an incident to police.
- vii. The arrest and detention of a young person should only be used as a last resort.

³ The NSW Therapeutic Care Steering Committee leads a joint ACWA and FACS project to establish a common understanding of the definition of best practice in therapeutic care, with the goal of developing an accepted Framework for Therapeutic Care in NSW that will be used in planning and funding. The Steering Committee includes a range of government departments, residential care services, clinical practitioners and academic experts in therapeutic care and has agreed on the following definition of Therapeutic Care: Therapeutic care for a child or young person in statutory care is a planned, evidence-based, intensive and team approach to the complex impacts of abuse, neglect and separation from families and significant others. It seeks to provide positive, safe and healing relationships and experiences to address attachment and developmental needs.

⁴ A breach of the peace occurs when harm is done or likely to be done to a person or to property when a person is present. It includes, for example, a situation where a person is in fear of being assaulted. Police are empowered to arrest a person they reasonably believe will commit or cause a breach of the peace. There must be some level of violence, threatened or actual, in order to justify an arrest for breach of the peace. [*R v Howell* (1982) QB 416] This allows police to take action to prevent serious injury or damage to property. However, a person arrested in relation to a breach of the peace will not be charged unless they commit a statutory offence.

2. BACKGROUND

It is well established that for a variety of reasons, young people living in residential services are at increased risk of coming into contact with police and other parts of the criminal justice system.⁵

In NSW, less than 3% of young people in OOHC live in residential care – about 480 young people.⁶ However, these young people have typically experienced numerous placement breakdowns and often present with multiple, complex needs. The placement of these young people in residential care aims to provide a safe and supportive environment in which to address the combined impacts of abuse, neglect and separation from family.

In 2008, the link between OOHC and contact with the criminal justice system was highlighted by the Special Commission of Inquiry into Child Protection Services in NSW, which observed that significant proportions of juvenile detainees had a history of being placed in care.⁷ In its 2011 issues paper, *The Drift from Care to Crime*,⁸ Legal Aid NSW identified a growing trend towards the criminalisation of young people living in OOHC. According to the Children's Legal Service, a large number of their 'high service user' clients have a history of being in OOHC, with a significant proportion of these having lived in residential services.

In NSW, residential care is primarily provided by accredited non-government OOHC agencies funded by the Department of Family and Community Services (FACS). Specialist Homelessness Services (SHS) also provide care and accommodation for young people with backgrounds of trauma and/or neglect. It is anticipated that this Protocol will be extended to SHS in future.

The NSW Police Force (NSWPF) has responsibilities under the *Young Offenders Act 1997* (YOA) to divert young people from the criminal justice system. The *NSWPF Youth Strategy* also promotes the use of collaborative approaches to policing young people. The NSW Police Force *Corporate Plan 2012-2016* explicitly endorses prevention and early intervention strategies for young offenders and has set a target of diverting at least 58% of young offenders from court.

⁵ Legal Aid NSW, *The Drift from Care to Crime: A Legal Aid NSW Issues Paper*, October 2011; Katherine McFarlane, *From Care to Custody: Young Women in Out-of-Home Care in the Criminal Justice System*, Current Issues in Criminal Justice, Vol 22. No. 2, November 2010, p. 345; Special Commission of Inquiry into Child Protection Services in NSW, *Report of the Special Commission of Inquiry into Child Protection Services in NSW*, 2008.

⁶ Australian Institute of Health and Welfare, *Child Protection Australia 2012-13*, Child welfare series no. 58, 2013.

⁷ Special Commission of Inquiry into Child Protection Services in NSW, *Report of the Special Commission of Inquiry into Child Protection Services in NSW*, 2008. The Commission reported that between 2003 and 2006, 28% of male and 39% of female juvenile detainees had a history of OOHC.

⁸ Legal Aid NSW, *The Drift from Care to Crime: A Legal Aid NSW Issues Paper*, October 2011.

2.1. Trauma and challenging behaviour

Many young people in OOHC have experienced ‘complex trauma’ – exposure to multiple and ongoing interpersonal trauma such as abuse, neglect or emotional or physical deprivation.⁹ The impact of past experiences of trauma often surface for young people in a range of disruptive and difficult behaviours harmful to themselves and/or others. These behaviours are often referred to as ‘challenging behaviours’. Challenging behaviours can involve risk taking, poor impulse control, resistance to boundaries (for example being absent from care without permission) and in some situations, can escalate into violent and/or criminal behaviour.¹⁰

While some challenging behaviour exhibited by young people in residential services may meet the threshold of criminal behaviour, the same behaviour occurring in family homes would likely be managed without the involvement of police. Challenging behaviours need to be managed in the residential care environment in a way that not only supports the young person who is exhibiting the behaviours but also ensures the safety of all residents and workers. Residential services have a duty to ensure the safety of their staff and the young people in their care. Police are also responsible for taking action to ensure community and individual safety.

A ‘trauma informed’ approach recognises the presence of trauma symptoms; and acknowledges the role of trauma in patterns of behaviour and aims to support young people to manage their emotions and regulate their behaviour. A key responsibility for those involved in providing care to this group of young people is to provide planned, positive and supportive strategies to assist them to work towards more positive patterns of behaviour, and where possible, to avoid more punitive approaches. Individual Behaviour Support Plans (BSPs) can be useful in identifying strategies to assist carers and young people to manage behaviour.

A trauma informed approach also seeks to protect young residents in residential services from further trauma caused by conflict with, or victimisation from, other young people living at the service. It is important that ‘client mix’ is a key consideration in the placement of young people and that the needs and views of any victim are always taken into consideration when responding to incidents at residential service.

2.2. Interagency collaboration

Young people with complex and multiple needs are likely to require the combined support of a number of different services and agencies. The parties to this Protocol share a commitment to working collaboratively on early intervention and prevention strategies which support vulnerable young people, enhance their wellbeing and assist them to develop

⁹ Toro, Dworsky and Fowler 2007; Kezelman and Stavropoulos 2012, cited in Youth Health Resource Kit, NSW Kids and Families, 2014, p.84.

¹⁰ Other examples of challenging behaviour include stress intolerance; alcohol and other substance abuse; self-harming; behaviours; social isolation and limited capacity to form relationships with peers and/or adults; sexually inappropriate behaviour; anti-social behaviours, including aggression and or violence towards people, and in some instances, criminal behaviour. (Source: *Out-of-home Care Service Model – Residential Care*, April 2007.)

positive behaviour patterns which are less likely to bring them into contact with the criminal justice system.

It is widely acknowledged that collaborative interagency approaches which facilitate integrated responses to vulnerable young people are preferable to dealing with incidents in isolation. This kind of collaborative case management should ideally lead to improved service delivery by reducing duplication and clarifying roles and responsibilities. It can also enhance the opportunity for creative solutions.¹¹ Incidents in residential services can present opportunities for collaborative problem solving and trigger revision of current strategies and/or involvement of additional partner agencies in the support for the young person.

3. ROLES AND RESPONSIBILITIES

3.1. Joint Responsibilities

While each agency has a specific role to play in implementing the Protocol, all parties endorse the Guiding Principles (above) and agree to:

- i. Act within the spirit of the Protocol when responding to incidents involving young people living in residential services.
- ii. Implement procedures for residential services and police to ensure the safe, appropriate and proportionate response to individual incidents at residential services (i.e. consistent with Annexures A and B).
- iii. Ensure systems are in place to facilitate the implementation and evaluation of the Protocol, including appropriate record keeping.
- iv. Liaise and share information with other parties to the Protocol (and where appropriate, with other prescribed bodies such as schools, health providers and other support services).
- v. Promote the safety, welfare and wellbeing of young people in accordance with the provisions of Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998*.
- vi. Develop, implement and promote the delivery of appropriate training and guidance about the Protocol and related policies.

3.2. Family and Community Services

As the government agency with the lead role for ensuring the safety, welfare and wellbeing of children and young people in NSW, FACS has an overriding interest in the promotion of interagency practices which minimise the involvement of young people in the criminal justice system. As the funding body for OOHC, FACS is responsible for promoting good practice in providing services to vulnerable young people assisted by residential services through its ongoing management of service contracts and related performance monitoring.

FACS will promote the effective implementation of the Protocol to residential services through existing governance mechanisms such as interagency meetings within each District. FACS will develop resources and work with peak bodies to encourage local implementation

¹¹ http://www.community.nsw.gov.au/kts/guidelines/case_management/case_management.htm

of these protocols as part of their annual planning, including information sessions and practice forums to promote provider requirements. In this regard, FACS will work with peak bodies and the residential OOHC sector to identify and promote examples of best practice in relation to behaviour management in individual residences and local processes between residential services and police.¹²

The Children's Guardian is responsible for the accreditation of designated agencies in accordance with the NSW Standards for Statutory Out-of-home Care.¹³ Designated agencies are required to meet the requirements of their accreditation and funding obligations outlined in the Out-of-home Care Contracted Care Program Guidelines and the Out-of-home Care Service Model: Residential Care (the Residential Care Service Model). A key feature of the Residential Care Service Model is that residential service staff need to have an understanding that the behaviour of young people often has its basis in past traumatic experiences and that this should be taken into account when responding to the behaviour to avoid inadvertently adding further trauma. It also suggests that when responding to crisis situations, residential care agencies should have clear guidelines around the involvement of the police with an understanding that attempts should be made to minimise police involvement where possible.

To support the implementation of the Protocol, FACS will review the existing behaviour management/support policy in collaboration with NSW Health, the Office of the Children's Guardian (OCG) and non-government agencies. FACS, in partnership with ACWA, is also developing a Therapeutic OOHC Framework to support agencies to embed trauma theory, child brain development and attachment theory in service delivery, aiming to improve the wellbeing and outcomes for young people in OOHC whilst also supporting carers, staff members and significant others caring for the young people (see also Annexure A).

3.3. Residential out-of-home care services

As day-to-day care givers, residential service staff are uniquely placed to know about the history, relationships and current situation of young people residing at their service. They are frequently called upon to decide whether to contact police in response to incidents and should be provided with the necessary support and guidance to make these decisions in often difficult and demanding circumstances. To effectively implement this Protocol, it is acknowledged that residential service staff require appropriate training and guidance to appropriately manage challenging behaviour. This includes training about the effective use of strategies in behaviour support plans,¹⁴ and to more easily identify situations which require a call for police assistance.

The Residential Care Service Model provides guidance to services about appropriate procedures for the management of crisis situations and advises services to have in place 'clear guidelines around the involvement of the police in response to crisis situations, with

¹² See also Section 5: Training and Identifying best practice.

¹³ The Office of the Children's Guardian will reflect the principles of this Protocol in its revised standards which are currently being reviewed.

¹⁴ Where a young person exhibits challenging behaviour that exceeds what is normally expected to be managed by the carer, a Behaviour Support Plan may be required. These are prepared by a psychologist or other skilled professional in behaviour management of young people who display challenging behaviour.

the understanding that attempts should be made to minimise police involvement, wherever possible'.¹⁵ This Protocol will assist services to meet this objective.

To implement this Protocol, residential services will nominate an appropriate senior residential staff member (e.g. service coordinator or manager) as the 'liaison officer' to regularly liaise with local police. The liaison officer is also responsible for ensuring information is provided to police following an incident involving police attendance at the service according to the *Procedures for residential OOHC services* (Annexure A).

3.4. NSW Police Force

A key aim of the Protocol is to provide practical guidance for police in implementing their existing legislative responsibilities in the context of dealing with young people in residential OOHC.

The NSW Police Force (NSWPF) recognises the benefits of early intervention and prevention to divert young people from the criminal justice system.

Each Local Area Command's Crime Management Unit (CMU) is the 'hub' for community information and plays a significant role in local crime prevention strategies. The CMU within each Local Area Command will be responsible for Protocol case management, including engagement with local residential services, information sharing and recording. In addition to the Crime Manager and Crime Coordinator, CMUs typically also include the various liaison roles within the command such as the Domestic Violence Liaison Officer (DVLO) and Youth Liaison Officer (YLO), and unsworn officers such as the Aboriginal Community Liaison Officer and Multicultural Community Liaison Officer.¹⁶ The Crime Coordinator will have responsibility for liaison with residential services within the local area command.

Police usually attend residential services in response to calls from staff members, young people or other members of the community, such as neighbours. Some behaviour, such as 'boundary testing' behaviour of young people, may reflect normal teenage behaviour and should generally be managed without police assistance where there is little risk of harm to the young person or any other person. However, where criminal or other behaviour that could lead to a breach of the peace occurs, police involvement is necessary. Frontline police will often subsequently consult with the YLO in relation to incidents they attend which involve young people. Better engagement between the CMU and residential services will allow frontline police to gain a better understanding of a young person's circumstances and ideally will lead to a more informed response.

When responding to incidents at residential services, police will consider information provided by staff members, victims and witnesses, and have regard to relevant legislation, Standard Operating Procedures, and their own judgement in applying the Protocol. The Young Offenders Act makes clear that criminal charges should not be pursued against a

¹⁵ *Out-of-home Care Service Model – Residential Care*, NSW Department of Community Services, April 2007, p.9.

¹⁶ The DVLO and YLO roles are sworn officers. A primary aspect of their role is stakeholder engagement. However, these officers do not generally attend incidents.

young person if there is an appropriate alternative for dealing with the matter.¹⁷ For appropriate offences which are not dealt with by warning or caution, police in consultation with the Specialist Youth Officer will consider whether the young person is entitled to be dealt with via a Youth Justice Conference.¹⁸

Local CMUs will ensure frontline police officers are provided with appropriate training and guidance to ensure consistent implementation of this Protocol. (Annexure B provides an outline of Police responsibilities in implementing the Protocol.)

The NSW Police Force Domestic and Family Violence SOPS advise frontline police about responding to personal and domestic violence offences in accordance with the *Crimes (Domestic and Personal) Violence Act* and other relevant legislation. The SOPS make clear that although the YOA 'does not apply to stalking, intimidation and breach AVO' offences, the YOA may be applied to other domestic violence offences.¹⁹

A statutory review of the *Crimes (Domestic and Personal) Violence Act* is currently underway and will consider the definition of 'domestic relationship'. A number of submissions to the review have argued that certain relationships – including those involving young people living in residential services – should no longer fall within the category of 'domestic relationship' unless the requisite dynamic of coercion and abuse in the relevant relationship exists. This Protocol will be amended to keep pace with the legislative review and any related legislative change.

4. GOVERNANCE

A state-wide interagency governance structure underpinned by local arrangements will be established to ensure the consistent and effective implementation of the Protocol and will provide clear pathways for resolution of any systemic issues.

4.1. State-wide Steering Committee

The implementation of the Protocol will be overseen by a steering committee – chaired by FACS – that is comprised of representatives of the following agencies:

- NSW Police Force
- Family and Community Services
- Department of Justice
- Office of the Children's Guardian
- Association of Children's Welfare Agencies
- AbSec
- Youth Action
- Legal Aid NSW
- Aboriginal Legal Service
- Residential service provider representative(s)

¹⁷ *Young Offenders Act, 1997, s.7(c).*

¹⁸ *Young Offenders Act, 1997, s.37.*

¹⁹ *Domestic and Family Violence Standard Operating Procedures, 2012, NSW Police Force, p. 31.*

The State-wide Steering Committee (SSC) from time to time will invite other agencies and experts to participate in its deliberations on discrete issues. In this regard, it is noted that the Ombudsman's office will have observer status on the committee and the Advocate for Children and Young People will provide advice and feedback to the committee in relation to the engagement of young people in relation to issues being considered by the committee.

The functions of the SSC include:

- i. Identifying the type of data residential OOHC services and police will need to systematically collect, and report on, to inform the effective implementation and evaluation of the Protocol.
- ii. Developing a communication and promotion strategy to support the implementation of the Protocol.
- iii. Ensuring that local arrangements are in place to guide the implementation of the Protocol (these should not be prescribed by the committee and wherever possible, should seek to utilise existing suitable mechanisms).
- iv. Monitoring the initial rollout of the Protocol and related procedures, and identifying the need for any other processes or related tools to be developed to support this process.
- v. Identifying and addressing any systemic issues associated with the Protocol's implementation.
- vi. Developing a strategy for identifying and promoting good practice in implementing the Protocol, including effective strategies used by services to manage challenging behaviour and households more generally.
- vii. Providing regular feedback to local police and services in relevant locations to inform the ongoing rollout of the Protocol.
- viii. Overseeing provision of training to support the Protocol's implementation, including providing specific information relevant to supporting Aboriginal young people²⁰ and young people with disability.
- ix. Developing an evaluation strategy, including identifying key benchmark data and outcome measures.

The SSC will initially establish two working groups to provide advice to the committee on priority issues associated with the initial rollout of the Protocol including data collection, training and evaluation; as well as how best to involve young people²¹ in the ongoing implementation and evaluation of the Protocol.

²⁰ The NSW Police Force *Aboriginal Strategic Direction 2012-2017*, requires police commands with significant Aboriginal populations to work with local Aboriginal agencies – including providers of residential and/or other OOHC – to prevent contact between Aboriginal young people and police and promote the diversion of Aboriginal youth from the criminal justice system through initiatives such as the Cautioning Aboriginal Young People (CAYP) protocol and the Protected Admissions Scheme (PAS). In implementing the ASD, police will have regard to the application of this Protocol in locations where Aboriginal residential OOC services exist.

²¹ This working group will provide an avenue for the Office of the Advocate for Children and Young People, CREATE Foundation and Youth Action and other stakeholders to advise the SSC about how best to engage young people in decision making about the Protocol's implementation and evaluation.

4.2. Internal agency governance

Signatory government agencies – the NSWPF and FACS – will identify suitable internal governance processes to facilitate consistent implementation of the Protocol across each agency. Residential services will also need to ensure consistent implementation of the Protocol occurs across their organisation.

Agencies will assign responsibility for implementation of the Protocol to a suitably senior officer.

4.3. Local level arrangements

Local police, local FACS representatives and frontline residential services will determine the nature and frequency of liaison necessary to meet the objectives of the Protocol. Where appropriate, existing local governance structures will be utilised.

At a local level, residential services and local area commands will agree on the practical arrangements and information required to implement the Protocol, such as:

- relevant parties e.g. 'X' Local Area Command and 'Y' Residential Service
- designated liaison officer for each party and contact details e.g. service manager and crime coordinator (or other member of the CMU)
- other local agencies/organisations (for example, Juvenile Justice) that should participate in meetings associated with the Protocol's implementation
- governance processes e.g. frequency of liaison, location of meetings, secretariat support for meetings, and local dispute resolution/escalation and processes for reporting outcomes.

Residential services vary according to governance structures, size and geographic distribution. Some of the larger service providers will have individual frontline services across a number of local area commands. Accordingly, it will be a matter for each provider to determine the best way to ensure that arrangements are in place with the corresponding local area command to ensure consistent implementation of the Protocol across its service outlets.

4.4. Dispute resolution

Open and honest communication will be maintained between parties to the Protocol. Parties should aim to resolve any disputes about procedures or actions in relation to this Protocol at the local level as soon as possible. Local level resolution includes escalation of unresolved issues to the local area commander (or region commander where relevant), district director and/or residential service chief executive officer (or equivalent).

As needed, local level disputes about how best to resolve systemic issues can be escalated to the SSC when attempts to resolve the issue locally have been unsuccessful. The SSC will not be involved in resolving concerns about the performance of individual services or police commands.

5. TRAINING AND IDENTIFICATION OF BEST PRACTICE

Initially, the relevant working group will provide advice to the SSC about the nature and delivery method of training on the implementation of the Protocol and any related subject areas.

A range of training methods will be considered within and across agencies. Training will be informed by a process which seeks to identify good practice across organisations in relation to their management of residences, behaviour management of young people, and the relationship between residences and local police. The training will also address the type of data and key outcomes measures that will be used to inform the Protocol's ongoing implementation and evaluation.

6. EVALUATION AND MONITORING

Initially, the relevant working group will provide advice to the SSC on developing a strategy for evaluating the Protocol's implementation and the necessary data collection and reporting processes to support the evaluation process.

The process for collecting data should not be onerous and should be consistent with the type of records that should already be made by police and residential services in responding to incidents. A critical component of evaluation and monitoring will involve assessing not only the contact between residential services and police, but also the systems and processes residential services have in place to monitor and guide their ongoing collaborative work with police; and how services manage challenging behaviour and incidents more generally.

7. TERM AND REVIEW OF PROTOCOL

The Protocol will be reviewed on an annual basis and a comprehensive review will be conducted every three years.

8. SIGNATORIES

The following parties agree to the terms and guiding principles of this Protocol

- NSW Police Force
- Family and Community Services
- Association of Children's Welfare Agencies
- AbSec

The following agencies support the principles of this Protocol:

- Legal Aid NSW
- Department of Justice
- Youth Action
- YFoundations
- NCOSS
- CREATE Foundation

- Office of the Children’s Guardian
- Office of the Advocate for Children and Young People
- Mental Health Commission of NSW
- Aboriginal Legal Service (NSW/ACT)
-

9. RELATED LEGISLATION AND GUIDELINES

- *Young Offenders Act 1997*
- *Children Young People (Care and Protection) Act 1998*
- NSW Office of the Children’s Guardian, *NSW Standards for Statutory Out-of-Home Care*
- NSW Police Force Youth Strategy 2013 – 2017
- Protected Admissions Scheme (Information Sheet)
- *Out-of-home Care Contracted Care Program Guidelines*
- *Out-of-home Care Service Model: Residential Care*
- The report of the NSW Therapeutic Care Steering Committee (when available)
- Charter of Victims Rights, Part 2, Division 2, *Victims Rights and Support Act 2013*
- NSW Police Force *Aboriginal Strategic Direction 2012 -2017*

10. ANNEXURES

- A. *Procedures for residential OOHC services*
- B. *Policing responses to incidents in residential OOHC services*

PROCEDURES FOR RESIDENTIAL OOH SERVICES

1. Overview

This document:

- i. Provides residential service staff with additional guidance for managing young people's behaviour consistent with principles of therapeutic care.²²
- ii. Promotes adherence to the *NSW Standards for Statutory Out Of Home Care*.²³
- iii. Reinforces the right of young people who are victims of crime to report an incident to police, and to be provided with appropriate assistance from residential service staff to do so.²⁴
- iv. Recognises the right of residential service staff to a safe workplace and to exercise informed judgement about when a call for police assistance is required.
- v. Encourages residential services to use a measured and consultative decision-making process to determine whether a call for police for assistance is necessary - except in circumstances where there are immediate safety risks requiring an expedited response.

2. Behaviour Support Plans and other support issues

Where a young person exhibits behaviour that exceeds what is normally expected, a Behaviour Support Plan (BSP) may be required. These are prepared by a psychologist or other skilled professional in the area of behaviour management. A BSP may also be appropriate where existing strategies have had little impact in addressing the behaviour or the behaviour continues to escalate. Residential services should develop a BSP tailored to the needs of each individual young person. BSPs should demonstrate a positive approach to behaviour support and address presenting behaviour in the context of the young person's overall support requirements. Intervention should be child-centred and culturally appropriate.

The nature of the relationship between residential services, neighbours and the local community can also be a factor in the frequency of police attendance at a service. A focus by services on developing positive relationships with neighbours and other community members is critical to encouraging discussion of non-urgent issues with service staff before police are contacted for assistance.

Residential services should give consideration to:

- i. The training provided to staff to:
 - manage challenging behaviour
 - identify the situations and behaviours that require police assistance
 - minimise client-initiated conflict, and
 - implement, review or refine the BSP.

²² These Procedures should be read in conjunction with the young person's current Behaviour Support Plan.

²³ The Office of the Children's Guardian will reflect the principles of the Protocol in its revised standards which are currently being reviewed.

²⁴ In responding to an incident, it will be important for residential service staff to take into account the age of the young people involved. In particular, when responding to the victim's wishes about police involvement, the victim's age and any other relevant factors such as mental health or intellectual disability should be considered.

- ii. The routines in the household and environmental factors such as the provision of quiet spaces and privacy which can help regulate behaviour.
- iii. The client mix in the household.
- iv. Household strategies promoted to support residents to manage stressful and escalating situations.
- v. Strategies to improve the relationship between the household and the neighbourhood if police are being called by neighbours to deal with concerns about the residential service.

3. Appointing a liaison officer for Police

The residential service will appoint a senior residential staff member (e.g. service coordinator or manager) to be the liaison officer for the purposes of this Protocol. The liaison officer is the main (though not necessarily the only) point of contact between the local police Crime Management Unit and the Residential Service. The liaison officer should be kept informed of all contact between the staff of the residential service and police.

The liaison officer is responsible for ensuring that regular meetings occur with local police to implement the aims of this Protocol according to the local level arrangements set out in section 4.2.

4. Before calling police

Before calling police, be clear about the purpose of the call.

Police should always be called in circumstances where a staff member believes there are immediate safety risks.

4.1 The Helpline and the Mandatory Reporter Guide (MRG)

Where there is a risk of significant harm to a child under 16 years of age, a report should be made to the Child Protection Helpline. When the staff member suspects there is risk of significant harm to a child under 16 years of age, the MRG should be applied to inform whether or not a report to the Child Protection Helpline should be made. If the MRG indicates a report should be made to FACS, contact the Child Protection Helpline on 133 627.

The MRG may recommend that the Child Protection Helpline not be contacted if the circumstances do not reach the risk of significant harm (ROSH) threshold. The MRG may recommend other actions, including that the staff member:

- talks through concerns with their supervisor or a colleague, or a person nominated by the relevant residential service
- refers the young person to another service for assistance
- documents the concerns, continues a professional relationship with the young person and monitors the situation.

Young people in residential services with a history of complex trauma may have limited ability to regulate their behaviour. As a result, service staff should implement trauma-based

responses through identifying a young person's trigger points and ways to de-escalate their behaviour.

4.2 Strategies for residential service staff

Some strategies for residential service staff to consider are outlined below:

- i. Ensure there is a comprehensive handover at the beginning of every shift. The changeover should include an outline of the events of the day (including the young person's mood, presence of conflict or tension, any incident that occurred during the day) as these may provide a context to any triggers that arise later.
- ii. When a young person starts exhibiting challenging behaviour, apply the strategies for de-escalation contained in the young person's BSP.
- iii. If the behaviour cannot be de-escalated, contact senior residential service staff (i.e. House Co-ordinator, Residential Program Manager, Head Office (business hours) or the On-Call Manager (after hours)) to discuss options, including on-call attendance at the residential service, deployment of additional staff etc. Senior residential service staff will discuss:
 - the nature and seriousness of the incident
 - any legal requirements to notify police and/or the Child Protection Helpline
 - the views of any victim about calling the police (including any age or capacity issues)
 - the current behaviour and situation of the young person and any victim
 - the age of the young person involved in the incident
 - steps already taken to de-escalate the behaviour
 - previous incidents or behaviour of a similar nature by the same young person
 - the staff member's views about calling police
 - any relationships which may have an impact on the young person's behaviour e.g. between young people involved in the incident
 - potential impact (positive and negative) on the young person if police involvement is requested and whether the situation can be managed safely without police involvement, and
 - alternative courses of action.

5. Authorisation to call police

In emergency situations residential service staff should not hesitate to call 000.

For non-emergency situations, the following guidance applies:

- i. Only senior residential service staff (i.e. House Co-ordinator, Residential Program Manager, Head Office (business hours) or the On-Call Manager (after hours)) can *authorise* seeking police assistance.
- ii. Once authorisation has been given, the relevant staff member will contact local police and provide the following information:
 - an explanation of what has occurred

- the wishes of any alleged victim
- any historical context
- any relevant information about the young people involved e.g. mental or physical health issues, intellectual disability
- the existence of any bail/AVO conditions
- what has been done so far to de-escalate the behaviour
- the strategies contained in the BSP which have already been implemented, and
- the nature of the police assistance sought.

6. After calling police (post-incident response)

6.1 Records

An incident report must be completed before the end of the staff member's shift. The incident report provides a summary of the incident(s) leading up to a request for police involvement, including what was done to de-escalate the presenting behaviour. Records should be sufficiently detailed (although not onerous) to ensure continuity of care at staff changeovers and inform agency liaison meetings, risk assessments and evaluation of the Protocol.²⁵ Records should be made in all circumstances where police assistance is requested. Ideally records will be made whenever the Protocol is utilised, including where a decision is made not to call police.

Record keeping should also have regard to any Insurance and/or Work Cover requirements.

6.2 Within two weeks of incident*

[* Two weeks is the maximum period and is indicative only. Police and senior residential service staff may agree on a different and lesser time period as appropriate.]

- i. Senior residential service staff will undertake a review of the incident with the staff member on duty at the time the incident occurred. This will allow for discussion and consideration of the options which were available throughout the course of the incident. The circumstances leading up to the incident and any previous similar incidents will be considered. Behaviour support strategies will also be reviewed.
- ii. As a result of the incident review, the BSP will be reviewed and (where appropriate) amended.
- iii. Where the care team assesses it is appropriate, a meeting with the young person will be arranged to reflect upon the incident and identify what could be done differently in future (including alternative behaviours). Where appropriate, the meeting may include local police (preferably the police officer who responded to the incident or the Youth Liaison Officer or Specialist Youth Officer). The young person may choose to have a support person present.
- iv. Where there is on-going conflict between the young person and another resident or a staff member involved in the incident, ideally all people involved in the conflict

²⁵ This is consistent with the current Standard 21, *NSW Standard for Statutory Out-of-Home Care*, which encourages services to develop processes that monitor performance and decision making procedures and identify systemic and operational weaknesses.

should attend a mediation meeting facilitated by a senior residential service staff member or external clinician.

- v. Senior residential service staff will give consideration to whether the service should engage other support services for the young person, including liaison with their school where relevant, to ensure that the young person is supported through an integrated case plan.
- vi. After discussing the above actions with the appointed liaison officer,²⁶ an appropriate staff member will update the Police and provide relevant information about the actions taken. (Police will use the information provided in exercising their discretion to determine whether and how to proceed.)

²⁶ The Protocol requires that a senior residential staff member be nominated as the liaison officer.

ANNEXURE B:

POLICING RESPONSES TO INCIDENTS IN RESIDENTIAL OOHC SERVICES

The NSW Ombudsman, in consultation with the NSW Police Force (NSWPF), has prepared this document to outline how local police will work with service providers in responding to incidents that occur in residential services.

The NSWPF has committed to providing guidance and training to frontline police to facilitate the effective implementation of the Protocol; and ensuring it has adequate processes in place to support the evaluation of the Protocol's use and impact.

This document outlines:

- Police responsibilities when responding to incidents notified by residential OOHC services.
- Factors to be considered by police when determining how to respond to incidents at residential services
- Available options for dealing with young people, including diversionary measures under the *Young Offenders Act 1997*
- Police responsibilities to take action to protect victims consistent with the *Crimes (Domestic and Personal Violence) Act 2007*, and
- Recording incidents and relevant information.

1. Responding to incidents in residential OOHC services

The appropriate and informed use of police discretion is central to the effective operation of this Protocol. Police will respond to incidents reported by residential service providers consistent with usual police practice.

Once police have attended a residential OOHC service in response to an incident, they will determine the appropriate action. Police will adopt a consultative approach with services in reaching a decision however police retain the ultimate authority to make the decision.

Police may need to take immediate action to deal with the young person involved however where immediate action is not necessary, police will consult with their local Crime Management Unit (CMU) to determine the most appropriate way to respond. All matters involving young people residing in residential services will be reported to the CMU as soon as practicable for its review.

In considering what action should be taken by attending police, the following factors will be considered:

- the seriousness of the offence
- the degree of actual or threatened violence involved and any harm caused to alleged victims
- age of any alleged victims and any capacity issues
- the wishes of any alleged victim
- the age of the involved young person, and

- any other matter the investigating officer thinks appropriate in the circumstances.²⁷

Following the initial response, and in consultation with the CMU, police should consider the following factors:

- the number and nature of any offences committed by the young person, including the number of times the young person has been dealt with under the Young Offenders Act
- information provided by the service about the young person's situation (including disorders/illnesses/medication issues) or other factors impacting on the young person's behaviour
- the young person's behaviour management plan and any proposed actions to amend it
- the views of the victim/s
- whether the young person has shown remorse, apologised or made reparations (e.g. damage has been repaired), and
- the views of staff as to the potential effect of a criminal justice intervention on the young person

An approach which first considers the appropriateness of exercising discretion to deal with a young person informally or by issuing a warning is likely to leave police with more diversionary options down the track. This is especially applicable to young people in their early or pre-teens who have already been the subject of three cautions and as a consequence are more likely to be dealt with via criminal proceedings.

Where police attending a residential service initially determine that formal action is required (e.g. under the YOA or by instituting criminal proceedings), they will consult with the relevant residential service liaison officer, and directly with any alleged victim within two weeks of the incident and prior to making a final determination about taking action. This consultation will allow police to take into account any measures which have been put in place by the service to manage the young person's behaviour and any additional information which the service may provide.

2. A stepped approach to deciding how best to respond

2.1. No further action

Police may determine, after discussing the incident with relevant residential service staff, the young person and any victim/s, that no further action is required in response to an incident.

2.2. Use of diversionary options under the Young Offenders Act

If police determine that an offence has been committed, they must identify whether it can be dealt with by one of the diversionary options provided by the *Young Offenders Act*. If the offence is covered by section 8 of the Act police, may:

- issue a warning, pursuant to Part 3

²⁷ See NSW Police Force, *Young Offenders Act Pocket Guide*.

- issue a caution, pursuant to Part 4 (including by utilising the *Protected Admissions Scheme*²⁸ where appropriate), and
- refer the matter to a specialist youth officer to determine, pursuant to Part 5, whether a youth justice conference should be held.

Police must first consider whether a warning – the least punitive sanction – is appropriate. If a warning is not appropriate, police should consider whether the young person is eligible to receive a caution and if so, follow the requirements of the Act. These include informing the young person of the nature and circumstances of the offence; their rights to obtain legal advice and have the matter dealt with by a court; and the purpose, nature and effect of the caution.²⁹ Where the young person does not initially admit to the offence, police are encouraged to make use of the *Protected Admission Scheme*, which provides a guarantee to the young person that any information they disclose in relation to the relevant offence will not be used against them in criminal proceedings.

Where the police officer considers that the young person is not entitled to a caution, the police officer must refer the matter to a specialist youth officer who will decide whether the matter should be dealt with by caution, through a Youth Justice Conference or the Children’s Court.

Police will liaise with the residential service to help ensure that the young person has access to legal advice (e.g. Legal Aid or the Aboriginal Legal Service) and/or other services. Police will ensure contact is made with the service within 14 days of the incident to discuss action taken by the service to manage the young person’s behaviour and any additional information which the service may provide.

2.3. Criminal Proceedings

Criminal proceedings are only to be pursued against a young person in the absence of appropriate alternatives.³⁰ The age³¹ and capacity³² of a young person are relevant factors for police to consider when determining whether to initiate criminal proceedings. Where a decision to initiate formal criminal proceedings is made, police will continue to liaise with the service to ensure the ongoing wellbeing of the young person, including linking them with programs and services to divert them from crime.

²⁸ The reluctance of young offenders to make admissions to an offence, which is a precondition for police giving a caution, was impeding police use of cautions under the YOA. Operating since April 2014, the PAS is designed to enable young offenders to seek advice on whether they should make admissions to an offence whilst preserving their right not to provide self-incriminating evidence.

²⁹ *Young Offenders Act 1997*, s.22 & s.39.

³⁰ It is noted that children under 10 years of age are legally incapable of committing a criminal offence. See *Children (Criminal Proceedings) Act 1987*, s.5.

³¹ The common law presumption known as ‘doli incapax’ is a legal presumption that a young person between 10 and 14 years of age is incapable of forming the necessary intent to commit a criminal offence. This is often understood to require the prosecution to prove that the child knew what they did was seriously wrong in the criminal sense.

³² The question of legal capacity (or fitness to be tried) may be raised in relation to some young people for reasons such as intellectual disability or mental health. The *Mental Health (Forensic Provisions) Act 1990*, sets out the law in relation to fitness to stand trial, which refers to the accused’s capacity to understand and participate in the court proceedings.

3. Police responsibilities to take action to protect victims consistent with the *Crimes (Domestic and Personal Violence) Act 2007*

Domestic violence law in NSW is largely governed by the *Crimes (Domestic and Personal Violence) Act 2007*. This legislation obliges police to apply for an AVO in certain circumstances.³³ In line with legislative provisions, NSWPF *Domestic and Family Violence Policy* ‘enforces a proactive victim support response and will ensure appropriate protective measures are taken to keep victims safe and prevent further violence against them, including applying for an Apprehended Violence Order (AVO)’.

The *Crimes (Domestic and Personal Violence) Act* broadly defines ‘domestic relationship’ and includes relationships between long-term residents living in the same residential services (s.5(e)), and between carers and the young people dependant on their care (s.5(f)). This broad definition was designed to protect the most vulnerable in our community – in particular to protect people with disabilities, older people and young people from abuse and violence in formal care settings.

The legislation requires police to proactively apply for AVOs in a wide range of circumstances and settings, which can include within residential services. Police must apply for AVOs for the protection of victims of violence who are under 16 years of age, including situations where young people are the alleged perpetrators of violence. The sole fact that a victim is reluctant to apply for an AVO does not override a police officer’s obligation to apply for an AVO in circumstances where the officer believes there has been violence to the victim or where a significant threat of violence exists.³⁴

The NSWPF *Domestic and Family Violence Policy* recognises that ‘domestic and family violence involves an abuse of power’.³⁵ While the relationships between young people and their carers are within the legislative definition of domestic relationship, they do not typically demonstrate the kind of power imbalance which sets domestic violence apart from other forms of personal violence.³⁶

Police attending residential services will consider all the circumstances of an incident and any history of violence between the parties before determining whether an AVO is necessary. The routine use of AVOs can further disadvantage vulnerable young people who have often been placed in care as a consequence of their own experience of trauma and abuse. The NSWPF recognises that AVOs are designed to protect victims from violence and should not be viewed as a tool for behaviour management.

Breaching an AVO can expose young people to criminal sanctions, loss of a dwelling and the possibility of incarceration – NSWPF policies seek to divert young people from this kind of

³³ *Crimes (Domestic and Personal Violence) Act 2007*, s.27 and s.49.

³⁴ *Crimes (Domestic and Personal Violence) Act 2007*, s.27(6) and s.49(6). In addition, where the victim is reluctant to apply for an AVO and the police officer believes that the victim has an intellectual disability and no guardian, this reluctance cannot be the sole reason for not applying for an AVO (s.49(6)(b) and s.27(6)(b)).

³⁵ *NSW Police Force Domestic and Family Violence Policy*, 2012, p.8.

³⁶ Legal Aid practitioners report that the majority of protection orders dealt with in the context of the Children’s Court in NSW do not demonstrate the type of power imbalance which the legislation seeks to address.

pathway into the criminal justice system. The use of AVOs may not always be the most effective or suitable method to address the behaviour of young people towards carers and other residents of residential services. In many circumstances, a collaborative interagency approach between the service and other relevant agencies may achieve better and more enduring outcomes.

Police will always focus on the protection of the victim when responding to incidents of violence.

However, there are a number of options currently available to police dealing with incidents at residential services. In some circumstances, police may determine that there is a good reason not to apply for an AVO. The *Crimes (Domestic and Personal Violence) Act* provides that where the police officer investigating the matter believes that there is good reason not to apply for an AVO, and any victim is 16 years of age or older, an application for an AVO need not be made.³⁷

In determining whether there might be good reason not to apply for an AVO against a young person in a residential service, a police officer should take into account all the circumstances of the incident, including consideration of the:

- nature of the incident, including whether there was violence or significant threats of violence to the victim
- views of the victim, including whether the victim wants an AVO in place
- age of the victim and any capacity issues, and
- nature of the relationship between the people involved in the incident, including whether the incident occurred in the context of a coercive and abusive relationship.

If a police officer decides not to apply for an AVO the *Crimes (Domestic and Personal Violence) Act* requires that they make a written record of the reason.³⁸

‘[T]here has been a misconception that the YOA does not apply to domestic violence offences,’³⁹ when in fact, the YOA may be used in relation to many domestic violence offences. ‘Domestic violence offence’ is defined in the *Crimes (Domestic and Personal Violence) Act*⁴⁰ as a ‘personal violence offence’⁴¹ where the victim and offender are, or were, in a ‘domestic relationship’. It should be noted that the *Crimes (Domestic and Personal Violence) Act* includes personal violence offences such as breaching an AVO and stalking or intimidation offences – these offences cannot be dealt with under the YOA.⁴² Young people

³⁷ *Crimes (Domestic and Personal Violence) Act 2007*, s.49(4) and s.27(4).

³⁸ *Crimes (Domestic and Personal Violence) Act 2007*, s.49(5) and s.27(5).

³⁹ *Domestic and Family Violence Standard Operating Procedures*, NSW Police Force, 2012, p.32.

⁴⁰ *Crimes (Domestic and Personal Violence) Act 2007*, s.11.

⁴¹ Personal violence offence is defined in s.4 of the *Crimes (Domestic and Personal Violence) Act 2007* to mean: ‘(a) an offence under, or mentioned in, section 19A, 24, 25, 26, 27, 28, 29, 30, 31, 33, 33A, 35, 35A, 37, 38, 39, 41, 44, 46, 47, 48, 49, 58, 59, 61, 61B, 61C, 61D, 61E, 61I, 61J, 61JA, 61K, 61L, 61M, 61N, 61O, 65A, 66A, 66B, 66C, 66D, 66EA, 80A, 80D, 86, 87, 93G, 93GA, 195, 196, 198, 199, 200, 562I (as in force before its substitution by the *Crimes Amendment (Apprehended Violence) Act 2006*) or 562ZG of the *Crimes Act 1900*, or (b) an offence under section 13 or 14 of this Act, or (c) an offence of attempting to commit an offence referred to in paragraph (a) or (b).’

⁴² *Young Offenders Act 1997*, s. 8(2)(e).

may, however, be dealt with under the YOA in relation to certain 'eligible' domestic violence offences as set out in the YOA.⁴³

4. Recording incidents and relevant information

There are concerns that some young people living in residential OoHC services attract numerous police records in relation to minor incidents and that this can impact the decisions of police when they attend an incident involving these young people. The Protocol aims to reduce the frequency of police attendance at residential services in relation to behaviour which could be safely managed within a service and this in turn, should lead to a reduction in or prevention of the number of police records held about a young person relating to minor incidents. Even where police attend a residential service, there may still be scope for police to determine that no formal action is required and no entry needs to be made against the young person's record on COPS. If the attending officers choose to make a record of the incident on COPS, the entry should record the factual events of the incident and reference any decision not to take further action based on the Protocol, such as any consultation with the OoHC residential service.

Residential services may provide police with information about a young person's history (for example relevant medical conditions, behavioural issues, and/or traumatic events) where this information will assist them to provide an appropriate response to a young person. It will be a matter for the residential service to determine the nature of any additional information that should be provided to police to inform their responses to the young person, in accordance with the principles and objects of Chapter 16A of the *Children and Young Persons (Care and Protection) Act 1998*.

If a young person moves to another residential service, the Local Area Command's Crime Coordinator will ensure the new command is promptly provided with relevant background information about the young person.

The NSWPF has committed to ensuring it has adequate processes in place to support the appropriate recording of information about its response to incidents which occur in residential OoHC services.

⁴³ The YOA does not apply to strictly indictable offences and some drug and other offences are otherwise ineligible for the application of the YOA (*Young Offenders Act s.8*).

Annexure 3

Roads to Recovery: 10 themes that must be considered by Victoria's Royal Commission into Mental Health

**Submission to the Consultation on the Royal Commission into Mental Health Terms
of Reference**

January 2019

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Written requests should be directed to Victoria Legal Aid, Research and Communications, Level 9, 570 Bourke Street, Melbourne Vic 3000.

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Executive Summary and Recommendations

Victoria Legal Aid congratulates the Victorian Government for establishing Australia's first Royal Commission into Mental Health (**RCMH**).

The RCMH is a critical opportunity to look at a system that is not currently working to support people's personal recovery. At its best, the RCMH has the potential to help shape Victoria's laws, policies, services and culture into a system that protects and promotes the rights of Victorians experiencing mental health issues or mental distress. It has the potential to inform and build a system that supports people's choices and their recovery in ways that enable them to live the best lives they can, as determined by them.

A critical opportunity for consumer-led, system-wide reform

Recognition of the importance of consumer co-production and leadership should be at the foundation of the RCMH and the system it helps redesign. Consumers must be engaged to shape and have influence over the RCMH process and outcomes, and the reformed mental health system that emerges.

The RCMH presents an opportunity for a review of the experiences of consumers of mental health services before, during and after their engagement with the mental health system. To make sure this happens, we encourage the Government to include within the scope of the RCMH a review of the way mental health services interact – or should interact – with other services and systems.

By way of example, through our work, VLA sees the way in which lack of access to housing, disability services, employment, income support, therapeutic services and mental health services in the community can contribute to escalating issues, which can include family breakdown, criminal offending or hospitalisation. Once people have entered these crisis-based systems, their exit, reintegration and/or recovery is again dependent on access to adequate housing and supports in the community. The RCMH presents a critical opportunity to understand the ways in which these, and other, systems could work together more effectively to deliver better outcomes for individuals and the Victorian community. One overarching comment about how the RCMH approaches its task is that it must consider system-wide context and reform. We caution against a narrow review of the mental health system or one that replicates the silos of the current service system, which will not present the same opportunity for positive change.

The scope of the RCMH should be informed by social determinants of mental health and be framed within a social model of health rather than a purely medical model. In our view, the proposed themes presented as part of the 'Royal Commission into Mental Health Terms of Reference Consultation' online engagement do not offer sufficient scope to deliver the much-needed system-wide reform (and risk reinforcing existing silos) and we commend you for consulting outside these parameters.¹

¹ State Government of Victoria, *Royal Commission into Mental Health Terms of Reference Consultation* (available at: <https://engage.vic.gov.au/royal-commission-mental-health-terms-of-reference>).

Our perspectives and recommendations

VLA's position and recommendations have been informed by:

- VLA's specialist legal and non-legal expertise in the mental health system via our Mental Health and Disability Law service, and our non-legal Independent Mental Health Advocacy (**IMHA**) service. This expertise includes direct knowledge of consumer experience.
- The views of members of our advisory group of consumer experts, *Speaking from Experience*.
- VLA's direct experience of the flow-on effects of the gaps in the mental health system, which are apparent through our work in summary crime, indictable crime, child protection, family law, family violence, discrimination, social security, tenancy and legal help for people in prison.

Informed by this work and these perspectives, we would like to see Terms of Reference (**TOR**) that allow for the system to be reimagined. The current mental health system is not broken; it is poorly designed. Rather than try to "fix" the system as it is currently conceived, we should be moving toward a social model of health, designed with people with lived experience of mental health issues.

In reimagining a new system, we should not brush past or gloss over the harm people have experienced through the current system. We must listen to the voices of people who have experienced this system in order to move on from it.

To make sure the RCMH achieves its potential, here are 10 themes that must be within its scope.

Roads to Recovery: 10 themes that must be considered by Victoria's Royal Commission into Mental Health

1. Consumer leadership and co-production

Consumers – people whose lives are directly affected by the mental health system – should shape and have influence over the process and outcomes of the RCMH. This includes: consumer leadership of the RCMH; processes to ensure that consumers can contribute to and be heard by the RCMH; and embedding consumer leadership in the redesigned mental health system that emerges from the RCMH.

2. The regulation of compulsory treatment – rights and recovery

The RCMH provides an opportunity to consider whether the principles and provisions of the Mental Health Act 2014 (Vic) – including a rights-based and recovery-oriented framework for the delivery of treatment and support – are operating as intended and, if not, how to change this.

3. Services and supports in the community

The RCMH should consider the availability and appropriateness of services and supports in the community, including mental health and interdependent systems such as rehabilitation services, housing and NDIS.

4. Forensic mental health and justice services

The RCMH should consider the way in which the mental health system directly impacts on people's justice outcomes, including their entry into and exit out of the criminal justice system. This includes early intervention and diversion (including the role of Victoria Police), courts, secure therapeutic

facilities, prisons, transition back into the community, and the needs and experiences of young people in the justice system.

5. Overlapping life and legal issues

The RCMH should recognise that the experience of mental health issues can contribute to a broad range of legal issues. The existence of these issues – and the stress they bring with them – can also contribute to or exacerbate mental health issues for people. The RCMH should expressly consider the interaction between people’s mental health and the following legal issues and systems: family violence; child protection; family law; discrimination; fines; housing and tenancy; social security; migration law; and guardianship and administration.

6. Inpatient services

The RCMH should consider the conditions, physical environment, culture, safety and treatment of people who are hospitalised for their diagnosis or experience of a mental health issue or mental distress.

7. Tailored, appropriate, culturally safe services

The RCMH should consider the need for tailored, appropriate and culturally safe services for groups within our community, including Aboriginal and Torres Strait Islander people, CALD communities, LGBTIQ people, older Victorians, women and young people. The RCMH’s consideration of the service needs of these priority groups should be informed by engagement with consumers who are members of these communities.

8. Regional issues

The RCMH should consider the way in which a person’s postcode affects the treatment and services available to them.

9. Governance, accountability, data and transparency

The RCMH should consider the effectiveness of the current governance, oversight and accountability mechanisms in the mental health system. It should also consider the lack of publicly available data regarding the mental health system, including data on how many people are subject to compulsory treatment, geographical location, age, gender, cultural background, type and length of order, and complaints. Data is critical to service design, evaluation and consumer choice, and essential to ensure accountability.

10. Models that work

The RCMH should take a social determinants of health approach, and should encourage evidence and ideas about models that work, including prioritising the expertise of people who have directly experienced the mental health system, and contemplating international best practice.

Victoria Legal Aid, our clients and consumers, and the mental health system

VLA is an independent statutory agency responsible for providing information, advice and assistance in response to a broad range of legal problems.² Working alongside our partners in the private profession and community legal centres, we help people with legal problems such as criminal matters, family breakdown, child protection, family violence, fines, social security, mental health, migration, discrimination, guardianship and administration, tenancy and debt.

Our Legal Help telephone line is a resource for all Victorians to seek information, advice and assistance with legal problems. We also deliver specialist non-legal services, including our Family Dispute Resolution Service and our Independent Mental Health Advocacy service, provide community legal education, and contribute to policy and law reform.

Our contribution to the RCMH will be informed by our work with clients and consumers experiencing mental health issues, including:

- **Over one-quarter of our clients.** During 2017–18, VLA helped 94,485 unique clients: 11% were in custody, detention or psychiatric care, and 26% disclosed having a disability or mental health issue.³ While some of this work is specifically within the mental health system, much of it is VLA's other day-to-day work across summary crime, indictable crime, child protection, family law, family violence, discrimination, social security, migration, tenancy and legal help for people in prison.
- **Specialist mental health legal practice.** The Mental Health and Disability Law program provides advice and representation to people with a mental health diagnosis or cognitive disability. We work to realise people's rights and autonomy, and to help make sure the justice and health systems operate fairly. In 2017–18, we represented 1046 people before the Mental Health Tribunal, including 772 matters for people with inpatient treatment orders. We also appeared for clients in 93 *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic) hearings in the County Court and Supreme Court, as well as at the Forensic Leave Panel for clients on supervision orders seeking access to leave.
- **Non-legal advocates and consumer experts.** The Independent Mental Health Advocacy (IMHA) service, a non-legal advocacy service, supports people who are receiving compulsory psychiatric treatment to have as much say as possible about their assessment, treatment and recovery. IMHA's *Speaking from Experience* advisory group is made up of people who have lived experience of mental health issues. IMHA is included in Victoria's *10-Year Mental Health Plan* as a service that will 'strengthen a rights-based framework for the delivery of treatment and support, and help embed person-directed assessment, treatment and recovery as the norm for service delivery'. IMHA has been favourably externally evaluated over three years, providing insights into current issues within the mental health system and the importance of advocacy, as

² See Victoria Legal Aid, *Annual Report 2017–18* (available at: <https://www.legalaid.vic.gov.au/about-us/our-organisation/annual-report-2017-18>) (VLA Annual Report).

³ Ibid. This includes clients seen by a private practitioner duty lawyer. Unique clients are individual clients who accessed one or more of Victoria Legal Aid's legal services. This does not include people for whom a client-lawyer relationship was not formed, who received telephone, website or in-person information at court or at public counters, or participated in community legal education—we do not create an individual client record for these people. Neither does this client count include people assisted by our Independent Mental Health Advocacy service. We note that, because this figure relies on clients disclosing their disability or mental health issue at the time of receiving legal assistance, the actual number of clients experiencing mental health issues is likely to be significantly higher.

well as mechanisms to ensure coordinated oversight and safeguards.⁴

- **Specialist work in the criminal justice system.** Our Criminal Law program provides specialist support for people whose mental health issues intersect with their criminal law issues. This includes our Therapeutic Courts team, comprising lawyers working in the Assessment and Referral Court (**ARC**) List in the Magistrates' Court,⁵ and our specialist practice with clients who fall under the *Crimes (Mental Impairment and Unfitness to be Tried) Act 1997* (Vic).

Through this work we see the intersection of the mental health system with people's other life and legal issues.

It is this work that has informed our recommendations for 10 themes that, in our view, must be considered by the RCMH.

⁴ Dr Chris Maylea, Susan Alvarez-Vasquez, Matthew Dale, Dr Nicholas Hill, Brendan Johnson, Professor Jennifer Martin, Professor Stuart Thomas, Professor Penelope Weller, Social and Global Studies Centre, RMIT University, *Evaluation of the Independent Mental Health Advocacy Service (IMHA): Final Report* (November 2018) (**IMHA Evaluation Report**).

⁵ See also Law and Justice Foundation of New South Wales, *In Summary: Evaluation of the appropriateness and sustainability of Victoria Legal Aid's Summary Crime Program* (June 2017) (available at: <http://www.legalaid.vic.gov.au/about-us/research-and-analysis/summary-crime-evaluation-report>), which identified that, of 14,591 grants of legal assistance made in the review period, 64% related to family violence, mental ill-health and offending-driven by drug addiction.

10 themes that must be considered by Victoria's Royal Commission into Mental Health

1. Consumer leadership and co-production

Consumer leadership in establishing the RCMH and its processes and advisory structures

Recognition of the importance of consumer leadership and co-production should be reflected in the RCMH process. This means that consumers – people whose lives are directly affected by the mental health system – will have the opportunity to shape and have influence over the process and outcomes. We recommend a consumer co-chair for the advisory committee, a consumer Commissioner and an advisory group of consumers as crucial parts of the RCMH process.

Government should be mindful of the power imbalance that can exist in relationships (for example, between medical and legal professionals and consumers) and should proactively take steps to counter-balance this in establishing the RCMH and its advisory groups (for example, through avoiding having a solo consumer role, and having key supports in place for any consumer roles). Consideration should also be given to the background of non-consumers, including expertise in trauma-informed practice, the social model of health, and/or human rights.

There should be an opportunity for consumer advice and comment on the draft TOR.

Consumer participation in the RCMH

Once the RCMH commences, it is vital that individual consumers are able to contribute to the RCMH and be heard, and that there are measures in place to reduce the barriers people will face to participation. This should include access to advice and advocacy, as well as support. The RCMH must proactively reach those who may not otherwise participate, including people in prison or inpatient units. This could include resourcing peak bodies for consumers and carers, and other advocacy and legal services, to provide support for people with lived experience of mental health issues to participate in the process.⁶

Consumer leadership beyond the RCMH

The TOR should include consideration of the ways in which, beyond the RCMH process, consumer leadership and self-advocacy will be embedded as part of the mental health system and its reform, including opportunities, funding and support for consumer-led services.

⁶ We also note the need for the RCMH to consider appropriate whistle-blower protections to encourage those with system experience (including staff, families and carers) to share their experiences of the mental health system without fear of repercussions.

2. The regulation of compulsory treatment and a focus on people's rights and recovery

This year, the *Mental Health Act 2014 (Vic)* (**Act**) will have been in operation for five years. The RCMH provides an opportunity to consider whether the principles and provisions of the Act – including a rights-based and recovery-oriented framework for the delivery of treatment and support⁷ – are operating as intended and, if not, how to change this.

In particular, the RCMH should consider:

- The use of compulsory treatment and restrictive practices such as seclusion and restraint, and the rates of this in Victoria relative to other jurisdictions.⁸
- Fundamental concepts of capacity and informed consent, including as recently considered in relation to compulsory electroconvulsive treatment in *PBU & NJE v Mental Health Tribunal* [2018] VSC 564 (1 November 2018).
- Training and education for mental health professionals, and development of appropriate systems, to make sure there is genuine understanding and implementation of the Act and its safeguards.
- The role of – and access to – representation by lawyers or advocates where people are facing compulsory treatment.
- The impact that limited resourcing for the mental health system has on the ability to fulfil the principles in the Act.
- The current functioning and impact of safeguard and oversight bodies (see also part **Error! Reference source not found.** below).
- The reliance on medication and treatment of symptoms, rather than access to talk and other therapies (and diverse professionals to deliver these), who could help address underlying trauma or causes of mental distress.
- Workforce reform and support required for mental health system reform, including the role and availability of peer workforce staff.
- Cultural drivers that would ensure a rights-based framework in mental health services and quality improvement, accountability and monitoring mechanisms.
- The evidence-base regarding the nature and impact of a person's experience of treatment depending on whether treatment is received voluntarily or compulsorily.
- The impact of supported decision-making and whether or not the mechanisms under the Act are fully understood and implemented in mental health services.
- The compatibility of the Act, and how it is implemented in practice, with the United Nations *Convention on the Rights of Persons with Disabilities (CPRD)* and the *Charter of Human Rights and Responsibilities Act 2006 (Vic)*.

⁷ See, eg, Department of Health and Human Services, *Recovery Library* (available at: <https://recoverylibrary.unimelb.edu.au/>).

⁸ See Edwina Light et al, 'Community Treatment Orders in Australia: Rates and Patterns of Use' (2012) 20(6) *Australasian Psychiatry* 478, 480. Victoria has the highest rate of people subject to CTOs (98.8 per 100,000). This is compared with 61.3 per 100,000 in QLD, 48.6 per 100,000 in WA, 46.4 per 100,000 in NSW, and 30.2 per 100,000 in Tasmania. There was no data available for SA or NT. See also Piers Gooding and Yvette Maker, University of Melbourne, 'Why are the rates of restrictive practices in Victoria's mental health services so high?' *Pursuit* (January 2019).

3. Services and supports in the community

Through our work, VLA sees that when there is a breakdown in services in the community – in both mental health and interdependent systems, such as rehabilitation services, housing and NDIS – people can end up in crisis, and consequently in an inpatient mental health unit or the justice system. In addition to funnelling people in, people can also become stuck in these systems, including being indefinitely detained (for example, in Secure Extended Care Units (**SECUs**) or Thomas Embling Hospital), because of a lack of support and services to enable discharge back into the community (see also part 4 below).

Recognising this, the RCMH should consider:

- The availability and appropriateness of:
 - Care and supports for people after leaving acute inpatient services, including flexible ‘step up’ and ‘step down’ options where the service access points are visible and known to consumers so they can take an active role in the direction of their treatment.
 - Housing, therapeutic support, supported decision-making, advocates and free legal assistance for people experiencing mental health issues in the community.
 - Outreach mental health services tailored to individual consumer needs.
 - Services for people on Community Treatment Orders (including, for example, people who work). As one of our staff members said, ‘this treatment should be more than just an injection’.
- The impact of housing instability and homelessness on treatment and recovery, including the prevalence and impact of discharging people from hospital into rooming houses or onto the streets, and the links to readmission.
- The opportunities and gaps created by the National Disability Insurance Scheme (**NDIS**) for Victorians experiencing mental health issues and psychosocial disability.
- Lack of services and supports in the community resulting in long-term detention of people in SECUs or Thomas Embling Hospital.
- The social determinants of health, including the links between poverty and the inability to access adequate and appropriate mental health services.
- The gaps between service systems, and the need for a joined-up approach to improving access to housing and services⁹ to support people in the community and facilitate people’s transition out of SECUs, Thomas Embling Hospital or prison.¹⁰

⁹ Including specialist accommodation. See, eg, the new legislative and regulatory regime for specialist residential services and specialist disability accommodation providers.

¹⁰ See, eg, Victorian Ombudsman, *Investigation into the imprisonment of a woman found unfit to stand trial* (October 2018) (available at: <https://www.ombudsman.vic.gov.au/News/Media-Releases/imprisonment-of-woman-found-unfit-to-stand-trial>) (**Ombudsman’s Report on Imprisonment of a Woman Found Unfit to Stand Trial**).

4. Forensic mental health and justice services: Mental health assessment and treatment for people in contact with the criminal justice system

In her ‘investigation into the rehabilitation and reintegration of prisoners in Victoria’, the Victorian Ombudsman identified that 40% of the Victorian prison population had been assessed as having a mental health condition and found: ‘Failure to properly treat a prisoner’s mental health condition during their imprisonment will have a significant effect on their rehabilitation and ability to reintegrate into the community’.¹¹

During 2017–18, VLA helped 94,485 unique clients. Of these clients, 11% were in custody, detention or psychiatric care; and 26% disclosed having a disability or mental health issue.¹²

Through our work, we see how the mental health system directly impacts on people’s justice outcomes, including their entry into and exit out of the criminal justice system. For example, people without appropriate accommodation may be living in public spaces and may be subject to additional police surveillance. People may be refused bail due to the lack of appropriate accommodation and supports that meet their needs. People in custody may not have access to appropriate treatment and support which may impact their transition back to the community and increase the likelihood of reoffending.

It is essential that the RCMH’s focus on ‘forensic mental health and justice services’ should include explicit consideration of the different ways that access to treatment and supports impacts a person’s interaction with enforcement agencies and justice processes. The RCMH should examine:

- **Early intervention and diversion away from the criminal justice system.** Ways to reduce the frequency and intensity of contact with the criminal justice system for people experiencing mental health issues, including the role of Victoria Police, and the availability of diversion away from the justice system where conduct is connected with a person’s mental health.
- **Courts.**
 - The role of therapeutic justice programs, such as the ARC List, the Drug Court, supported bail programs and the Neighbourhood Justice Centre, in increasing access to therapeutic options and supports for people involved in the criminal justice system.
 - Potential benefits of increased geographical reach and timely access to services to support therapeutic justice programs.
 - The availability of mental health assessments for the purposes of criminal proceedings such as fitness to plead, mental impairment and sentencing and the impact on courts, prisons and clients of limited resources for these.
- **Secure therapeutic facilities.** The shortage of secure therapeutic facilities for mental health treatment for prisoners (whether remanded, sentenced, or found not guilty by reason of mental impairment), including the impact of prolonged detention in prison on people who have been found unfit to be tried on their stabilisation, recovery and wellbeing.¹³

¹¹ See, eg, Victorian Ombudsman, *Investigation into the rehabilitation and reintegration of prisoners in Victoria* (September 2015) 6 (Ombudsman’s Prison Report).

¹² See VLA Annual Report, above n 2.

¹³ See, eg, Ombudsman’s Report on Imprisonment of a Woman Found Unfit to Stand Trial, above n 10.

- **Prisons.**
 - The impact that Victoria’s record number of remandees is having on assessments, access to programs and supports, and access to medication and other treatments, as well as the flow-on effects for people’s recovery and rehabilitation.¹⁴
 - Growing pressure on prison populations and limited access to treatment facilities contributing to increased use of custodial management techniques that may negatively affect a person’s mental wellbeing while in custody.
 - The failure of treatment options and resources for prisoners to keep pace with the increase in the prison population, one of the effects of which is for those found not guilty by reason of mental impairment to remain in prison for longer periods before being transferred for treatment.
- **Transition back into the community.** The planning, services and supports that are available to people when they are bailed, paroled or complete their sentence. For example, access to housing, NDIS, case management or holistic support in the community and the impact this has on wellbeing, re-integration into the community and risk of reoffending.
- **The needs and experiences of young people.** The availability of forensic mental health services for young people experiencing mental health issues, recognising that the Youth Parole Board Annual Report 2017/18 records that 53% of people detained present with mental health issues, and 30% have a history of self-harm or suicidal ideation.¹⁵ Also, issues with the timely completion of assessment, planning and service delivery for young people entering detention, as set out in the 2018 VAGO Report.¹⁶
- **Disproportionate impact.** The impact of changes to the justice system on people experiencing mental health issues. For example, people experiencing mental health issues may find it difficult to comply with bail conditions and recent changes to bail laws have introduced more serious consequences for breach of bail conditions.
- **Training and practice changes.** The availability of, and need for, training for justice agencies – including Victoria Police, Corrections, Courts and Tribunals – to better understand and more effectively engage with people experiencing mental health issues.

We emphasise that any consideration of additional forensic beds needs to be carefully balanced with the RCMH’s consideration of the need for less restrictive alternatives and access to adequate services in the community.

We encourage the Government to see the RCMH as an opportunity to understand and address the additional pressure that defects in the operation of the mental health system (including a lack of housing and services in the community for people experiencing mental health issues) can transfer to the justice system, including Victoria Police, Corrections, the Courts and the legal assistance sector.

¹⁴ See, eg, Ombudsman’s Prison Report, above n 11, 6.

¹⁵ Department of Justice and Regulation (VIC), *Youth Parole Board Annual Report (2018)* x and 15.

¹⁶ Victorian Auditor-General’s Office, *Managing Rehabilitation Services in Youth Detention* (August 2018).

5. Overlapping life and legal issues

The intersection of the mental health system with the legal system is not limited to criminal justice or the mental health jurisdiction. There are other important examples of interactions between people's mental health and the legal system which should be considered by the RCMH. The RCMH should examine:

- **Family violence.** The way mental health is treated in the family violence intervention order system, including how a consistent therapeutic approach can be adopted to ensure best outcomes for all parties. While family violence is ultimately driven by dynamics of power and control between family members, a lack of adequate access to appropriate mental health supports and services in the community for both victim survivors and perpetrators of family violence contributes to increased risk.
- **Child protection and family law.** The way mental health is treated in the child protection and family law systems, including:
 - Limited understanding of mental health issues in the child protection system, including people and their parenting capacity being pre-judged or assumed to be low.
 - Removal of children or reduction of care because parents – predominantly women – cannot get access to the mental health supports they need.
 - Lack of access to child protection proceedings for people in acute mental health services.
 - The lessons from the Office of the Public Advocate's report regarding disproportionate rates of child protection removals for parents with disability, including mental health issues.¹⁷
- **Discrimination.** The discrimination faced by people experiencing mental health issues, including in employment, service provision and education.¹⁸
- **Fines.** The disproportionate impact of Victoria's fines system on people experiencing mental health issues, including where the person's mental health issue contributed to the relevant conduct (for example, not having a ticket on public transport or parking longer than allowed).¹⁹
- **Housing and tenancy.** The eviction into homelessness of public and community housing tenants due to conduct directly related to a person's mental health.
- **Social security.** The high rate of refusal of disability support pension claims due to difficulties with access to mental health services, particularly in regional Victoria.
- **Asylum seekers.** The risks presented by the lack of adequate access to appropriate mental health services and how this impacts on the ability of asylum seekers to present their claims through the refugee status determination process.
- **Guardianship and administration.** The impact of the guardianship and administration regime on the rights, autonomy and recovery of people experiencing mental health issues.²⁰

¹⁷ Office of the Public Advocate, *Rebuilding the village: Supporting families where a parent has a disability*, Report 2: Child Protection (2015).

¹⁸ See, eg, VLA's cases *Ella Ingram v QBE Insurance (Australia) Ltd* [2015] VCAT No H107/2014 (18 December 2015) regarding discrimination by insurance companies in relation to mental health issues; *Slattery v Manningham CC* (Human Rights) [2013] VCAT 1869 regarding mental health discrimination by a council. See also Victoria Legal Aid, *Submission to the Australian Human Rights Commission, Willing to Work: National Inquiry into Employment Discrimination against Older Australians and Australians with Disability* (December 2015) (available at: https://www.legalaid.vic.gov.au/about-us/strategic-advocacy-and-law-reform/other-activities#Willing_to_Work_Inquiry).

¹⁹ In 2017–18, VLA provided over 2000 advices on infringements matters, and representation at the Magistrates' Court Special Circumstances List in over 3000 cases for over 2000 clients.

²⁰ See, eg, Victoria Legal Aid, *State of Trust: Making sure State Trustees protects and promotes the rights of Victorians with disability* (September 2018) (available at: <http://www.legalaid.vic.gov.au/about-us/news/our-report-for-victorian-ombudsmans-investigation-into-state-trustees>). In the 2017–18 financial year, for example, we provided nearly 500 advices to over 250 people about administration orders; and legal information about administration orders in over 300 cases.

The experience of mental health issues can contribute to these legal issues arising. In addition, the existence of these legal issues – and the stress they bring with them – can contribute to or exacerbate mental health issues for people. Each of these issues leads to hardship for individuals and costs for the community, and the RCMH should contemplate whether these issues could be prevented, minimised or more effectively responded to through access to appropriate, holistic mental health services in the community.

The RCMH should also consider the role for early access to legal assistance in preventing these legal issues from escalating, for example, through integrated models of service provision and Health Justice Partnerships.²¹

²¹ See, eg, Health Justice Australia, 'Mapping a New Path: The Health Justice Landscape' (2018) (available at: <https://www.healthjustice.org.au/wp-content/uploads/2018/08/Health-Justice-Australia-Mapping-a-new-path.pdf>); State Government of Victoria, Access to Justice Review Report and Recommendations (August 2016) (available at: <https://engage.vic.gov.au/accesstojustice>); Victoria Legal Aid, 'Mallee region to benefit from health justice partnership' (December 2016) (available at: <https://www.legalaid.vic.gov.au/about-us/news/mallee-region-to-benefit-from-health-justice-partnership>).

6. Inpatient services: Physical environment, safety and recovery-focus

The conditions, physical environment, culture, safety and treatment of people who are hospitalised for their diagnosis or experience of a mental health issue or mental distress should be expressly identified as a TOR for the RCMH.

In addition to our discussion in part **Error! Bookmark not defined.** above regarding compulsory treatment and the extent to which the principles of choice, recovery and self-determination captured in the Act exist in practice, we recommend that the RCMH examines:

- Effective discharge planning (including from SECUs).
- Physical environment and culture, including thoughtful design, staffing levels and other policies that impact on consumer experience.
- The operation of SECUs, including the length of involuntary treatment and the long-term impact this has on people's recovery.
- Use of violence or unnecessary and disproportionate force by staff and security in inpatient facilities.
- Treatment and rights of voluntary consumers.
- The use and impact of coercive practices.
- The availability – and benefits – of holistic services that address trauma and other social issues, including psychologists, social workers, peer support workers and occupational therapists in clinical services.

7. Tailored, appropriate, culturally safe services

The RCMH should be required to consider the need for tailored, appropriate and culturally safe services for groups within our community. Our system must be accessible and responsive to our diverse communities to support recovery. The TOR should include consideration of the needs of:

- **Aboriginal and Torres Strait Islander people.**
 - The importance of cultural competency to ensure cultural safety, responsiveness and inclusive services.
 - An understanding of government policies that have contributed to trauma, such as the over representation of Aboriginal and Torres Strait Islander children in out of home care.
 - The importance of being trauma-informed and the value of cultural strengthening for healing.
 - The importance of Aboriginal self-determination and of having community inform the RCMH of their needs.
- **CALD communities.** The availability of, and need for, culturally appropriate services, including interpreters, bicultural workers and approaches that engage with community.
- **LGBTIQ people.** The availability of inclusive and appropriate services for lesbian, gay, bisexual, transgender, gender diverse and intersex members of the community, and the impact of discriminatory service provision on these groups.
- **Older Victorians.** The current availability of, and projected need for, mental health services for older Victorians who experience mental health issues and neurological diseases. Also, conditions in aged care psychiatric services (including capacity, use of coercion and rights-based frameworks), particularly in light of Victoria’s ageing population.²²
- **Women.** The need for female-only treatment spaces, consistent with trauma-informed practice (noting the Mental Health Complaints Commissioner’s recommendation of gender-specific wards).²³
- **Young people.** In addition to access to forensic mental health services discussed above in part **Error! Reference source not found.:**
 - Continuity of access to services for young people who turn 21, the impact of being cut off from youth services without adult services or case management planned, and the need for more flexible transition processes (recognising the differential funding levels for adult and youth services, and the experience of service drop-off when adulthood comes).
 - Access to mental health services for young people in state care to prevent homelessness and engagement with the youth justice, and later adult criminal justice, systems.

The RCMH’s consideration of the service needs of these priority groups should be informed by engagement with consumers who are members of these communities.

²² See also Terms of Reference in the Royal Commission into Aged Care Quality and Safety (available at: <https://agedcare.royalcommission.gov.au/Pages/default.aspx>).

²³ Mental Health Complaints Commissioner, *Annual Report* (2018) 45, 49 and 51. The Mental Health Complaints Commissioner’s 2017-18 Annual Report recommends: Gender-sensitive and trauma-informed practice; piloting and evaluating single-gender units, prioritising the piloting of women-only units; and support services to implement trauma-informed care and supported decision making as primary prevention strategies to prevent sexual safety breaches.

8. Regional issues and inconsistencies across settings

The RCMH should consider the way in which a person's postcode affects the treatment and services available to them. This should include:

- Limited access to mental health services in regional areas and the impact this can have, including escalation of mental health issues and associated conduct (for example, offending and family violence), and the impact on people's recovery (for example, for people in SECUs, this can mean isolation from family and supports and inability to get leave as a result).
- Limited access to therapeutic courts and differential access to court support services across the State (see also part **Error! Reference source not found.** above).
- Differences across sites, including the practice of health professionals and the physical environment.
- The governance structure needed to ensure consistency of practice and consumer experience across regions and services.
- Zoning of public mental health services, including lack of service choice.
- Challenges of mental health assessments and decisions by the Mental Health Tribunal made remotely via video-link.
- Access to specialists to address physical health needs of consumers experiencing mental health issues who are in inpatient units and the community, given the higher morbidity and mortality rates for people with mental health issues who are being treated with medications.

9. Governance, accountability, data and transparency

The RCMH should consider the effectiveness of the current governance, oversight and accountability mechanisms in the mental health system. It should also consider the lack of publicly available data regarding the mental health system, including data on how many people are subject to compulsory treatment, geographical location, age, gender, cultural background, type and length of order, and complaints.

Data is critical to service design, evaluation and consumer choice, and essential to ensure accountability.

In particular, the RCMH should consider:

- The role for publicly available data in helping improve quality and consistency of service provision, as well as informing consumer choice.²⁴
- The role of Victoria's 10 Year Mental Health Plan in shaping decisions regarding service design and funding.
- The extent to which consumer feedback, an assessment of rights protection, and a focus on recovery are included in evaluations of service effectiveness.
- The role and effectiveness of the Mental Health Tribunal in providing oversight and accountability of the system and supporting self-determination.
- The effectiveness of the current governance and oversight mechanisms, including via the Department of Health and Human Services, the Mental Health Complaints Commissioner, the Office of the Chief Psychiatrist, and Office of the Public Advocate Community Visitors.

²⁴ See *Targeting Zero: Supporting the Victorian hospital system to eliminate avoidable harm and strengthen quality of care*, Report of the Review of Hospital Safety and Quality Assurance in Victoria (2016) (available at: <https://grattan.edu.au/wp-content/uploads/2016/10/Hospital-Safety-and-Quality-Assurance-in-Victoria.pdf>); Victoria State Government, *Better, Safer Care: Delivering a world-leading healthcare system* (October 2016) (available at: <https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/hospital-safety-and-quality-review>).

10. Time for a fundamental shift in our approach to mental health in Victoria – models that work

We recommend that the TOR are framed to encourage evidence and ideas about models that work, including prioritising the expertise of people who have directly experienced the mental health system,²⁵ and contemplating international best practice. The RCMH should not be limited to considering the effectiveness of what is currently in place.

This is a unique opportunity to reimagine a system developed 30 years ago. A social determinants of health approach, rather than a purely medical approach, should be the lens for the RCMH. This will allow consideration of what is needed in the various systems people with mental health issues are navigating to make these systems effective and sustainable. This should include consideration of the resourcing necessary to implement recommendations and embed the reform they seek to bring about.

²⁵ See, eg, IMHA Evaluation Report, above n 4, which is both a source of evidence for the RCMH and an example of work that was co-produced and privileges consumer voices.

Annexure 4

State of Trust: Making sure State Trustees protects and promotes the rights of Victorians with disability

September 2018

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Written requests should be directed to Victoria Legal Aid, Research and Communications, Level 9, 570 Bourke Street, Melbourne Vic 3000.

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Executive Summary and Recommendations

The appointment of an administrator involves a significant restriction on a person's right to autonomy and to make their own decisions about their financial and legal affairs. It has far reaching effects on a person's day-to-day life and, for our clients who also experience social and financial disadvantage, it can be particularly disempowering.

This report contains 12 client stories that highlight consistent experiences reported by Victoria Legal Aid's clients. Our contribution is drawn from our legal advice, legal information and casework with people who are subject to administration orders, where State Trustees is very often the administrator. In the 2017-18 financial year, for example, we provided nearly 500 advices to over 250 individual clients about administration orders; and legal information about administration orders in over 300 cases. We provided over 2000 advices on infringements matters (which are of crucial importance to people subject to administration orders), as well as representation at the Magistrates' Court Special Circumstances List in over 3000 cases for over 2000 clients.

In our experience, State Trustees has a 'one size fits all' approach that does not consistently recognise the unique needs of the individuals whose financial affairs they manage. Many clients express frustration at the long wait times to speak with State Trustees, only to find they have to introduce themselves and explain their situation all over again to a different administrator. Even when they speak to their administrator it can still be difficult to get information about their account. At other times, the represented person's views are ignored or disregarded.

Our clients do not feel encouraged and supported to become capable of managing their own financial affairs. Many clients have been unreasonably denied access to financial independence programs and, when they do succeed to regain management of their finances, State Trustees does not support them to apply to the Victorian Civil and Administrative Tribunal (**VCAT**) to have their orders revoked.

We have assisted many clients for whom it appears State Trustees either did not know or understand how to advocate for their rights to have debts waived because they were 'judgment proof' or apply for their fines to be waived on the grounds of 'special circumstances'. For other clients, State Trustees' failure to notify Centrelink of changes in their income caused them to incur debts or be denied payments to which they otherwise would be entitled. In all these cases, our clients were effectively prevented from participating in activities or spending their funds in ways that they enjoy and contribute to their quality of life.

The workforce and culture of State Trustees only reinforces our clients' experiences that they are disproportionately or unreasonably restricted compared with others in the community. Furthermore, the safeguards in the regime, such as the oversight by VCAT, do not operate as effectively as they could to ensure the least restriction on the rights of people with disabilities and effective redress.

Informed by our day-to-day work with thousands of Victorians with mental illness and disability, this report highlights six key areas for improvements in both policy and practice to ensure State Trustees, and the regime in which it conducts its role as an administrator for vulnerable Victorians, can most effectively protect and promote the rights of Victorians with disability.

Making sure State Trustees protects and promotes the rights of Victorians with disability	
<p>1. Maximising autonomy and building capacity</p>	<p>To ensure State Trustees maximises autonomy and builds capacity of a represented person, we recommend:</p> <ul style="list-style-type: none"> • State Trustees changes its ‘Financial Independence Program’ (FIP) policy so that it is consistent with human rights principles and does not exclude people on limited orders or those without a support person. • State Trustees adopts an internal policy that it apply for revocation of an order once the FIP has been successfully completed. • Where a represented person is not accepted into the FIP, State Trustees must advise them of their right to apply to VCAT for reassessment of the order, and must support them to do so. • State Trustees adopts incentives to assist people to build their capacity (eg. KPIs for supporting represented persons to transition on to the FIP).
<p>2. Acting competently in a represented person’s ‘best interests’ and in consultation</p>	<p>To ensure State Trustees acts competently in a represented person’s ‘best interests’ and in consultation with them, we recommend:</p> <ul style="list-style-type: none"> • State Trustees works collaboratively with stakeholders to develop a best practice model for embedding individualised, tailored, supported decision-making, with proactive steps by administrators to consult in a meaningful way with represented persons and their support people. • State Trustees ensures it meets with a represented person regularly, preferably in person, at a minimum once a year to discuss their finances, proposed budget and the person’s goals, interests and preferences. The outcome of the review meeting should be provided to the represented person in writing. • Training for State Trustees staff on their obligations as a public authority to give proper consideration to human rights when making decisions on behalf of represented persons, including: <ul style="list-style-type: none"> – Seeking and giving effect to the person’s view and preferences wherever possible; – Capacity principles; – Supported decision-making principles; – Recognising the inherent dignity of the person; and – Least restriction on freedom of decision and action.

<p>3. Understanding the legal frameworks that determine the represented person's rights and responsibilities</p>	<p>To ensure State Trustees understands the legal frameworks that determine the represented person's rights and responsibilities, we recommend:</p> <ul style="list-style-type: none"> • State Trustees ensures all staff have the appropriate understanding and skills to advocate for the represented person's legal rights through an application on the basis of 'special circumstances' or other available mechanisms to resolve infringements (including newly introduced Work and Development Permits and options for victims of family violence). • State Trustees establishes internal policies to ensure a waiver or reduction of any outstanding debts is requested as a matter of course for all eligible represented persons and this is applied consistently regardless of the debt, where they are 'judgment proof'. • State Trustees develops and implements policies and processes that ensure compliance with Centrelink notification obligations. This includes notifying Centrelink without delay of any change in a represented person's income (whether employment income, income protection payments or otherwise). • State Trustees communicates without delay to the represented person: <ul style="list-style-type: none"> - Any change to their income and what action State Trustees is taking to minimise any adverse impacts on the person; and - Any action they propose to take to resolve outstanding debts or infringements and clearly explain the process and likely outcome.
<p>4. Improving the responsiveness, appropriateness and accessibility of services</p>	<p>To ensure that State Trustees improves the responsiveness, appropriateness and accessibility of services to represented persons, we recommend:</p> <ul style="list-style-type: none"> • State Trustees develops robust guidelines for communicating with and consulting the represented person in a timely way on all decisions. • State Trustees removes the 'pooled' system of administrators and reverts to a system where individual administrators are allocated to a represented person. • State Trustees ensures that phone calls and written communication and correspondence by or on behalf of the represented person are responded to in a timely way. This can be achieved by development and strict implementation of policies and prescribed timeframes. • State Trustees employs adequate numbers of skilled staff to respond in a timely manner to calls by the represented person.

	<ul style="list-style-type: none"> • State Trustees monitors staff caseload to ensure the administrator responsible knows the represented person’s circumstances and can offer meaningful opportunities to consult and participate in decisions. • State Trustees has regular in-person appointments with a represented person to discuss budget and finances – at least once per year.
<p>5. Making VCAT and the review process a meaningful safeguard</p>	<p>To make the Victorian Civil and Administrative Tribunal (VCAT) and the review process a meaningful safeguard and to encourage better practice by State Trustees, we recommend that:</p> <ul style="list-style-type: none"> • The Ombudsman investigates the most effective and accessible redress mechanisms for represented persons where State Trustees is not acting in their ‘best interests’. • VCAT adopt the following practices: <ul style="list-style-type: none"> – Ordinarily making orders for a fixed duration of a maximum of three years, with an ability for the administrator to apply for a further order prior to expiry. In determining the order’s duration VCAT must consider the nature of the person’s disability (eg. whether fluctuating or degenerative) and the likelihood of the person regaining their capacity or their circumstances changing (eg. when an appointment is made for a person with a mental illness during an acute period of hospitalisation); – If making an indefinite order, VCAT should exercise its discretion to nominate a date for reassessment in such a way that is consistent with human rights. For example, if a person is likely to regain decision-making capacity in a short period, then VCAT should consider a shorter reassessment period; – At a reassessment VCAT should not continue an administration order unless satisfied on the evidence before it that the criteria continue to apply; – VCAT and the Guardianship List Registry allow applications by the represented person themselves about the scope or powers under the administration order, or a matter arising out of the administration of the person’s affairs, pursuant to ss 55 or 56 of the <i>Guardianship and Administration Act 1986</i> (Vic) (Act) respectively; and – VCAT and the Guardianship List Registry take steps to maximise the participation of (proposed) represented persons in hearings (whether an initial application, rehearing or reassessment), including measurable targets for participation rates, and reports on those rates.

6. Building a workforce and culture that can bring the principles and protections in the current and new Acts to life	<p>In order to build a workforce and culture that can bring the principles and protections in the current Act and any new Acts to life, we recommend:</p> <ul style="list-style-type: none">• Updated minimum standards for administrators that accurately reflect a rights-based approach to decision-making and training for all State Trustees staff to embed them in practice.• State Trustees adopts a policy that all administrators embed the principles of the Act into their day-to-day decision-making for represented persons, including:<ul style="list-style-type: none">- Regular and meaningful consultation with the represented person; and- Giving effect to the represented person's will and preferences and only overriding this where their views can't be ascertained and where it is necessary to prevent serious harm to the person themselves.• These policies are updated if there are changes to the Act to bring them into line with newly applicable human rights norms.• State Trustees monitors its compliance with the standards, develops protocols for remedying breaches and undertakes regular reporting.
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1. Victoria Legal Aid and our work with Victorians with mental health issues and disability

Victoria Legal Aid (**VLA**)¹ is an independent statutory body established under the *Legal Aid Act 1978* (Vic) to provide access to justice to the community through legal advocacy, advice and assistance to socially and economically disadvantaged people across Victoria. Our organisation provides client-centred services through dedicated practice areas to address the legal needs of marginalised Victorians, including people with disabilities.

VLA is a leading provider of legal services to people with disabilities in Victoria, with 26% of clients identifying as having a disability or mental health condition in 2016-17.² VLA's service delivery model takes a dual-pronged approach to promoting access to justice for these clients. We provide both specialist legal services and non-legal advocacy and support, and conduct community legal education and law reform work.

Our Civil Justice Program includes a specialist legal service, the Mental Health and Disability Law sub-program (**MHDL**), which provides advice and representation at courts, tribunals and psychiatric hospitals for people with disabilities and mental health conditions. The Economic and Social Rights sub-program (**ESR**) provides advice and representation to clients who experience various forms of social and economic disadvantage, with legal issues including infringements and social security matters.

Our Independent Mental Health Advocacy (**IMHA**) program provides non-legal advocacy to promote and support the human rights of people experiencing compulsory mental health treatment or those at risk of being subjected to compulsory mental health treatment. The service is funded by the Department of Health and Human Services. It is free to use, independent of mental health services and has an advisory group of people who have lived experience of mental health issues, *Speaking From Experience*.³

VLA acts for clients with disabilities who have had their decision-making autonomy restricted or taken away entirely by virtue of guardianship or administration orders under the *Guardianship and Administration Act 1986* (Vic) (**the Act**), as well as by coercive treatment regimes under the *Mental Health Act 2014* (Vic) (**MHA**) or the *Disability Act 2006* (Vic).

Our advice and advocacy for represented persons and proposed represented persons in relation to administration orders often involves liaising directly with State Trustees and other agencies and providing representation at VCAT in relation to both guardianship and administration order matters.

In the 2017-18 financial year VLA provided:

- Nearly 500 advices to over 250 individual clients about administration orders
- Legal information about administration orders in over 300 cases
- Over 2000 advices on infringements matters to over 1300 clients
- Representation at the Magistrates' Court Special Circumstances List in over 3000 cases for over 2000 clients.

¹ For more information, please see our website: <https://www.legalaid.vic.gov.au/>.

² Victoria Legal Aid, *Annual Report 2016-17*.

³ See Independent Mental Health Advocacy, *IMHA gives choice and dignity back to consumers – evaluation* (13 June 2018) (<https://www.imha.vic.gov.au/about-us/news/imha-gives-choice-and-dignity-back-to-consumers-evaluation>).

VLA also publishes jointly with the Office of the Public Advocate the *Take Control* booklet which provides information and practical tips for appointing powers of attorney. We also work together with other stakeholders on policy and law reform work to promote the rights of people with disabilities.

2. Administration orders and State Trustees through a human rights lens

An administration order made by VCAT pursuant to the *Guardianship and Administration Act 1986* (Vic) (**the Act**) involves a significant restriction on a person's right to autonomy and to make their own decisions about their financial and legal affairs. It involves a limitation on a person's rights under the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (**the Charter**) not to have their privacy arbitrarily interfered with,⁴ not to be discriminated against on the basis of disability, as well as the right to equality before the law.⁵ It also involves a restriction on a person's legal capacity and autonomy enshrined in Article 12 of the *United Nations Convention on the Rights of Persons with Disabilities* (**CRPD**).

The limitation on a person's rights is engaged not only in the making (or continuation) of an order by VCAT, which is a public authority when so determining,⁶ but also when other public authorities exercise powers under the Act. We consider that State Trustees is a public authority when performing the functions of a financial administrator appointed by VCAT and is therefore obliged to give proper consideration to a person's rights under the Charter.⁷ Therefore, for each decision a State Trustees administrator makes on behalf of a represented person, they must consider if it is a reasonable, justified, proportionate and necessary restriction on the represented person's rights.

Whilst VCAT must apply strict criteria when making or reassessing an order, the Act also contains a number of core principles⁸ to ensure the least restriction on a person's freedom of decision and action, the best interests of the person are promoted and the wishes of the person are given effect to wherever possible.⁹ These core principles apply without qualification to the exercise of all powers and discretions under the Act, including by administrators. In *Patrick's Case*, Bell J explained the role of these principles in preserving a person's personal autonomy:

Personal autonomy is inherent in the least restrictive means and the wishes of the person principles. The purpose of requiring the adoption of the least restrictive means is to leave the person with as much personal autonomy as possible over their personal and financial affairs. The same value is inherent in the requirement to give effect to the person's wishes, where ascertainable and wherever possible. Specific provisions of the Act emphasize the importance of promoting, maintaining and enhancing the personal autonomy of persons with a disability.¹⁰

In addition, the Act mandates that administrators take an active role to support the represented person to build their capacity and maximise their autonomy even whilst on the order. This includes

⁴ *Charter of Human Rights and Responsibilities Act 2006* (Vic) s 13.

⁵ *Charter of Human Rights and Responsibilities Act 2006* (Vic) s 8.

⁶ *Patrick's Case* [2011] VSC 327.

⁷ *Charter of Human Rights and Responsibilities Act 2006* (Vic) s 38.

⁸ *Patrick's Case* [2011] VSC 327, [23].

⁹ *Guardianship and Administration Act 1986* (Vic) s 4(2)(a), (b) and (c).

¹⁰ *Patrick's Case* [2011] VSC 327, [18].

encouraging and assisting the represented person to become capable of administering their affairs, acting in consultation with them and taking into account, as far as possible, their wishes.¹¹

It is our view that, notwithstanding the broad powers of an administrator to manage a person's financial and legal affairs, these obligations, read together with the objects of the Acts mean more than merely acting in their *financial* best interests. The objects of the Act require State Trustees to use its powers as an administrator in ways which promote the represented person's own autonomy and participation in decision-making. In our view, 'best interests' is therefore a subjective test and it encompasses consideration of the person's unique circumstances, views and preferences including how they wish to live their life, what 'quality of life' looks like and what they perceive to be restrictive. Taking too narrow or paternalistic a view of 'best interests', without reference to these subjective factors, is not consistent with a contemporary human rights focus.

These core principles and obligations are designed to safeguard the rights of people with disabilities and ensure that rights limitations are proportionate and only justified in certain circumstances.

In our experience, State Trustees too often falls short of its obligations under the current regime to support and enhance the autonomy of represented persons and to encourage their participation in decision-making. Our experience also demonstrates a failure by State Trustees in their processes and decision-making, to comply with their obligations as a public authority to properly consider the human rights of represented persons. Furthermore, other safeguards in the legislative regime, such as the oversight by VCAT, do not operate as effectively as they could to ensure least restriction on the rights of people with disabilities. The combination of these factors means that many of our clients experience disproportionate or unreasonable restrictions on their rights, dignity and autonomy, and without access to effective and accessible redress.

We note that the *Guardianship and Administration Bill 2018 (Vic)* (**the Bill**) is currently in the Legislative Council of the Victorian Parliament after a significant process of consultation on the reforms. The Bill goes a significant way to ensuring the rights of people with disabilities and represented persons are brought in line with current human rights standards. Based on our knowledge and understanding of State Trustees' compliance with the existing regime, we are concerned that State Trustees would be poorly equipped to comply with stronger human rights obligations under the reforms.

This report highlights six key areas for improvements in both policy and practice to ensure State Trustees, and the regime in which it conducts its role as an administrator for vulnerable Victorians, can most effectively protect and promote the rights of Victorians with a disability.

This report also draws on VLA's previous submissions and consultations relating to review and reform of the Act.¹²

¹¹ *Guardianship and Administration Act 1986 (Vic)* s 49.

¹² See, eg, VLA's submission to the VLRC Review of Guardianship Laws (2010) (http://www.lawreform.vic.gov.au/sites/default/files/Submission_IP_43_Victoria_Legal_Aid_18-05-10.pdf).

3. Maximising autonomy and building capacity

In VLA's experience, State Trustees does not consistently comply with its obligation to assist represented persons to build their capacity to make decisions about their finances. Nor does State Trustees consistently support them to maximise their autonomy when subject to an administration order. This has significant detrimental impacts on the rights of represented persons and their ability to make or participate in decisions that affect their daily lives.

Financial independence program – accessible and supportive

For many years State Trustees has offered an internal 'Financial Independence Program' (**FIP**) which enables a represented person to regain their independence in decision-making by gradually increasing their management and responsibility for their finances. This would commonly start with managing an allowance for personal expenses over a fortnight, then, if successful, taking responsibility for a small regular bill, such as a chemist bill and progressing to managing more substantial bills like utilities and rent.

We note that, despite the fact that it appears to be designed to address State Trustees' obligation to assist a person to regain their capacity and was promoted in State Trustees' annual reports from as far back as 2008¹³ there is no mention of this program on State Trustees' website. Indeed, VLA frequently comes across clients who have been under administration for years who have not heard of the FIP. It is not uncommon for VLA lawyers to be the first to raise the FIP with State Trustees in circumstances where, arguably, State Trustees should have been proactive in initiating such a program based on the represented person's circumstances.

There is considerable inconsistency and lack of transparency about eligibility, and the way in which State Trustees administers the program, including the support they provide and the criteria used to determine success.

We understand that the Financial Independence Program may have been available to clients who satisfied the following criteria:

- Their affairs are administrated by State Trustees under a non-limited administration order made by VCAT
- They currently receive a regular allowance paid fortnightly
- They have an active support network for example family or caseworker.¹⁴

Whether or not these are the current criteria is unclear, however, we have been instructed by clients that they have been refused access to the FIP because they had no 'caseworker'. There does not seem to be any reason to exclude at first instance people on limited orders, or people who do not have an active support network.

By way of comparison, we understand that Australian Unity (which is also appointed by VCAT as an administrator under the Act), has a near identical program to State Trustees without such strict eligibility criteria. Australian Unity, we understand, does not exclude a person from their program merely because they do not have a support person or are on a limited order.

¹³ See State Trustees, *Annual Report 2008* 39 (<https://www.statetrustees.com.au/wp-content/uploads/2015/05/102-AnnualRep2008.pdf>).

¹⁴ See State Trustees, *Financial Independence Program* (https://www.guardianship.org/IRL/Resources/Documents/state_trustees_program_17.pdf) (Financial Independence Program).

We have assisted clients who have been, in our view, unreasonably refused access to this program due to insufficient supports.

As the case studies below demonstrate, State Trustees' failure to adopt a more individualised assessment based on a client's own capacity to be independent means they arguably fail to meet their statutory obligations under the Act to maximise a person's autonomy.

Mary's story: Failure to support building her capacity and autonomy

In 2011 Mary (not the client's real name) suffered a stroke and an application was made to VCAT seeking an administration order on her behalf. In early 2012, VCAT ordered that State Trustees be appointed as her financial administrator.

A section 61 report prepared by State Trustees for Mary's reassessment hearing at VCAT in early 2017 states that Mary was not considered suitable for the Financial Independence Program due to the nature of her disability but does not elaborate further.

In mid-2017 Mary obtained a letter from her GP who, after completing a cognitive assessment with her, concluded that she was mentally competent to make her own decisions. Mary has also been paying her electricity bills herself.

Despite these improvements in her capacity, the report prepared by State Trustees for Mary's VCAT hearing in late 2017 stated that, although Mary had been considered for the Financial Independence Program as she is receiving and self-managing a weekly living allowance payment, Mary continues to require assistance with large amounts and with her assets and as such is not relevant for the program. We are advocating directly with State Trustees for Mary to be given the opportunity to manage more of her finances and to be put on the FIP with a view to demonstrating that a more limited order, or revocation of the order itself, is the most appropriate outcome in the circumstances at the next VCAT hearing.

Mary's case illustrates the disconnect between measures theoretically designed to support a person to regain their autonomy and capacity, and their implementation in practice. We question whether State Trustees administrators have a clear understanding of their obligations and of key concepts such as capacity and supported decision-making and the steps they can and should be taking to enhance capacity of all people whose affairs they manage.

Actively supporting autonomy and embedding supported decision-making

Many clients complain that State Trustees make decisions about their discretionary spending with insufficient consultation with them directly. Other clients instruct that when they have requested assistance from State Trustees with budgeting, they are told to speak with their support worker to be referred to a financial counsellor as State Trustees does not assist with this. These examples do not appear consistent with the human rights obligations of a public authority, or the Act.

State Trustees' current information brochure on the website¹⁵ makes no mention of State Trustees' obligations to enhance autonomy and capacity, or how State Trustees will implement such obligations. Similarly, their information brochure for represented persons, entitled 'Looking out for your financial and legal affairs'¹⁶ makes no reference to supporting the person to make their own

¹⁵ State Trustees and State Government, *Looking out for your financial and legal affairs* (https://www.statetrustees.com.au/wp-content/uploads/2017/12/State_Trustees_Financial_Legal_Affairs_Brochure_14122017.pdf).

¹⁶ Ibid.

decisions. Under the heading ‘Reviewing your support’, the booklet does refer to a standard three-yearly review by VCAT to ‘check to see that [the represented person’s] needs are being met’.

By contrast, the National Standards of Public Guardianship 2016,¹⁷ to which the Office of the Public Advocate subscribes, include a specific minimum standard to make ‘all reasonable efforts to support represented persons to exercise their own decision-making capacity’, as well as guidelines on requesting a review of the order, ensuring the order is least restrictive and for the shortest time possible and ‘only where there is evidence that the represented person needs particular decisions to be made for them’.¹⁸

In practice, State Trustees does not consistently support represented persons to come off their administration orders and regain full independence. As the following case study demonstrates, failure to take proactive steps to apply to VCAT or support a person to do so can result in an unjustifiable restriction on a person’s autonomy.

Paul’s story: Failure to take steps to have order limited or revoked, despite successful Financial Independence Plan

Paul (not his real name) was made subject to an administration order in 2003 appointing State Trustees. The order was made in the context of Paul being diagnosed with schizophrenia, and concerns about his spending and ability to pay rent.

Paul commenced on State Trustees FIP in February 2011. In correspondence provided to VCAT, State Trustees stated that upon successful completion of the program over three months, the administrator would recommend a review of the order.

VCAT subsequently reassessed and confirmed the order on its own initiative in 2012, 2013 and 2015, each time ‘on the papers’. Despite State Trustees’ mandatory ‘Section 61 reports’ to the Tribunal on each occasion noting that Paul was successful on the FIP, State Trustees took no active steps to request reassessment of the order or request a hearing at VCAT.

State Trustees’ information sheet about the FIP states that the program is reviewed 6 or 12 months after its commencement to determine whether it should continue, increase or be cancelled.¹⁹

Paul spent much of the time on the program managing almost the entirety of his income. State Trustees was only paying one single expense on his behalf.

Paul sought the assistance of VLA to have the order revoked in 2017 and we represented Paul at VCAT. Finally, in 2018 – seven years after commencing on the FIP – the order was revoked by VCAT.

Throughout that seven year period State Trustees continued to take income commission and management fees, to which they were legally entitled as an administrator, but which amounted to over \$8,000.

Arguably, had State Trustees taken more active steps to support Paul to regain full independence, he may have succeeded in having his order revoked sooner, including avoiding having to pay significant fees to State Trustees.

¹⁷ See *National Standards of Public Guardianship 2016* (<https://www.publicadvocate.vic.gov.au/our-services/publications-forms/guardianship-a-administration/guardianship-1/357-national-standards-of-public-guardianship>).

¹⁸ *Ibid* 5.

¹⁹ See Financial Independence Program, above n 14.

State Trustees' failure to support or provide a meaningful pathway for Paul (and other clients like him) to seek variation or revocation of an administration order is arguably a breach of their obligations under both the Act and as a public authority under the Charter to maximise a person's decision-making autonomy and participation in decisions. Concerningly, at the same time, State Trustees benefitted from the receipt of fees as administrator.

Recommendation 1: Maximising autonomy and building capacity

To ensure State Trustees maximises autonomy and builds capacity of a represented person, we recommend:

- State Trustees changes its 'Financial Independence Program' (**FIP**) policy so that it is consistent with human rights principles and does not exclude people on limited orders or those without a support person.
- State Trustees adopts an internal policy that it apply for revocation of an order once the FIP has been successfully completed.
- Where a represented person is not accepted into the FIP, State Trustees must advise them of their right to apply to VCAT for reassessment of the order, and must support them to do so.
- State Trustees adopts incentives to assist people to build their capacity (eg. KPIs for supporting represented persons to transition on to the FIP).

4. Acting competently in a person's best interests and in consultation

The restrictions imposed by an administration order have ramifications for all aspects of a person's life. Many clients have expressed concerns that State Trustees make decisions without sufficient consultation with them (or people they authorise to support them) and, when decisions are made, they are contrary to what they want and State Trustees' reasons for those decisions are not explained.

'Best interests' is more than just balancing the account

As we explain in part 2, acting in a person's 'best interests' requires more than merely 'balancing the books'. It requires understanding the represented person's views and preferences, what is important to them, and their unique life circumstances. Whilst ensuring that the bills are paid is a critical function of State Trustees as an administrator, we question how often State Trustees consults effectively with the represented person to explain the decision that needs to be made, ascertain the views of the represented person, present and discuss options, including their benefits and drawbacks, as part of the decision-making process.

Understanding what is important to the represented person

Clients frequently instruct us that they struggle to contact their administrator and, when they do make contact, they are frustrated at the lack of personal care and interest. We hear complaints from clients about State Trustees having a 'one size fits all' approach and unreasonably limiting or refusing discretionary spending apparently in order to accumulate savings in circumstances where the person's

income is very modest. Were it up to them, some clients would prefer to spend their money on items or activities that enhanced their quality of life in the short-term, rather than 'save for their funeral' as they have put it.

Our clients often describe the indignity of having to call State Trustees to ask for money to buy toiletries or underwear or pay for a haircut or buy presents for their niece or nephew because their meagre allowance does not stretch that far. It takes significant effort and time by advocates, support workers and at times lawyers, for State Trustees to agree that, for example, the restrictive 'drip feed' approach to an allowance is no longer necessary and the represented person can be given the chance to manage a larger sum. Clients are often frustrated that State Trustees' system means they cannot take advantage of cheaper bulk-buy products.

From our advocacy directly with represented persons it appears that State Trustees' administrators do not have sufficient time, resources or interest to establish processes to consistently develop a good understanding of the views, preferences and needs of the individuals whose affairs they manage and how they may change over time.

Consultation impacts on a person's health and wellbeing

Many of our clients under administration orders have complex needs by reason of their disability and a failure to consult effectively and sensitively, having regard to their particular needs and circumstances, can have deleterious effects on the represented person's health and wellbeing, as the following case studies demonstrate.

Mahmoud's story: Not consulted before his possessions were thrown out

Mahmoud (not the client's real name) was in hospital for medical treatment when State Trustees was appointed to be his administrator by VCAT.

His treating team said he would not be able to go back to living at home due to his disability.

State Trustees told him that his house would need to be cleared for it to be sold, as he was not going to be able to live there again. He was told he would be consulted in the lead up to his house being cleared, but ultimately cleaners were arranged and a lot of his belongings were thrown out.

Mahmoud was already distressed about being in hospital and unable to return home, but he lost all faith in State Trustees to appropriately take care of his affairs after this incident.

After this, State Trustees advised that they would provide quotes before finishing work on his house, but never provided those quotes and Mahmoud subsequently discovered more work had been done on his house without it being discussed with him.

Because of Mahmoud's impairments, it is difficult for him to remember exactly what was in the house to get compensation for the good things that were disposed of. He knows there were things he did not need anymore, but he is devastated that State Trustees did not help him to sort through things and keep what was important to him.

Safeguards and standards

Where our clients have been concerned that State Trustees have acted contrary to their best interests there are limited accessible options open to them to seek redress. Where the person otherwise meets the criteria for an administration order, VCAT is not an effective mechanism given its current remit is limited, by and large, to reassessing the criteria of an order. Whilst VCAT can

vary the order and may make orders for State Trustees to reimburse the person, the latter is only available in exceptional circumstances.

The lack of effective and accessible sanctions for State Trustees' failure to act in a person's 'best interests' can impact significantly on represented persons who are already disempowered by their experience of the order.

When VLA is instructed to assess merit in having an administration order revoked, we request the VCAT file, which includes all the 'section 61 reports' that State Trustees has prepared for any reassessment hearings since the order was made. The fact that orders are generally only reassessed every three years means that there is no incentive for State Trustees to provide VCAT with evidence of how the represented person's affairs have been managed in the interim. This means there may be no documented evidence of the person's financial circumstances or the management of their affairs for up to three years, even if their circumstances or capacity has changed dramatically over that time.

State Trustees internal processes do not appear to be sufficiently robust in the absence of external safeguards as the following case study illustrates:

Sally's story: Missed fees meant client's apparent savings were illusory

In the course of preparing for Sally's (not the client's real name) upcoming reassessment of her administration order at VCAT, VLA requested State Trustees provide a copy of the report they were preparing (the section 61 report).

It was only when the administrator was preparing this report that they realised that Sally's supported accommodation payments had been mistakenly left unpaid for around eight months. This resulted in Sally having accumulated thousands of dollars in her cash common fund with State Trustees. Sally had been calling State Trustees frequently to check the balance of her savings and had lots of plans for how she wanted to use this money.

State Trustees said it was an 'oversight'. Sally was devastated to learn what she thought were thousands of dollars in savings were only illusory, as the fees needed to be repaid. This caused extreme distress for Sally and she was unable to participate effectively in the hearing.

VCAT reappointed State Trustees, despite their failure to act in Sally's best interests. Sally lost all faith in State Trustees as her administrators.

Sally's story, and the importance of greater oversight, safeguards and quality improvement of State Trustees is not isolated. For example, VLA is currently assisting a client who had his second property sold by State Trustees (his administrator) against his wishes and the wishes of his family, and without meaningful consultation.

We note that the National Standards for Financial Managers²⁰ to which State Trustees subscribes contains what are in our view weak minimum standards that arguably fall short of the obligations under s 49 and s 4(2) of the Act, and well below the obligations imposed by the Charter. For example, there is no minimum requirement for ascertaining a person's views or keeping them informed at regular intervals.

²⁰ National Standards for Financial Managers (2011) (https://www.agac.org.au/images/stories/nat_stds_fin_mgrs.pdf).

Not only is this example clearly in breach of the lesser standards (which mandates “fully considering” the represented person’s views and “carefully considering” the impact on their life before making a decision to sell property), it does not meet the obligations that the Act and human rights require.

Where the person has not been adequately consulted nor their views taken into account, we question how State Trustees can justify that they are acting in the person’s ‘best interests’.

Promoting personal and social wellbeing

We note that, under proposed reform to the Act, the Bill moves away from ‘best interests’ and instead requires administrators and guardians to ‘promote the personal and social wellbeing’ of the represented person. Regardless of the how this obligation is framed, effective and transparent decision-making processes, a skilled workforce, and a robust accountability mechanism are essential to making these rights a reality.

Recommendation 2: Acting competently in a represented person’s ‘best interests’ and in consultation

To ensure State Trustees acts competently in a represented person’s ‘best interests’ and in consultation with them, we recommend:

- State Trustees works collaboratively with stakeholders to develop a best practice model for embedding individualised, tailored, supported decision-making, with proactive steps by administrators to consult in a meaningful way with represented persons and their support people.
- State Trustees ensures it meets with a represented person regularly, preferably in person, at a minimum once a year to discuss their finances, proposed budget and the person’s goals, interests and preferences. The outcome of the review meeting should be provided to the represented person in writing.
- Training for State Trustees staff on their obligations as a public authority to give proper consideration to human rights when making decisions on behalf of represented persons, including:
 - Seeking and giving effect to the person’s view and preferences wherever possible;
 - Capacity principles;
 - Supported decision-making principles;
 - Recognising the inherent dignity of the person; and
 - Least restriction on freedom of decision and action.

5. Understanding the legal frameworks that determine people's rights and responsibilities

VLA has acted for clients in cases where State Trustees, as their administrator, has failed to fully understand key legal frameworks that determine that person's rights and responsibilities, and therefore to take steps to address their financial or other vulnerability, or maximise their entitlements. Three frameworks are most relevant to our clients in this regard – (a) resolving debts, (b) dealing with infringements and (c) notifying Centrelink of changes that affect social security entitlements.

Administration orders are often sought to resolve financial crisis

Many of our clients had their administration orders imposed in the context of having accrued debt or outstanding infringements or mismanagement of social security entitlements. The stated impetus for the order is often that the client was, at that time the order was made, unable to repay or otherwise address the debt or infringement themselves, or in the context of being unable, due to their disability, to maximise their social security entitlements. Such a 'need' is often also the catalyst for the administration order application, to ensure the administrator can step in to resolve these financial issues on a person's behalf.

The following examples and case studies from our practice highlight that State Trustees has a lack of consistent understanding of these legal frameworks, leading to poor decision-making. Their failure to act with due care and diligence can have a damaging impact on clients, not only their financial stability, but also their health and wellbeing.

The following examples demonstrate how State Trustees falls short of its obligation under the Act to act in the represented person's best interests and to take care of their affairs,²¹ and the urgent need for reform.

Infringements and 'special circumstances'

Amongst our clients, it is not uncommon for an administration order to be made as a result of them having accrued outstanding fines in the context of an acute mental health crisis or some other impact of their disability. A range of factors can contribute to clients' vulnerability to receiving fines, including mental illness or disability, lack of awareness of rights and responsibilities, inability to comply with the requirement to purchase a public transport ticket due to financial circumstances, or a greater public presence because of insecure housing or homelessness. These factors may also impact a person's capacity to pay a fine and impede their ability to navigate the complex infringements system.²²

Applying to have outstanding infringements addressed either by review or revocation on the basis of the person's 'special circumstances'²³ can result in a more lenient outcome, including through a significant reduction in the fine or waiver or complete dismissal. Payment in full is often not a viable option for clients in receipt of Centrelink benefits and a repayment plan may last years and in some circumstances carry the risk of imprisonment for default. Making effective use of the 'special circumstances' provisions to resolve infringements for a represented person (who by default have a

²¹ *Guardianship and Administration Act 1986* (Vic) s 58B.

²² See, eg, Victoria Legal Aid, *Vulnerable People and Fines* (2013) (<https://www.legalaid.vic.gov.au/sites/www.legalaid.vic.gov.au/files/vla-vulnerable-people-and-fines-position-paper.doc>).

²³ Defined in section 3 of the *Infringements Act 2006* (Vic) as a mental or intellectual disability, disorder, disease or illness; a serious addiction to drugs, alcohol or a volatile substance; homelessness; or family violence which results in the person being unable to understand or control the offending conduct.

disability) and who very often experience additional social or financial disadvantage is critical. As the NSW Law and Justice Foundation has most recently identified, without proactive assistance, fines systems, including the fines which arise from infringements, uniquely perpetuate and exacerbate a 'vicious cycle' of disadvantage that people with disability (and other particular communities) already experience.²⁴ However, we also know that 'when disadvantaged people do get appropriate assistance for their fines problems, they achieve outcomes on par with others'.²⁵

VLA has acted for clients where State Trustees, instead of pursuing a special circumstances application, established a repayment plan to resolve unpaid fines. For a person on the disability support pension, repayments of \$20 per week can make a significant difference to the person's discretionary income.

In our experience, revocation applications on the basis of a person's 'special circumstances' very often result in a full discharge of the fines, provided the person has strong medical evidence that their disability or mental health condition contributed to the offending.

We have acted for clients for whom State Trustees has paid thousands of dollars in fines rather than pursue a 'special circumstances' application which, although more time-consuming for State Trustees, is far more likely to be cost-effective for the represented person. At times State Trustees administrators have seemed not to understand that such an application is even an option for the represented person, let alone actively pursue it. This is another example of how State Trustees' failure to understand legal frameworks that affect their clients results in detrimental outcomes to the represented person.

Pat's story: Financial hardship from failure to apply for 'special circumstances'

Pat (not the client's real name) has been on an administration order with State Trustees for over six years. She has been diagnosed with a mental health condition and struggled with a significant drug addiction as well as periods of homelessness. Pat is frequently requesting extra money from State Trustees and money is always tight.

Nevertheless, State Trustees have paid over \$2,500 worth of infringements on her behalf over the years, including by way of payment plans. One of the fines was for over \$700, which State Trustees paid in full.

Despite the fact that Pat has experienced all three of the (then) grounds for 'special circumstances' – namely, mental illness, serious addiction to drugs and homelessness – State Trustees did not apply for review of these fines (or revocation of the enforcement orders) on this basis. Indeed, her administrator at the VCAT hearing was adamant that Pat was not eligible to do so. State Trustees' failure to use the available special circumstances provisions to Pat's benefit meant her discretionary income was significantly diminished.

Resolving debts for clients who are 'judgment proof'

Many people on administration orders have at some point encountered debt problems. These debts may be incurred because of non-payment of rent, entering large and unmanageable credit contracts or loans, or civil action taken against a person, which the person is unable to resolve or repay. Their

²⁴ S Wei, Z, McDonald, HM and Coumarelos C, 2018, *Fines: are disadvantaged people at a disadvantage?*, Justice issues paper 27, Law and Justice Foundation of NSW, Sydney (<http://www.lawfoundation.net.au/ljf/app/&id=D5D375991CE8E1B68525823A000641F4>).

²⁵ Ibid.

disability or other social or financial disadvantage may mean that they cannot resolve these debts in a timely and cost-effective way.

A common practice by State Trustees is to enter the represented person into a repayment plan. For people on modest incomes, and especially where income is solely derived from Centrelink benefits, the repayment amount can be significant, and will last a long time into the future (potentially the rest of their life). However, at law, where a person's income is solely derived from a social security benefit, and their income and assets fall under the threshold, they will be deemed 'judgment proof'.²⁶ That is, they cannot be forced to pay the debt and have no assets to be seized to satisfy the debt against them. Many clients we see fall into this category. It is evident from the case studies below, however, that State Trustees has been making decisions against the person's best interests by entering repayment plans on debts that are effectively unenforceable.

Failure to pursue waiver of debts causes financial hardship

We have been instructed by some clients that State Trustees have entered into payment plans (eg. for rental arrears) at high rates which cause financial stress, or at a higher repayment rate than may strictly be necessary to maintain their tenancy.

When coupled with a failure to pursue redress mechanisms for debt, such as seeking a waiver on the basis of the client being 'judgment proof', these payment plans can cause financial hardship to clients, as Tran's case below illustrates.

Tran's story: Burdening clients with high debt repayment without seeking waiver

Tran has been diagnosed with a mental illness and had been detained in a psychiatric unit for some years before State Trustees was appointed.

Tran had refused to pay his accommodation fees for the time he had spent in hospital and, whilst the hospital had not actively sought to recover the debt, when State Trustees was appointed, they soon arranged a payment plan of around \$100 per fortnight to pay off the approximately \$15,000 in arrears.

Tran was receiving DSP of around \$900 a fortnight and had little if any savings. He really enjoyed shopping but had very little money left over to do this once his accommodation and other fees were paid by State Trustees. This was frustrating for Tran. When Tran contacted VLA we advocated to State Trustees to seek waiver or reduction of the debt. In response, the hospital agreed to waive the debt and Tran's discretionary spending was able to increase and he could again go shopping and attend outings with his friends.

Without VLA's advocacy, Tran would have been stuck making repayments of a considerable proportion of his income for years to come.

²⁶ *Judgment Debt Recovery Act 1984* (Vic) s 12.

Failure to pursue waiver of debts means lost opportunity and quality of life

Jamie is one of our clients who experienced financial loss, as well as the loss of opportunities to engage in activities which he enjoyed, due to State Trustees not carefully examining his financial responsibilities.

Jamie's story: Failure to seek waiver of debt meant client missed out on cricket and camps

Jamie lives on his own in regional Victoria. He loves playing cricket for the local cricket club and he also has an intellectual disability.

In 2015 a court ordered that Jamie pay a large insurance company \$27,000 in compensation following a car accident where Jamie was driving. State Trustees, who have been Jamie's administrators for over a decade, entered Jamie into a payment plan where he was to pay \$50 a fortnight. That payment plan would require Jamie pay this amount each fortnight until the year 2037.

State Trustees entered Jamie into this payment plan without contacting the insurance company and asking whether they would waive the debt because of Jamie's circumstances. Because Jamie's only income is from the Disability Support Pension and he has no assets he is 'judgment proof'. This means that if the insurance company sought to enforce the debt against Jamie, the court would refuse to make an order forcing Jamie to pay unless he consented to that order.

Jamie was unhappy with being on an administration order and sought advice from VLA through our Legal Help phone line. Jamie and his VLA lawyer read through the State Trustees documents and talked about the payment plan. Jamie's lawyer told him that State Trustees may have been paying this debt unnecessarily.

We contacted State Trustees on his behalf and advised them of their obligations to act in Jamie's best interests, including in relation to this debt. State Trustees took six months from when Jamie's lawyer first brought the payment plan to their attention to stop making the payments and start advocating on Jamie's behalf to have the debt waived.

By the time payments were stopped, Jamie had been making payments for nearly three years. This means over \$3,000 of Jamie's limited income from the Disability Support Pension had been paid to the insurance company by State Trustees over that time. Jamie had missed out on doing things he loved like participating in his local cricket club games and going on camps for people with disabilities during that time because he was not able to afford them.

State Trustees' failure to properly examine our client's financial situation at the earliest opportunity and pursue redress to which he was entitled, meant that he had to miss out on doing things that really mattered to him and that contributed to his rehabilitation and a life in the community.

Failure to notify Centrelink of changes in income

As an administrator, State Trustees is arguably responsible for maximising a represented person's entitlements to social security, consistent with their obligation to act in their best interests.

In our experience, when clients seek assistance with a Disability Support Pension (**DSP**) matter where State Trustees is their administrator, there appear to be issues with State Trustees notifying Centrelink about changes in the client's circumstances. This directly and adversely affects the rate of payment they may be entitled to. We have come across cases where there was such a significant delay in State Trustees notifying Centrelink about income protection payments being

stopped, that our clients received a reduced rate of benefit than what they would have otherwise been entitled to if the notification had been made in a timely way.

The following case study illustrates the damaging impact that such issues can have on our clients. In the most serious cases, such conduct may raise a question about whether a client could be advised to commence a claim for negligence.

Sam's story: Eight month delay in notifying Centrelink caused hardship and distress

Last year, VLA assisted a woman called Sam (not her real name) in relation to her social security debt. Sam has been experiencing long-term mental health issues which impacted her functionality and caused multiple hospital admissions as an involuntary patient. In 2010, she was granted DSP due to her mental illness and in 2011, she was placed under an administration order and State Trustees was appointed to manage her finances.

Sam was also eligible for some income protection payments and received funds in February 2012 (back dated to July 2010). As the Centrelink recipient, Sam had the obligation to inform Centrelink of any change of circumstances within 14 days. However, State Trustees only formally advised Centrelink of these payments after a significant delay of nearly eight months. This notification subsequently led to a significant debt which would have been partially averted or minimised had there been a prompt notification by her administrator.

Internal records of Centrelink expressly stated that the lack of timely action by State Trustees '*could be perceived as negligent and financially abusive and there was no false misrepresentation [by Sam] who had nil capacity herself to update Centrelink with her financial affairs*'. However, Centrelink only waived part of her debt (finding the remainder as arising out of the ordinary operation of income test provisions).

Sam subsequently made a significant recovery and her administration order was revoked in 2014. The ongoing debt caused her significant stress and financial hardship especially as she strongly believed that she was not responsible for the delay by the State Trustees.

Sam had to lodge a further review application at the first tier of the Administrative Appeals Tribunal to make her arguments. VLA assisted her by making written submissions highlighting that her particular circumstances met the high threshold requirement of 'special circumstances' waiver under s 1237AAD of the *Social Security Act 1991* (Cth). The Tribunal agreed to exercise its discretion and waived her debt in full.

Sam is relieved that the saga is finally over.

In our view, these various failures by State Trustees to comply with reporting obligations to Centrelink and pursue effective avenues to resolve unpaid debts and infringements, amount to serious breaches of its obligations to act in the represented person's best interests – both in terms of their finances and their quality of life and wellbeing. Perversely, these failures by State Trustees are examples of precisely the kind of decision-making that VCAT has determined warrant an administrator being appointed. This calls into question the extent to which, in these cases, State Trustees' role as an administrator was in fact a benefit to the represented person.

Recommendation 3: Understanding the legal frameworks that determine the represented person's rights and responsibilities

To ensure State Trustees understands the legal frameworks that determine the represented person's rights and responsibilities, we recommend:

- State Trustees ensures all staff have the appropriate understanding and skills to advocate for the represented person's legal rights through an application on the basis of 'special circumstances' or other available mechanisms to resolve infringements (including newly introduced Work and Development Permits and options for victims of family violence).
- State Trustees establishes internal policies to ensure a waiver or reduction of any outstanding debts is requested as a matter of course for all eligible represented persons and this is applied consistently regardless of the debt, where they are 'judgment proof'.
- State Trustees develops and implements policies and processes that ensure compliance with Centrelink notification obligations. This includes notifying Centrelink without delay of any change in a represented person's income (whether employment income, income protection payments or otherwise).
- State Trustees communicates without delay to the represented person:
 - Any change to their income and what action State Trustees is taking to minimise any adverse impacts on the person; and
 - Any action they propose to take to resolve outstanding debts or infringements and clearly explain the process and likely outcome.

6. Improving responsiveness, appropriateness and accessibility of services

Supporting represented persons to understand the order and their rights

For many of our clients, the imposition of an administration order occurs in the context of a crisis of some kind which impacts on their ability to manage their finances. This includes, for example, an acute episode of psychosis resulting in a person falling behind in their bills and a prolonged admission to hospital, or the death of a family member who had previously been supporting a person with an intellectual disability to manage their day-to-day expenses. The current legislative regime is particularly disempowering as it does not require the (proposed) represented person to be given information prior to their hearing, or provide incentives for them to attend.

VLA has come across many cases where the applicant social worker from the hospital has, mistakenly, advised the person that an administration order will be put in place for a limited period until the person's finances are back on track (eg utilities debt or rent arrears paid off and the order will be cancelled once they are discharged). This is a mischaracterisation of what are effectively indefinite orders and the person is left frustrated by the reality of the situation – that it is often more difficult to have the order revoked than to contest it being made in the first place.

As a result, many people are left in the dark about what an order means, the reasons it was sought and/or ultimately made, what State Trustees are in fact doing on their behalf, and their rights.

This is in stark contrast to other substitute decision-making regimes such as the *Mental Health Act 2014* (Vic) which has far stronger positive obligations on the person applying for the order (the psychiatrist) to provide reports and information prior to the hearing,²⁷ as well as information about decisions being made on their behalf.²⁸

Responsive and accessible administrators

A common complaint from our clients is that State Trustees administrators are unresponsive and often inaccessible and that the system of ‘pooled’ administrators results in decisions that are not individualised or consistent.

Our clients instruct they have excessively long wait times when they call to speak with their administrator and when they do finally get through to speak with someone, it is frequently a different person who does not know about them or their case.

Despite the fact that State Trustees routinely advises that they will respond to emails within 10 business days, this is rarely the case and multiple follow-ups are required. Other times, clients complain they received no response to their written communication.

For our clients – many of whom have complex needs in addition to their disability – this causes unnecessary frustration and stress.

Tom’s case highlights the unnecessary stress and distress our clients experience due to State Trustees’ lack of responsiveness and failure to take necessary proactive steps. It is one example of what clients instruct is an all too common impersonalised, inflexible system.

Tom’s story: Failure to follow up letters of demand for over four months

Tom (not his real name) has been on an administration order since 2013 with a stated disability of hoarding. Tom resides in supported elderly accommodation, renting out two storage containers for the remainder of his possessions. The storage container invoices are paid by State Trustees. In around May this year Tom told VLA he had concerns one of storage facilities was not being paid as he had received letters from a debt collector demanding \$5,000 for apparently unpaid storage fees.

Tom had not heard from State Trustees in months. He had tried to visit the State Trustees’ office but this had moved since last time he was there. Although he does not have a personal phone, his VLA lawyer had no trouble making phone appointments ahead of time with staff at his accommodation. Tom has attended these phone appointments promptly without fail.

VLA contacted State Trustees on Tom’s behalf to follow up both issues – his possessions from the storage facility and the letters of demand. The administrator confirmed that the storage facility had been closed in around July 2017 because State Trustees deemed it was not financially viable for Tom to have two storage units. The financial consultant did not know if Tom had been consulted regarding this decision or where his possessions had gone. We asked State Trustees to contact Tom directly about the letters of demand.

After following up with State Trustees by email and phone for several months, VLA was told in mid-September, that Tom had in fact been consulted last year regarding the closure of his storage facility and had agreed that his possessions be sold or donated. State Trustees had not done anything about the letters of demand – they claimed they were waiting for VLA to send the letters through.

²⁷ *Mental Health Act 2014* (Vic) s 191.

²⁸ *Mental Health Act 2014* (Vic) ss 68, 69, 71(3) and (4).

We stressed it was State Trustees' obligation to resolve this as Tom's administrator and yet they had made no effort to contact either Tom or the storage facility. Tom's diagnosis of hoarding means that maintenance and storage of his possessions is particularly important to him and State Trustees' conduct has added to his distress.

The debt collection issue remains unresolved after more than four months.

Tom's case highlights the inaccessibility, uncertainty and lack of responsiveness of State Trustees. Represented persons very often already have their own challenges (recognised by the making of the relevant administration order) with executing follow-up decision-making and marshaling information, and for people with disabilities and complex needs, the impact of poor practice by their administrators can be significant.

Keeping the represented person informed

We are frequently instructed by clients that they have difficulty obtaining information about their accounts from State Trustees, including a statement of account and their fortnightly budget prepared by State Trustees. VLA lawyers have also experienced considerable delays (up to months in some cases) when we have requested this information from State Trustees.

When a person's financial affairs are taken out of their control, this can cause considerable frustration and distress. This is compounded when the person has difficulty accessing information about their finances and what is being done with their money. Failure to provide this information and in a timely way also impedes the person's ability to understand financial decisions that are being made on their behalf. It also risks adversely impacting a person's financial literacy and their autonomy by discouraging rather than encouraging informed participation in decision-making.

'Pooled' administrator system – impersonal, inconsistent and ineffective

Another common issue shared by our clients is the uncertainty caused by State Trustees' move to having 'pooled' administrators instead of the previous practice of allocating specific administrators to clients. This causes further frustration to clients as they are left to speak to someone who they have no personal relationship with and who has no (or only limited) first-hand knowledge of the client's circumstances.

Siobhan's story: Impersonal and inconsistent decision-making

VLA's client, Siobhan (not her real name) said she was much happier with the old system, before State Trustees pooled their administrators. Siobhan, who has a mild intellectual disability, says she found it much easier speaking to one person instead of now just "speaking to anyone". Siobhan finds it confusing as with the pooled administrator system they do not know anything about her and she has to continually re-tell her story.

Siobhan also receives different answers to her requests for funds, depending who answers her telephone call. For example, she wanted funding to get a tattoo for her birthday. In one telephone call she was told funding had been approved, and in a later telephone call with a different administrator, she was told the opposite and the money had not been approved.

Clients like Siobhan also tell us they have less understanding or control over how their money is budgeted because they no longer have an individual case manager at State Trustees. This can

result in less meaningful consultation with, and participation by, the person in decisions that affect them. Jamie was also in this situation.

Jamie's story: Frustration at lack of individual case management

Jamie lives on his own in regional Victoria. He loves playing cricket for the local cricket club and he also has an intellectual disability. Part of Jamie's story is outlined above in part 5.

Jamie's finances have been managed by State Trustees under an administration order for over a decade. Jamie used to have a case manager who managed his budget for him. They met on a regular basis and his case manager explained to Jamie what his money was being spent on, what bills were being paid and what he was saving.

Since State Trustees has moved to a system of pooled administrators Jamie no longer has one single person he can discuss his financial situation with. Jamie now does not feel he understands where his money is going and is confused by how State Trustees budget for him.

Apart from having less understanding about how his money is spent, Jamie also gets really frustrated that each time he calls State Trustees he speaks to someone who does not know him or his case. He must explain his situation to a new person each time he calls.

Jamie finds being an administration order a frustrating experience and would prefer to have management of his own funds. Previously his case manager regularly included him in discussions and if they refused a request for additional funds they explained why they made that decision. This made it much easier for Jamie to accept and understand and made Jamie feel he had some autonomy over his finances. The pooled administrators model means that the small amount of autonomy Jamie felt is now gone.

Recommendation 4: Improving the responsiveness, appropriateness and accessibility of services

To ensure that State Trustees improves the responsiveness, appropriateness and accessibility of services to represented persons, we recommend:

- State Trustees develops robust guidelines for communicating with and consulting the represented person in a timely way on all decisions.
- State Trustees removes the 'pooled' system of administrators and reverts to a system where individual administrators are allocated to a represented person.
- State Trustees ensures that phone calls and written communication and correspondence by or on behalf of the represented person are responded to in a timely way. This can be achieved by development and strict implementation of policies and prescribed timeframes.
- State Trustees employs adequate numbers of skilled staff to respond in a timely manner to calls by the represented person.
- State Trustees monitors staff caseload to ensure the administrator responsible knows the represented person's circumstances and can offer meaningful opportunities to consult and participate in decisions.
- State Trustees has regular in-person appointments with a represented person to discuss budget and finances – at least once per year.

7. Making VCAT and the review process a meaningful safeguard

As previously outlined, the appointment of an administrator has significant ramifications for a person's autonomy and it is therefore imperative to have effective safeguards in relation to the making (and continuation) of orders as well as the exercise of powers by the administrator pursuant to such orders. Currently, VCAT is effectively the only accessible safeguard for represented persons against broad and prolonged loss of independence. However, we see through our work that this mechanism is not working as it should.

Reassessments every three years is not best practice

The Act does not require administration orders to be time-limited – they are effectively indefinite orders. We often see clients who have been placed on an administration order in the context of an acute episode of mental illness, who are then maintained on the order for many years without any up-to-date evidence establishing that the criteria for an order continue to be met. In practice, once a person is made subject to an order, VCAT places an onus on the represented person to provide (usually expert, medical) evidence that the criteria no longer apply to them. This is, in effect, a reversal of the onus of proof required for the making of an order.

This is particularly problematic for people diagnosed with a condition that can fluctuate, like mental illness, whose circumstances may have changed markedly since the initial hearing. This undermines a safeguard that is critical to ensuring the order is still necessary. The lack of any need to re-establish the necessity of the order, combined with the current ability to make indefinite orders, also removes pressure from VCAT or any other oversight body to 'check in' regularly on State Trustees. In practice, administration orders are rarely reassessed more frequently than the statutorily required minimum three-year period and, as the case study of Paul's in part 3 above demonstrates, VCAT is not a consistently effective oversight mechanism in practice at these reassessment hearings.

Indefinite orders are not best practice or consistent with human rights principles

The Act is silent on consequences for VCAT's failure to reassess an order within the three-year period. A similar scheme (including indefinite restrictive orders with tribunal review obligations under the previous *Mental Health Act 1986* (Vic)) in the context of mental health orders was the subject of detailed scrutiny in the case of *Kracke*,²⁹ including in relation to whether that scheme was compatible with the human rights obligations under the Charter.

In that case, Justice Bell found that, notwithstanding the Tribunal's review obligation in the legislation, Mr Kracke's involuntary treatment order was not invalid. Critically, in this case, the order was valid because oversight of the tribunal was only one of a number of safeguards in the legislation, including regular review by Mr Kracke's psychiatrist.

For administration orders however, there is no 'psychiatrist' equivalent to provide that safeguard.

²⁹ *Kracke v Mental Health Review Board & Ors* (General) [2009] VCAT 646. April 2009.

Arguably, this places a greater onus on public authorities like State Trustees to take a more assertive role in ensuring orders are only continued where necessary and supporting a person at reassessments by VCAT.

We also note that, since the *Kracke* decision, the ability to make indefinite orders has been removed from the relevant mental health legislation.

Participation of the (proposed) represented person at a hearing

The current Act provides no incentive for VCAT to prioritise the represented person’s participation in a hearing before a decision is made to restrict their decision-making autonomy. Unlike the Mental Health Tribunal for example, VCAT does not report on the attendance rates of represented persons at administration order hearings, or on the proportion of reassessment hearings that take place ‘on the papers’ without a hearing.³⁰

We come across many clients who were not present at the hearing at which the order was made, sometimes because they were detained in hospital for mental health treatment following an acute crisis. Many clients we assist are under the mistaken apprehension that an administration order cannot be made against them if they do not attend the hearing.

We note that a key priority in VCAT’s Accessibility Action Plan 2018-2022 relates to VCAT services and the community. The core objectives related to this priority include:

- “hearings are fully inclusive and accessible for people with disability” and
- “promote the inclusion and participation at VCAT of people with disability.”³¹

However, we are frequently instructed by clients (all of whom have been deemed to have a disability) that they were unable to participate in the VCAT hearing of the application or at subsequent reassessments, either because they were unaware of the hearing, they did not receive their notice with sufficient time, they couldn’t open the notice when it arrived, or they did not receive sufficient support to attend or otherwise participate in the hearing.

VCAT process on a reassessment

Reassessments comprise the majority of cases before VCAT in the Guardianship List³² and our experience is that more needs to be done to improve the process at VCAT.

It is our understanding that VCAT considers it sufficient to send a proforma letter to the last known address of the represented person, but not to make any further inquiry. Unless a hearing is specifically requested, we understand that VCAT would often conduct a reassessment ‘on the papers’.

Ahmed’s story: Order confirmed ‘on the papers’ without VCAT opening the file

VLA represented Ahmed at a reassessment of his administration order which the client himself had requested. The Member adjourned the matter to deliberate as the issues were complex.

³⁰ See Victorian Civil and Administrative Tribunal, *VCAT Annual Report 2017*; Mental Health Tribunal, *Annual Report 2017* 29

³¹ Victorian Civil and Administrative Tribunal, *Accessibility Action Plan 2018-2022* (<https://www.vcat.vic.gov.au/sites/default/files/resources/VCAT-Accessibility-Action-Plan-2018-2022.pdf>).

³² Victorian Civil and Administrative Tribunal, *VCAT Annual Report 2017* 49 indicates that, of the 13,896 cases that originated regarding making or reassessing guardianship or administration orders, over half (7,177) involved reassessments (<https://www.vcat.vic.gov.au/sites/default/files/resources/annual-report-2016-17.pdf>).

In the course of waiting for a decision on Ahmed’s proactive reassessment application, an ‘automatic’ (three-yearly) reassessment of the order took place ‘on the papers’ and the administration order was confirmed.

Assuming that VCAT had recorded or filed the proactive reassessment application material, VCAT’s conduct in this case suggests that the Member who conducted the ‘automatic’ reassessment on the papers had done so without looking at the file. Alternatively, it indicates that there is either (a) no rigorous process which accompanies automatic reassessment including checking any outstanding unresolved proactive reassessment hearings or (b) that the presence of an unresolved, complex reassessment application was not considered relevant to whether the order should be automatically confirmed without the appearance of the represented person.

We have also seen cases where clients’ administration orders have been reassessed and confirmed ‘on the papers’ despite an apparent lack of evidence that the criteria continue to apply. In other cases, orders are confirmed on the papers where there is medical or lay evidence before the Member that suggests the person may have regained their capacity. In either case, arguably, further inquiries should have been made to include the represented person and conduct a hearing to consider more closely if the criteria are met.

We welcome the inclusion of provisions in the new Bill which place a greater onus on VCAT to involve the person in a hearing (including being satisfied of certain matters before hearing an application in the person’s absence) and to take ‘reasonable steps’ to contact the person before a reassessment.³³

Represented person seeking advice or other determination from VCAT

If a represented person is concerned that the administrator is acting beyond power, their only option currently is seeking judicial review in the Supreme Court (coupled with an urgent interlocutory injunction) which is very often prohibitively time-consuming, expensive and complex.

By contrast, the Act currently has provision for guardians and administrators to seek the advice of VCAT under s 55 as to the scope of the relevant order or the exercise of powers under the order.

Similarly, s 56, entitled ‘application... by a creditor [etc]’ enables a broad range of people³⁴ to apply to VCAT ‘upon any matter arising out of the administration of the estate by the administrator’ and VCAT has broad discretion to make orders ‘as the circumstances of the case may require’.

It is unclear whether the represented person themselves can apply for advice or an order, as the case may be, under these provisions.

³³ Guardianship and Administration Bill 2018 (Vic) cls 29 and 165(2)(a).

³⁴ Including ‘any person interested as a creditor, beneficiary, next of kin, guardian, nearest relative, primary care or the Public Advocate or otherwise in any estate administered by an administrator’.

Recommendation 5: Making VCAT and the review process a meaningful safeguard

To make the Victorian Civil and Administrative Tribunal (**VCAT**) and the review process a meaningful safeguard and to encourage better practice by State Trustees, we recommend that:

- The Ombudsman investigates the most effective and accessible redress mechanisms for represented persons where State Trustees is not acting in their ‘best interests’.
- VCAT adopt the following practices:
 - Ordinarily making orders for a fixed duration of a maximum of three years, with an ability for the administrator to apply for a further order prior to expiry. In determining the order’s duration VCAT must consider the nature of the person’s disability (eg. whether fluctuating or degenerative) and the likelihood of the person regaining their capacity or their circumstances changing (eg. when an appointment is made for a person with a mental illness during an acute period of hospitalisation);
 - If making an indefinite order, VCAT should exercise its discretion to nominate a date for reassessment in such a way that is consistent with human rights. For example, if a person is likely to regain decision-making capacity in a short period, then VCAT should consider a shorter reassessment period;
 - At a reassessment VCAT should not continue an administration order unless satisfied on the evidence before it that the criteria continue to apply;
 - VCAT and the Guardianship List Registry allow applications by the represented person themselves about the scope or powers under the administration order, or a matter arising out of the administration of the person’s affairs, pursuant to ss 55 or 56 of the *Guardianship and Administration Act 1986* (Vic) (**Act**) respectively; and
 - VCAT and the Guardianship List Registry take steps to maximise the participation of (proposed) represented persons in hearings (whether an initial application, rehearing or reassessment), including measurable targets for participation rates, and reports on those rates.

8. Building a workforce and culture that can bring the principles and protections in the current and new Acts to life

We know from our work with clients around the 2014 reforms to the *Mental Health Act 2014* (Vic) that, even with progressive legislation focussed on safeguards, autonomy and promotion of a person’s rights, the reforms will not lead to substantive change in conduct if the actors or agencies with power under the law are not willing or equipped to comply with their obligations. Likewise, without effective accountability mechanisms for exercise of coercive or restrictive powers, there is little to guarantee that restrictions imposed are those which would least restrict people’s rights.

Complying with existing principles and striving for evidence-based best practice

As our case studies throughout this report illustrate, there are concerns that the culture of State Trustees and the skills of its administrators do not promote consistency in consulting with the

represented person, rigorously pursuing their rights and entitlements or supporting their autonomy and participation in decision-making.

As a public authority, State Trustees must do more to ensure its administrators have the skills and training to ensure the rights of represented persons are promoted and that, for each decision, their freedom of decision and action is restricted only to the extent necessary in the circumstances.

State Trustees must improve its workforce and culture to bring it in line with the Act. Failing to do so will mean it is not only breaching its obligations under the current Act, but also that it will be unable to meet the requirements proposed in the new Bill which reflect a stronger focus on the rights and dignity of people with disabilities.

Existing standards must reflect human rights norms

State Trustees' annual report³⁵ states that it follows the Australian Guardianship and Administration Council National Standards for Financial Managers³⁶ (**the Standards**). The Standards relate to providing the client with information, ensuring client views and involvement are taken into consideration and protecting and respecting the client's legal rights. They are dated 2010 and, in our view, do not go far enough to provide sufficient guidance for State Trustees to meet their obligations even under the current Act.

There is no reporting on what measures State Trustees takes to ensure its personal financial administrators are in fact complying with the Standards and skilled in best-practice.

By contrast, the comparative standards for guardianship (the National Standards of Public Guardianship) are dated 2016 and, as we have outlined above, contain better rights protections.

Recommendation 6: Building a workforce and culture that can bring the principles and protections in the current and new Acts to life

In order to build a workforce and culture that can bring the principles and protections in the current Act and any new Acts to life, we recommend:

- Updated minimum standards for administrators that accurately reflect a rights-based approach to decision-making and training for all State Trustees staff to embed them in practice.
- State Trustees adopts a policy that all administrators embed the principles of the Act into their day-to-day decision-making for represented persons, including:
 - Regular and meaningful consultation with the represented person; and
 - Giving effect to the represented person's will and preferences and only overriding this where their views can't be ascertained and where it is necessary to prevent serious harm to the person themselves.
- These policies are updated if there are changes to the Act to bring them into line with newly applicable human rights norms.
- State Trustees monitors its compliance with the standards, develops protocols for remedying breaches and undertakes regular reporting.

³⁵ State Trustees, *Annual Report 2017: People Protecting People* (<https://www.statetrustees.com.au/wp-content/uploads/2015/03/State-Trustees-Limited-Annual-Report-2017-2209.pdf>) 34.

³⁶ *National Standards for Financial Managers*, above n 20.

Annexure 5

The NDIS: Six priority issues and models that are working well

Submission to the Joint Standing Committee on the National Disability Insurance Scheme: Inquiry into general issues around the implementation and performance of the NDIS

March 2019

Overview

Victoria Legal Aid (**VLA**) welcomes the opportunity to contribute to the Joint Standing Committee on the National Disability Insurance Scheme's *Inquiry into general issues around the implementation and performance of the NDIS*.

Informed by our work with clients with disability across Victoria, we identify six priority issues with the implementation and operation of the NDIS:

1. 'Market failure', 'thin markets' and the 'maintaining critical supports' project or 'provider of last resort'.
2. Plans and supports that do not adequately meet people's needs.
3. Interface issues and lack of service coordination.
4. Delay in updating the Operational Guideline on Transport in response to the Federal Court decision in *McGarrigle*.
5. Discharge and release planning.
6. Conduct of the NDIA as a model litigant in the Administrative Appeals Tribunal (**AAT**).

In addition, we have highlighted models that are working well in the hope that these models can be invested in, maintained and replicated.

Ultimately, VLA hopes to work with other agencies and organisations toward these five outcomes:

1. Victorians have access to tailored, appropriate NDIS plans that improve their lives and wellbeing.
2. There are reliable, engaged and expert services to provide supports funded under the NDIS, and clear responsibility for making sure people get the services they are funded to receive.
3. Legal and social support sectors are equipped to understand the NDIS and make it work for the people we work with.
4. The NDIS supports people to live independently in the community, avoid interaction with the justice system and build pathways out of restrictive environments, including mental health services and prisons.
5. The NDIS works effectively with mainstream health, justice, housing and transport services.

We look forward to continuing to work with the National Disability Insurance Agency (**NDIA**), the Victorian and Federal Governments and our partners in the community and legal assistance sectors to make the NDIS – and related systems – work as well as possible for our clients and consumers.

Victoria Legal Aid, our clients and the NDIS

VLA is an independent statutory agency responsible for providing information, advice and assistance in response to a broad range of legal problems. Working alongside our partners in the private profession and community legal centres, we help people with legal problems such as criminal matters, family separation, child protection, family violence, fines, social security, mental health, immigration, discrimination, guardianship and administration, tenancy and debt.

Our Legal Help telephone line is a resource for all Victorians to seek information, advice and assistance with legal problems. We also deliver specialist non-legal services, including our Family Dispute Resolution Service and our Independent Mental Health Advocacy, as well as providing community legal education, and contributing to policy and law reform.

VLA and our work with people with disability

VLA is the largest provider of legal services to people with disability in Victoria. During 2017–18, VLA helped 94,485 unique clients: 26% disclosed having a disability or mental health issue and 11% were in custody, detention or psychiatric care.¹

We offer a specialist legal service which provides advice and representation at courts, tribunals and psychiatric hospitals for people with disabilities and mental health conditions.

We receive funding from the Department of Social Services to provide legal representation in NDIS matters on review at the AAT. Since 2013, we have provided legal representation to over 100 people with NDIS AAT appeals in ‘novel or complex’ matters.

In addition, through our work across criminal law, child protection, tenancy and family law, we see the flow-on effects when our disability services systems, including the NDIS, are not working at their best.

VLA and the NDIS

We consider the NDIS holds great promise for our clients and we will continue to work closely with the NDIA and the Victorian and Federal Governments to help make the NDIS work at its best.²

We also see through our work that when the NDIS is not working as intended, the consequences for individuals and for the State and Federal Governments can be serious, including extended detention in mental health services, prolonged custody without conviction, inability to obtain bail or parole, homelessness, deterioration in health, increased risk of re-offending and family breakdown (including through the child protection system).

We continue to see the need for a framework of NDIS service provision and accountability that makes sure people receive the supports and services they need, and that provides an established process for when supports fail.

¹ See Victoria Legal Aid, *Annual Report 2017–18* (available at: <https://www.legalaid.vic.gov.au/about-us/our-organisation/annual-report-2017-18>). This includes clients seen by a private practitioner duty lawyer. Unique clients are individual clients who accessed one or more of Victoria Legal Aid's legal services. This does not include people for whom a client-lawyer relationship was not formed, who received telephone, website or in-person information at court or at public counters, or participated in community legal education—we do not create an individual client record for these people. Neither does this client count include people assisted by our Independent Mental Health Advocacy service. We note that, because this figure relies on clients disclosing their disability or mental health issue at the time of receiving legal assistance, the actual number of clients experiencing disability or mental health issues is likely to be significantly higher.

² See, eg, Victoria Legal Aid submissions to: this Committee's *Inquiry into market readiness of the National Disability Insurance Scheme* (March 2018) and *Inquiry into transitional arrangements for the NDIS and into general issues around the implementation and performance of the NDIS* (November 2017); Productivity Commission's *Inquiry into the National Disability Insurance Scheme Costs* (July 2017) (available at: <https://www.legalaid.vic.gov.au/about-us/strategic-advocacy-and-law-reform/access-to-justice-for-people-with-mental-illness-and-disability>).

Six priority issues

This short submission sets out six key issues with the operation and implementation of the NDIS that we continue to see through our work.

A theme that arises in each of issues 1, 3 and 5 below is the lack of systemic coordination i.e. no-one holding the matter and navigating the system, particularly for people who face additional barriers to doing that themselves. Similarly, with the points we raise about what is working well, in both cases it relates to skilled coordination by someone with a strong knowledge of the system.

1. 'Market failure', 'thin markets' and the 'maintaining critical supports' project or 'provider of last resort'

We continue to see the consequences of 'market failure' or 'thin markets' for our clients – particularly people with complex needs and people in regional areas – where service providers are not ready, willing or able to provide the services and supports a person needs to live well and safely in the community.

We have heard repeatedly that the 'maintaining critical supports' project and/or 'provider of last resort' (PLR) framework will be released shortly, but we have not yet seen this. The absence of this framework means 'market failure' and 'thin markets' continue to contribute to our clients falling through gaps, including offending, imprisonment, inability to get bail or parole, housing insecurity, inability to be discharged from secure mental health facilities and child removal.

This Committee's 'Market Readiness Report' recommended that 'the NDIA publicly release the outcomes of the Maintaining Critical Supports project and its policy on provider of last resort (PLR) arrangements as a matter of urgency' (recommendation 24) in September 2018. This is the third time that this Committee has highlighted that the publication and implementation of a PLR arrangement (or similar framework) is necessary.³ These remarks have been echoed by the Productivity Commission, the Australian National Audit Office and in the McKinsey & Company Independent Pricing Review.⁴

Despite this, there is still no enforceable obligation on any government body to ensure that an NDIS participant receives their funded supports.

The damage being caused through this deficiency is difficult to overstate. By way of example, in our client Francis's case, in granting him bail after he had spent 180 days in jail because his NDIS accommodation and supports failed, Justice Lasry said:

'He's in 23-hour lockdown at Melbourne Assessment Prison. I can't imagine a worse place for him. The longer he is there the more he will be damaged. Who knows what damage has been done already?'⁵

We reiterate the urgent need for a planned, reliable and engaged framework of expert assistance, with accountability and real safeguards built in.⁶

³ Joint Standing Committee on the NDIS, *Report on Transition Arrangements for the NDIS* (2018) and *Report on Provision of services under the NDIS for people with psychosocial disabilities related to a mental health condition* (2017).

⁴ See, Productivity Commission, *National Disability Insurance Scheme – Costs* (2017) 36; Australian National Audit Office, *National Disability Insurance Scheme—Management of the Transition of the Disability Services Market* (2016–2017) 27; McKinsey & Company, *Independent Pricing Review*, Final Report (2018) (see especially 59 onwards).

⁵ Emma Younger, 'Man with intellectual disability released from Melbourne prison after judge 'horrified' by conditions' (24 November 2017) (available at: <https://www.abc.net.au/news/2017-11-24/judge-releases-man-with-autism-from-melbourne-jail/9186352>); 'Emergency intervention removes disabled young man from prison' 7.30 (9 November 2017) (available at: <https://www.abc.net.au/7.30/emergency-intervention-removes-disabled-young-man/9135942>).

⁶ For more information on VLA's recommendations regarding market failure see Victoria Legal Aid, *Explainer – the NDIS and the need for a provider of last resort* (November 2017) (available at: <https://www.legalaid.vic.gov.au/about-us/news/explainer-ndis-and-need-for-provider-of-last-resort>).

2. Plans and supports that do not adequately meet people's needs

Where people with disability do not have skilled assistance to apply for the NDIS and assess supports, the funded services they receive may not adequately respond to the person's needs.

By way of example, we have worked with a number of clients with complex support needs, including as a result of intellectual disability, autism spectrum disorder or psychosocial disability, combined with experiences of homelessness and offending, who have received plans that cover only activities such as weekly bowling or cooking, rather than more intensive core supports.

In John's case,⁷ his plan initially included nine hours of core supports, which were largely consumed with taking John to multiple weekly appointments. With these more limited supports, he committed further offences and was taken into custody.

After his plan was reviewed by a worker with greater experience and skill in relation to John's disability, his NDIS funding was increased to cover more intensive services, including 24/7 support.

John: Inadequate supports contributed to offending

John has an ABI and schizophrenia, and his disabilities have contributed to past substance abuse, lack of employment, and limited community engagement. He has a history of offending, most commonly at the lower level. His disabilities have a significant impact on John's everyday functioning. His housing has been unstable, and his behaviours of concern make his housing options limited. John has been most successful in retaining accommodation and reducing recidivism when he has received consistent supports both at his accommodation and during outreach.

In John's case, however, his NDIS plan initially included only nine hours per week of core supports for him, which were absorbed by taking John to and from multiple weekly appointments. This necessary use of his support funding meant that his support provider did not provide support for John to engage in daily activities of his choice or interest, or provide opportunities for him to be active and safe in the community.

With these more limited supports, he committed further offences and was taken into custody. John's existing plan was ultimately considered by a specialist support coordinator with established expertise working with people with complex needs. In addition, John's case was escalated to the Intensive Support Team, which is a Victorian Government team that intervenes to respond to crises on a referral-in model (see below). Ultimately, John's support coordinator and DHHS liaised with the NDIA regarding a necessary plan review given the acknowledged insufficiency of John's plan.

After a series of significant delays, resulting in John's continued remand in custody, his plan was reviewed and his supports increased to provide 24/7 support for him in his home. These supports made an innovative shared accommodation option feasible for John in circumstances where previously his disability had made shared accommodation options impossible to maintain.

Recognising the potential benefits of effective planning for participants with complex support needs, we welcome the commencement of the Complex Support Needs Pathway and look forward to working with the specialised planners and skilled support coordinators in the Brimbank-Melton and Western Melbourne areas (although we note that these remedial factors currently have limited scope).⁸

The capacity to equip and resource skilled planning that facilitates supports that are appropriate to the particular person and their needs is critical to the effectiveness of the NDIS.

⁷ Not his real name.

⁸ NDIS, 'Improved NDIS planning for people with complex support needs' (16 November 2018) (available at: <https://www.ndis.gov.au/news/1002-improved-ndis-planning-people-complex-support-needs>).

3. Interface issues and lack of service coordination

The uncertainty regarding the NDIS/mainstream service interface is contributing to a lack of responsibility for applying for supports, and obtaining those supports and accommodation to assist people to exit prison, be discharged from inpatient units, maintain their housing and maintain care of their children with disability.

At VLA, across a range of restrictive contexts, we are seeing these issues arise for clients whose complex support needs arise at the NDIS/mainstream interface.

One client, Sam, was recently the subject of a story in *The Age*.⁹

Sam: Young man in an acute psychiatric ward because he's at the interface of the NDIS and mainstream systems

Sam has spent over two years in an acute psychiatric ward of a public mental health service, despite not requiring inpatient treatment. Sam has Huntington's disease – a neurodegenerative disease which is terminal and can lead to complex support needs and behaviours of concern.

His successful discharge from the health service relies on a delicate balance of housing and supports, which span across NDIS and mainstream services. There are questions, for example, about whether Sam is eligible for Specialist Disability Accommodation (SDA) funding, and what packages of State-based and Federal funding could be combined to build durable housing and support options for him.

For over two years Sam has been confined to the restrictive environment which is not designed for his care because he does not have housing, is not funded to receive SDA (meaning that neither State nor Federal options are realistically available), and has not been the subject of any overarching consideration of what supports could be provided across the NDIS/mainstream interface to create a pathway out of the psychiatric ward.

Recently, VLA escalated Sam's case to the Intensive Support Team. *The Age* reported that the Victorian Minister has 'directed the department to prioritise finding suitable accommodation options' for Sam. It was also reported that the NDIA reiterated that state and territory governments remain responsible for providing affordable and accessible housing to the community, including people with disability.

VLA is also witnessing intractable issues at the justice interface in the prison context. In John's case (above), interface issues compounded a range of other systemic issues, including chronic delay, and jeopardised his exit from custody.

The NDIA should adopt a measured approach to interface issues, based on past decisions and clear lines of responsibility between State and Federal agencies.

While we appreciate that novel issues may arise at the State/Federal interface, at present we see that NDIS participants are themselves left to navigate this tension, rather than government agencies working together to join up the multiple, applicable regimes.

We know that Sam and John's cases are not unique and that a system-wide approach needs to be adopted.

⁹ Miki Perkins, 'We are drowning': Sam doesn't have mental illness, yet he's living in a psych ward' *The Age* (7 March 2019) (available at: <https://www.theage.com.au/national/victoria/we-are-drowning-sam-doesn-t-have-mental-illness-yet-he-s-living-in-a-psych-ward-20190306-p5128a.html>).

4. Delay in updating the Operational Guideline on Transport in response to the Federal Court decision in *McGarrigle*

It has been approximately two years since the Federal Court decision in *McGarrigle v National Disability Insurance Agency* [2017] FCA 308 (**McGarrigle**). However, VLA continues to assist clients in the AAT where the funding amount for transport supports has been determined through application of a fixed cap at the primary and internal review phases by the NDIA.

The Operational Guideline on Transport which informs NDIA decision-makers (as well as participants and their advocates) continues in the same form as before the McGarrigle decisions and refers directly to and applies the erroneous elements of the AAT decision. This practice continues to burden NDIS participants with the (now, technically, resolved) legal uncertainty in relation to the funding of reasonable and necessary supports.

We recommend quickly and accurately embedding the reasoning of Federal Court and AAT decisions regarding transport (as well as other interface issues) in NDIA decision-making. This includes:

- Updating the NDIA Operational Guideline on Transport so that it conforms with the existing law.
- Building clear communication channels and ways of making sure decision-makers and advocates on the ground are aware of these decisions quickly so that the reasoning in AAT and Federal Court decisions starts to simplify the complexity of the NDIS.
- Refraining from relitigating these issues on review in the AAT once they have been authoritatively determined.

5. Discharge and release planning

Discharge and release planning (whether it is from custody, a secure extended care unit (**SECU**) or another restrictive environment) requires earlier engagement and an awareness of the multiple ways that exit from a SECU, custody and remand can happen.

Last year, the Victorian Ombudsman tabled her *Investigation into the imprisonment of a woman found unfit to stand trial* in the Victorian Parliament. She described the imprisonment of a VLA client, a 39-year-old woman with a significant developmental disorder, as ‘the saddest case I have investigated in my time as Ombudsman’.¹⁰ The judge in Rebecca’s case said she might have been sentenced to a month in prison if she had pleaded guilty and been sentenced for the charges. Instead, she was in prison for 18 months. Rebecca would have been released if she had housing and supports in the community. As the Ombudsman said, ‘[s]he remained in prison simply because there was nowhere else for her to go’.¹¹ The NDIS is a potential source of optimism and may be able to help fill some of the gaps in disability accommodation and services. In its current form, however, it has added another layer to an already complex system, and in some cases is exacerbating rather than resolving problems.

We reiterate the importance of planning for a person’s release before their sentence is complete or discharge is imminent so that supports are in place to facilitate successful discharge or release and reduce risk of reoffending or readmission. This may require the funding of supports for transition prior to release.

¹⁰ See, eg, Victorian Ombudsman, *Investigation into the imprisonment of a woman found unfit to stand trial* (October 2018) (available at: <https://www.ombudsman.vic.gov.au/News/Media-Releases/imprisonment-of-woman-found-unfit-to-stand-trial>).

¹¹ *Ibid.*

6. Conduct of the NDIA as a model litigant in the AAT

As a model litigant, the NDIA is required to deal with claims promptly and not cause unnecessary delay. It is required to limit the scope of legal proceedings wherever possible, including by considering alternative dispute resolution and offers of settlement, and making early assessments of prospects of success.¹²

As we outlined in a submission to the statutory review of the AAT last year, we have observed a difference between the obligations set out in the model litigant guidelines, and the conduct of litigation.¹³

Our submission detailed the case of our client Todd.¹⁴

Todd: Unnecessarily protracted proceedings in the AAT for a young boy

Todd was nearly four years old, with autism spectrum disorder, ADHD, a generalised anxiety disorder and a developmental delay. Soon after diagnosis, Todd received NDIS supports. When Todd's plan was renewed 12 months later, his supports were reduced. Todd applied to the NDIA for an internal review of this decision. The NDIA confirmed its original decision. As a result, he applied for a review to the AAT.

Todd had submitted detailed medical evidence at the time of his plan review, at internal review, and at the AAT proceedings. Despite having this material, the NDIA did not make any settlement offer. As a result, VLA prepared and filed Todd's statement of facts, obtained witness statements, funded further expert reports to support Todd's application and arranged for witnesses to attend the hearing.

The day before the scheduled hearing, we received a settlement offer.

A settlement was agreed after business hours that day, under which the NDIA agreed to fund nearly all the supports originally sought by Todd.

The NDIA had failed to make an early assessment of the matter and to keep the costs of litigation to a minimum.

During Todd's litigation, we also saw the NDIA miss deadlines for filing. This led to additional hearings and the use of substantial extra resources, both on VLA's part and for the Tribunal.

We encourage the NDIA to acknowledge the burden created by this conduct both for individuals and for the legal system. We understand these concerns have been brought to the NDIA's attention and that improved processes will be introduced. We recommend that attention should be paid to the essential role of the model litigant guidelines in promoting the good faith, efficient resolution of matters and the benefits this has for all involved.

¹² Appendix B to the Legal Services Directions 2017, made under s 55ZF of the *Judiciary Act* 1903 (Cth) (**Model Litigant Guidelines**).

¹³ Victoria Legal Aid, *On the Merits: Getting important and complex decisions right* (August 2018) (available at: <https://www.legalaid.vic.gov.au/about-us/news/our-submission-to-statutory-review-of-administrative-appeals-tribunal>).

¹⁴ Not his real name.

Models that are working well

Models we see that are working well, which should be continued, invested in and replicated are set out below.

1. Victorian State-based Intensive Support Team – an expert escalation service

This model has been largely successful when VLA has escalated clients in acute crisis to the Intensive Support Team. As John's case (above) highlighted, this model reinserts an accountability and whole-of-government (State and NDIA) coordination piece into the puzzle and enhances the skills of the multiple bodies engaging with the person.

It is not clear whether this service will continue post-transition and, in our view, it should (whether resourced and coordinated at the State or Federal level).

We also note that this mechanism continues to be ad hoc, based on case-by-case escalation. We reiterate that a systematised and efficient approach for people with complex needs at the interface NDIS and mainstream systems needs to be put in place and promoted.

2. Small number of innovative, specialist support coordinators emerging

In our view, for clients with complex needs and behaviours of concern, innovative, specialist support coordinators are an essential part of the NDIS regime. VLA clients have been directly assisted by the capacity of skilled and experienced case managers to problem-solve complex cases and think creatively about supports. Such specialised services are essential to ensure that those who have complex needs and can't advocate for themselves do not become subject to a second tier NDIS that entrenches disadvantage. For this reason, we would suggest that support coordination should not be seen as merely an initial or introductory requirement for those with complex needs, but is recognised as the foundation that keeps other supports in place, either until they are clearly established, or ongoing.

In this context, we are concerned to learn of cases where support coordination is being reduced or removed for clients at plan reviews, including those with complex needs.

We are pleased to have been able to contribute evidence from our casework to the Committee's inquiry, including the stories of five of our clients. We look forward to continuing to work with the NDIA, the Victorian and Federal Governments and our partners in the community and legal assistance sectors to resolve these priority issues and maximise the potential of the NDIS for our clients and the community.

Annexure 6



Change the Culture, Change the System:

Urgent Action needed to
End Sexual Harassment at Work

Change the Culture, Change the System: Urgent Action Needed to End Sexual Harassment at Work

Submission to the Australian Human Rights Commission's National Inquiry into Sexual Harassment in Australian Workplaces

28 February 2019

Key contacts

Rowan McRae
Executive Director
Civil Justice Access and Equity
(03) 9269 0136
Rowan.McRae@vla.vic.gov.au

Melanie Schleiger
Program Manager, Equality Law Program
Civil Justice Access and Equity
(03) 9269 0112
Melanie.Schleiger@vla.vic.gov.au

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Executive Summary

Everyone deserves to feel safe and respected at work and to live free from sexual harassment. Sexual harassment causes significant harm to individuals, workplaces and society. We know what the solutions are, but we need governments and employers to draw the line and implement them. We need strong action to prevent and respond to sexual harassment, and we need it now.

Our recommendations have been informed by our practice experience advising and assisting people who have experienced sexual harassment at work to take legal action. In the last five years, the Victoria Legal Aid Equality Law Program has provided over 6,500 legal advices regarding discrimination matters, including 994 advices about sexual harassment and sex discrimination. Eighty-three percent of the clients we assisted with a workplace sexual harassment complaint were women. This submission includes the deidentified stories of 8 of our clients who we have helped to tell their stories in their own words. Their stories highlight a system that fails both to prevent workplace sexual harassment, and to adequately address it when it does occur. In the words of two of our clients:

“I felt like the process was a battle and afterwards I didn’t have anything left in me to keep pursuing my rights. I felt depleted. I was unable to obtain any outcome and in the end I just let the matter go” (**Fiona**).

“As a result of the harassment, I was diagnosed with depression and I ended my relationship with my boyfriend because I developed a distrust of men. I did not have the emotional resources or social supports needed to go to court and fight my employer, so I settled my claim for a small pay out rather than taking the case further. I felt like there were no consequences for the harasser” (**Alice**).

In addition to the evidence from our legal work, and the insights of our clients, our submission is informed by our research and consultation with leading organisations across the legal, health, community and government sectors. Together, we have worked to make sure our advocacy is informed by best practice and cross-sector perspectives, recognising that sexual harassment is not just a legal issue; sexual harassment is a complex social problem that requires cultural and systemic change.¹

A flawed regulatory framework that burdens the victim, lacks transparency and fails to prevent sexual harassment

Sexual harassment is experienced by a far greater number of women than men and is often tied to gender inequality at work. Below we outline our practice experience of the drivers and impact of sexual harassment in the workplace.

Through our work, we see the failure of our laws and regulators to address these cultural and systemic drivers of sexual harassment. We see the failure of our laws to require employers to take steps to prevent sexual harassment at work. We also see the inability of our individual

¹ Victoria Legal Aid has facilitated a high degree of collaboration and consultation with key organisations in the legal and community sectors regarding sexual harassment reform. We organized a Roundtable in November 2018 and a full day Forum in January 2019 in Victoria. Attendees included women’s health and advocacy organisations, regulators, unions, lawyers, and academics. As a result of this work a [Joint Statement](#) has been developed which highlights five key areas for reform and has been endorsed by over 100 organisations and individuals as at 28 February.

complaints system to create sexual harassment-free workplaces. We see the barriers to individuals enforcing their rights by making a complaint, the lack of consequences for employers and perpetrators, and how rarely an individual complaint results in workplace change.

Building a culture and a system that can help protect us all from sexual harassment

In our view the most important reform is for our regulatory system to stop treating sexual harassment as an individual workplace issue and treat it as a cultural, systemic, and health and safety issue.

We consider that the regulators best suited to preventing sexual harassment as a systemic and cultural problem are work health and safety agencies. Our work health and safety legislation already places a positive duty on employers to provide a safe workplace, and our agencies already have the existing powers necessary to enforce this. The essential missing pieces are a framework around sexual harassment prevention that incorporates best practice and draws on primary prevention strategies, and the resourcing and training necessary for our work health and safety agencies to address sexual harassment and do so as a priority.

We also need to recognise and strengthen the key role played by our human rights commissions and ensure they are also empowered and adequately resourced to address sexual harassment as a cultural and systemic issue, including through investigation powers and the ability to enforce compliance with anti-discrimination laws.

Even with these systemic solutions, we know that the existing individual complaints system will remain a key feature of our sexual harassment laws, and it is therefore important to remove barriers to legal claims and maximise the impact of individual claims. As it stands, this system is individualised and not well-suited to redressing harm or generating change that will prevent harassment recurring. Modest changes, including prompting parties to consider settlement outcomes that promote systemic change (such as organisational training and improved policies), as well as improved accessibility of complaint and settlement data, could help identify trends, build deterrence, and encourage measures that tackle sexual harassment as a systemic issue. In addition, barriers to women taking action, including restrictive time limits and prohibitive legal cost orders, should be addressed. Further, holistic services and support should be available to assist women to report and recover from sexual harassment in the workplace.

It is clear that we need a better, stronger way to support victims of sexual harassment and prevent it from occurring in the first place. As the system stands, unaddressed or inadequately addressed sexual harassment in Australian workplaces is stopping women reaching their full potential. It is causing women harm personally and professionally. It is damaging their mental health, their relationships and their futures.

Informed by our work, we recommend 18 reforms to build an environment where women are truly safe in the workplace and can progress in their careers without the lingering threat of sexual harassment. Our reforms propose that when sexual harassment takes place there should be meaningful consequences which reduce the risk of it happening again.

Eventually, we will be part of a community where we don't hear clients say:

"The traumatic incidents that I dealt with [at work] impacted on my ability to succeed in a personal relationship. My employer failed to support me in the traumatic incidents that I experienced, as I was expected to deal with whatever came my way.

If I had received support and psychological counselling I would not have resigned and would have been able to work through to my retirement age. My employer prevented me from reaching my potential by not providing a safe work environment for me ...

What happened to me had and continues to have a detrimental impact on my mental health and everyday life" (**Emily**).

"The interplay of bullying, sexual harassment and the subsequent impact this had on my health resulted in a debilitating post-traumatic stress disorder and other related ill health that affects every facet of my life. After 25-years as a confident successful career woman, my health, personal life and career have all been impacted. I've gone from someone who wouldn't think twice of travelling solo around the world to someone who fears walking down my own street after dark.

Situations like mine would occur less in the workplace if companies, management and employees were made more accountable for harassment, homophobia and bullying. The stigma, methods and systems associated with raising complaints doesn't work to protect injured workers, it only causes more damage to workers' health." (**Chloe**).

Summary of Recommendations

Urgent Actions Needed to End Sexual Harassment at Work	
Preventing sexual harassment as a systemic problem	
1.	Primary prevention. Governments should invest in dedicated primary prevention efforts to address the underlying gendered drivers of sexual harassment. These efforts should be part of a holistic strategy to prevent violence against women and promote gender equality in line with <i>Change the story: A shared framework for the prevention of violence against women and their children in Australia</i> .
2.	Enforce the positive duty under work health and safety laws. The Model Work Health and Safety Regulations and Codes of Practice should be amended to create an effective framework to prevent and address sexual harassment, and these amendments should be adopted by all jurisdictions that have adopted the model laws. Victoria and Western Australia should likewise incorporate any necessary amendments into their work health and safety laws to effectively prevent and address sexual harassment.
3.	Create an enforceable positive duty under anti-discrimination laws. Commonwealth, State and Territory anti-discrimination laws should impose an enforceable positive duty on employers to prevent sexual harassment supplemented by guidelines for compliance.
4.	Resourcing and training for work health and safety agencies. Commonwealth, State and Territory work health and safety agencies should be resourced and trained to effectively address sexual harassment.
5.	Stronger powers and resourcing for human rights commissions. Commonwealth, State and Territory human rights commissions should be granted increased powers and resources to effectively address sexual harassment including greater investigation powers, the power to enter into enforceable undertakings, and the power to issue compliance notices.
Increasing the impact of individual complaints	
6.	Settlement agreements. Standard form settlement agreements for sexual harassment complaints should include terms requiring duty holders to implement systemic measures to prevent and address sexual harassment.
7.	Complaints data. The Commonwealth, State and Territory human rights commissions should be required to regularly record and report deidentified complaint data and information.
Complaint processes must be fairer and more accessible	
8.	Fair Work Act. The Fair Work Act should be amended to protect workers from sexual harassment with a stand-alone civil remedy provision to enable the Fair Work Commission to receive complaints and the Fair Work Ombudsman to tackle sexual harassment.

9.	Public life. Commonwealth, State and Territory anti-discrimination laws should be amended to expand protection from sexual harassment to all areas of public life.
10.	Burden of proof. Commonwealth, State and Territory anti-discrimination legislation should be amended to shift the burden of proof to the employer once the employee has established a prima facie case.
11.	Time limit on complaints. Commonwealth, State and Territory anti-discrimination legislation should be amended to extend the time limit for bringing a complaint to 6 years.
12.	Costs orders. Commonwealth, State and Territory anti-discrimination laws should be amended to include a costs rule which provides that costs orders against an unsuccessful defendant are allowed, but costs orders against unsuccessful applicants are limited to instances where the application is frivolous, vexatious or without foundation.
13.	Resourcing for conciliation. The Commonwealth, State and Territory human rights commissions should be resourced to reduce the current wait times for conciliations.
Better support for victims of sexual harassment	
14.	Alternative dispute resolution framework. A basic framework for alternative dispute resolution procedures in courts, tribunals and commissions that deals with sexual harassment complaints should be provided to the parties and any representatives prior to a conciliation or mediation, and should include specific time for individuals to speak about their experience and the impact of the harassment on them.
15.	Training for conciliators and mediators. Conciliators and mediators should receive consistent training in alternative dispute resolution theory and techniques from experts in the field, including in how to mitigate power imbalances.
16.	Protection against retaliation. Consideration should be given to reforming Commonwealth, State and Territory anti-discrimination laws and the Fair Work Act to improve protection and redress for people who complain of sexual harassment and suffer detriment because the employer or other duty holder fails to respond reasonably or handles an investigation badly.
17.	Pilot online reporting tool. Funding should be granted to pilot an accessible and confidential online reporting tool that (a) assists people to report and address problem behaviour and seek support, and (b) identifies trends to assist with prevention and enforcement efforts.
18.	Specialist support services. Specialist support services should be funded to assist people who have experienced sexual harassment.

Victoria Legal Aid, our clients and sexual harassment

Victoria Legal Aid

VLA is an independent statutory agency responsible for providing information, advice and assistance in response to a broad range of legal problems.² Working alongside our partners in the private profession and community legal centres, we help people with legal problems such as criminal matters, family breakdown, child protection, family violence, fines, social security, mental health, immigration, discrimination, guardianship and administration, tenancy and debt.

Our Legal Help telephone line is a resource for all Victorians to seek information, advice and assistance with legal problems. We also deliver specialist non-legal services, including our Family Dispute Resolution Service and our Independent Mental Health Advocacy service, provide community legal education, and contribute to policy and law reform.

VLA is also the largest provider of family violence legal services in the state, as well as funding several community legal centres across Victoria to deliver family violence legal services. We assist children, victim survivors, and alleged perpetrators of family violence with their legal matters. We recognise that family violence is driven by gender inequality and we are committed to the elimination of violence in the community. We are working to improve the way we respond to family violence and gender inequality and have implemented several initiatives and projects in recent years.

Equality Law Program

VLA's dedicated Equality Law Program promotes and protects substantive equality by addressing individual and systemic discrimination through advice, casework, legal education, and strategic advocacy. We work to enable people to obtain and retain employment, to remain engaged with key service and education providers, to receive fair compensation, and to use the law to help stop discrimination and sexual harassment occurring again in the future.

The Equality Law Program provides advice and representation to clients who suffer discrimination, sexual harassment, victimisation and vilification. We represent clients with complaints of discrimination and sexual harassment in various jurisdictions, including the Federal Court and the Federal Circuit Court, utilising federal anti-discrimination legislation, the *Fair Work Act 2009* (Cth) (**FW Act**) and the *Equal Opportunity Act 2010* (Vic) (**EO Act**).

In the last five years the Equality Law Program provided over 6,500 legal advices regarding discrimination and sexual harassment matters. By helping people seek redress for discrimination and sexual harassment, we seek to promote equality and reduce disadvantage in the community.

² See Victoria Legal Aid, *Annual Report 2017–18* (available at: <https://www.legalaid.vic.gov.au/about-us/our-organisation/annual-report-2017-18>) (**VLA Annual Report**).

Our clients and sexual harassment

Over the past three years, 252 people have sought assistance from VLA specifically in relation to workplace sexual harassment. Of these people:

- The majority – 83% – were women.
- Approximately 50% were between the ages of 25 and 34 years of age.
- Almost 30% disclosed having a disability with the vast majority of these clients (78%) experiencing mental health issues.³
- 36% were born overseas.

Through this work, we see the impact of sexual harassment on our clients, as well as the factors that make people more vulnerable to experiencing it. While we represent and advise hundreds of clients regarding sexual harassment matters, we also know that many clients do not make formal or informal complaints to address their sexual harassment. We see directly the need for systemic changes aimed not only at reforming the complaint and compliance system but also cultural and social attitudes that lead to high rates of sexual harassment.

PART 1: DRIVERS AND IMPACT OF SEXUAL HARASSMENT

1.1 Drivers of sexual harassment

We provide legal assistance to people who have experienced sexual harassment at work. Through obtaining instructions of our clients' experiences of sexual harassment and of their workplaces, we have gained an understanding of certain factors that are likely to be present when people experience sexual harassment and that drive the occurrence of sexual harassment.

Our practice-based observations are consistent with the observations of VicHealth,⁴ Our Watch⁵ and Women's Health Victoria that the prevalence of sexual harassment in Australian workplaces is driven by wider gender inequality and attitudes that condone violence against women in our communities.

In particular, in the past three years 83% of the clients who we assisted with a sexual harassment complaint were women and in the large majority of cases, the perpetrators of the sexual harassment were men. The higher proportion of women who seek our services supports our view that sexual harassment is experienced by a far greater number of women than men and that sexual harassment is often tied to inequality between men and women at work, just as other forms of violence against women are tied to gender inequality more broadly.

³ While we do not have data which demonstrates whether these clients had existing disabilities at the time of their experiences of sexual harassment, in practice, many clients experience mental health impacts as a result of being sexually harassed. We discuss these impacts further in our submission.

⁴ Victorian Health Promotion Foundation (2018) *Submission: Australian Human Rights National Inquiry into Sexual Harassment in Australian Workplaces*, pages 9 and 10.

⁵ Our Watch (2018) *Submission to the Australian Human Rights National Inquiry into Sexual Harassment in Australian Workplaces*, pages 8 and 9.

Our practice experience also reflects that rigid gender and sexuality norms in society play a contributing role to driving sexual harassment even though drivers of sexual harassment in the world of work are varied and can be idiosyncratic based on the characteristics of the particular work environment.⁶ In Jessica's story below we see how a culture which facilitated inappropriate jokes about violence against women and gender stereotypes at her University was interlinked with her experience of sexual harassment.

Negative gender attitudes: Jessica's story

I don't have many happy memories of my time at university. I undertook tertiary studies in a male-dominated field of study and I frequently experienced sexist remarks and sexual harassment from both students and staff. It was often done in a joking manner, but I found it very isolating.

It made me feel unsafe. I would constantly ask people to stop making these remarks, which would include jokes about family violence and gender stereotypes, including women's place being in the kitchen.

I came very close to withdrawing from my studies because I was worried that the same blokey, sexist culture would continue when I commenced work in the industry.

I spoke up and made an internal complaint. I really wanted to try and change the culture. I asked the University for better policies, awareness training, intervention and help. I spoke to numerous lecturers who did nothing. One lecturer subsequently reprimanded me when I escalated my complaints above them. I did all I could to make the University take it seriously, but I was treated like I was a trouble maker. The victimisation I experienced after speaking up changed me as a person. My mental health suffered significantly and I truly struggled to complete my degree. In the end, my complaints were lodged as a grievance. This was a tiresome, lengthy and mentally tormenting process. Although the University ultimately agreed to introduce new policies to address the behaviour, this wasn't consistently or meaningfully implemented. I had to engage a lawyer to obtain an outcome to address the harm I had suffered.

This experience is consistent with VicHealth's submission to the National Inquiry,⁷ which recognises that social norms, including community attitudes towards violence against women generally, influence the prevalence of sexual harassment. Unfortunately, the ANROWS National Survey of Community Attitudes to Violence Against Women 2017 demonstrates that some concerning attitudes to sexual harassment and gender equality are widely held within our community.

Jessica's story also shows that the organisational response to victims once they complain about sexual harassment can contribute to an organisational climate that tolerates sexual

⁶ As submitted in Initial Submission to the AHRC's National Inquiry into Sexual Harassment in Australian Workplaces by Professor Paula McDonald, QUT and Professor Sara Charlesworth, RMIT University, page 10.

⁷ Victorian Health Promotion Foundation, above footnote 4, page 6.

harassment and discourages other victims from complaining. Jessica experienced victimisation, a lack of organisational support and an arduous and ineffective complaints process, which damaged her mental health and led to her view that the University failed to meaningfully address both her complaint and sexual harassment at the University more broadly. Ineffective organisational responses also signal a culture that is permissive of sexual harassment.

Hulin, Fitzgerald, and Drasgow suggest that ‘organisational climate’ is a significant predictor of sexual harassment incidents at organisations, and there are three aspects of organisational climate that are of particular importance: perceived risk to victims for complaining; a lack of sanctions against offenders; and the perception that one’s complaints will not be taken seriously.⁸ This accords with our practice experience that many clients are distressed by the inadequacy of their employer’s response to their complaint of sexual harassment and consider this a factor influencing the condoning of the sexual harassment in the workplace.

1.1.1 Demographics of clients who seek assistance with sexual harassment

Victims of sexual harassment in workplaces can come from a broad range of backgrounds and life experiences. Through our client work we know that there are people with certain experiences that make them more vulnerable to sexual harassment. These client experiences support an intersectional approach to understanding the drivers and impact of sexual harassment.

Over the past three years, 252 people have sought assistance from VLA in relation to workplace sexual harassment. As indicated, the majority of these individuals were women (83%).

Clients who sought our assistance for sexual harassment were of various ages. However around half of the clients we saw were between the ages of 25 and 34 years of age.

Of the clients who have sought assistance for sexual harassment in the past three years, almost 30% disclosed having a disability, with the vast majority of these clients (78%) experiencing a mental health issue. While we do not have data which demonstrates whether these clients had existing disabilities at the time of their experiences of sexual harassment, in practice, many clients experience mental health impacts as a result of being sexually harassed. We discuss these impacts further in our submission.

Our clients who seek assistance with sexual harassment come from various cultural backgrounds. Of the clients we have advised on sexual harassment in the past three years, 36% were born overseas.

⁸ See Chelsea R Willness, Piers Steel, Kibeom Lee, ‘A Meta-Analysis of the Antecedents and Consequences of Workplace Sexual Harassment’, 60 *Personnel Psychology* (2007) 127 at page 133, citing Hulin CL, Fitzgerald LF, Drasgow F. (1996). *Organizational influences on sexual harassment in Stockdale MS (Ed.), Sexual harassment in the workplace: Perspectives, frontiers, and response strategies. Women and work: A research and policy series, (vol. 5, pp. 127–150). Thousand Oaks, CA: Sage.*

Clients who are otherwise in a minority group within their workplace, either due to their sexuality, disability and/or being culturally and linguistically diverse, often describe being easy targets of sexual harassment by perpetrators in their workplaces.⁹

In Nomusa's story, we see that her experience of sexual harassment was combined with being subjected to discriminatory and derogatory comments about her race. Nomusa's experience of sexual harassment was also compounded by her unique isolated work environment – the home of her client, who was also the perpetrator.

Intersection between sexual harassment and other protected attributes: Nomusa's story

I was working in a person's home looking after their children. I was placed there by a service provider. Working in someone's house was a big challenge for me, the first thing that came into mind was "What if a husband or wife works in the house, will something happen to me?" Which something did happen as I was touched inappropriately and subject to racially discriminatory comments.

It made me so uncomfortable when he made discriminatory comments about my skin colour; I didn't want the kids to hear those comments as I was meant to be a role model for those children and it was so awkward. I told him that he can't do that in front the children. Also, each time he touched me inappropriately it made me feel awkward and uncomfortable and I would tell him that it was not nice.

There was no one else that I could turn to for help as I was working in the home, and I thought no one would believe me. Since I was working in a big house, I was scared, I thought what happens if I go downstairs and go to the toilet? What's going to happen to me next? It made me feel awkward and I didn't want to go back to work but I was the sole income earner at the time, so I felt like I had to put the issues behind me. I was also pregnant at the time and knew I wouldn't be able to get a job anywhere else.

I felt like I would've felt safer if the service provider gave me information to help me understand my rights and also provided information to the person that I was placed with about their obligations towards me.

I brought a complaint about the conduct and it was a mentally draining experience. While it was difficult I was glad to have pursued a complaint.

⁹ In Our Watch's submission to the National Inquiry, see above footnote 5, the Australian data on sexual harassment reveals that women who live at the intersection of gender inequality and other forms of discrimination and marginalisation are more likely to experience sexual harassment is helpfully summarised at page 12 of the Submission and we confirm this accords with our practice experience.

Chloe's story, below, likewise illustrates the experience of intersecting forms of discrimination, as well as the way in which people who do not conform to norms relating to gender roles and sexuality are at increased risk of sexual harassment. Chloe was subjected to sexualised and derogatory comments from co-workers about her sexuality.

Intersection between sexual harassment and other protected attributes – Chloe's story:

I was employed at a large international company as a Business Development Manager for 10 years. During that time, I was coming to terms with my sexual identity and was steadily sharing this with my friends. I didn't feel able to do this at work after a manager, referring to another gay colleague, told me 'senior staff need to understand they're managers first and gay second'.

A colleague started spreading derogatory rumours about me, making sexual innuendos about lesbians, referring to me to newcomers as the "carpet muncher" and telling workmates they shouldn't eat food I brought in to share. Colleagues changed their behaviour towards me. I felt progressively ostracised.

A male colleague with a volatile temper was hostile, aggressive and sabotaged my work. He was stalking another female colleague and tried to intimidate us by driving dangerously to meetings when he had us alone in his car.

Complaints were made about both employees by multiple team members, but they socialised with management and complaints weren't dealt with adequately or at all.

There were problems countrywide and many made complaints about the culture. Within a year of the new national manager joining, nearly half the team left. This manager summonsed remaining staff and told us 'I won't hear a bad word against my management. You're either on the bus or off the bus'. It was clear nothing was going to be done about the toxic environment.

Left unchecked, the harassment intensified, and my health started to suffer. Following my complaints, I started being undermined and treated in a demeaning way by management. The situation escalated and HR became involved.

Following interviews/statements, HR advised I had a sexual harassment case, but my health was declining and I assumed the company would not take any necessary action. But, despite his manager stating, 'he was too difficult to manage, and he wanted him off the team' the man was kept on because 'we couldn't afford to lose more staff'.

The behaviour escalated and I feared for my safety. It reached a point I'd ask colleagues to walk me to my car at night and advised a manager 'if something were to happen to me at least everyone would know who it was'.

Eventually the man's ongoing conduct resulted in him being fired and the homophobic colleague spreading rumours was disciplined, but by this stage my health had already been impacted.

Due to his own conduct, I was told my manager was to be moved out of his role, but after I'd spoken up to HR about the culture, the harassment and bullying from my manager and the national manager only escalated further. Eventually I had a breakdown.

My doctor recommended I submit a WorkCover claim and after a time I reluctantly accepted his support. I considered making an official harassment claim but worried about my declining health, the associated stigma and I feared managements' reactions. After my breakdown, the company never provided reassurance things would change if I returned and because no official government investigation occurred, those responsible for sexual harassment, bullying and homophobia moved onto new companies without penalty.

The interplay of bullying, sexual harassment and the subsequent impact this had on my health resulted in a debilitating post-traumatic stress disorder and other related ill health that affects every facet of my life.

After 25 years as a confident successful career woman, my health, personal life and career have all been impacted. I've gone from someone who wouldn't think twice of travelling solo around the world to someone who fears walking down my own street after dark.

Situations like mine would occur less in the workplace if companies, management and employees were made more accountable for harassment, homophobia and bullying. The stigma, methods and systems associated with raising complaints doesn't work to protect injured workers, it only causes more damage to workers' health.

1.1.2 Male dominated workplaces and sexual harassment

Further to the specific characteristics of people who experience sexual harassment, there are certain factors evident in workplaces that drive sexual harassment.

In particular, women and non-binary people who work in male dominated workplaces often find that the cultures in their workplaces played a role in allowing or driving the sexual harassment they experienced, as illustrated in Jessica's story above. This phenomenon is supported by extensive research, but as McDonald, Charlesworth and Graham state below, it is the culture and structures of these workplaces that are problematic, rather than their gender composition.

Cross-sectional and meta-analytic studies consistently demonstrate that SH is more prevalent in male-dominated occupations and work contexts than in gender-balanced or female-dominated workplaces. However, it is not the organizational sex-ratio of the workplace that renders SH problematic, but rather organizational environments that

are hierarchical, especially those where cultural norms are associated with sexual bravado and posturing and where the denigration of feminine behaviours is sanctioned.¹⁰ (References omitted.)

The harmful effects of such organisational environments and cultural norms are evident in Alice's story, where she talks about the constant sexual harassment she experienced throughout a career working in male-dominated fields.

Sexual harassment in male dominated industries: Alice's story

I'm a woman who is interested in cars and motorbikes. I have worked in male-dominated fields my whole life and have been subjected to sexual harassment and discriminatory behaviour in almost every job.

I was 15 when I started my first job as a casual petrol station attendant. I worked with an older full-time male who would regularly slap me on my bottom. It made me feel very uncomfortable, but I was too shy and embarrassed to say anything to anyone.

At about age 21, I worked at a truck company. My male co-workers would constantly tell dirty jokes and talk about 'hot chicks' and what they 'do to their missus'.

Among the many offensive comments that were made to me, I recall sitting in a truck and my male colleague sitting next to me saying 'shut your legs, it's smiling at me'. I pretended that I didn't hear him.

In my late twenties, I worked for a retailer. A co-worker regularly made numerous offensive sexual comments to me, such as 'I'd like to tie you up and whip you', and forcefully grabbed my bottom in front of my manager and other co-workers. However, despite seeing this offensive and illegal behaviour take place, my manager would not take action against the harasser and my co-workers were unwilling to support my complaints because they were worried they would be victimised for doing so.

As a result of the harassment, I was diagnosed with depression and I ended my relationship with my boyfriend because I developed a distrust of men. I did not have the emotional resources or social supports needed to go to court and fight my employer, so I settled my claim for a small pay out rather than taking the case further. I felt like there were no consequences for the harasser.

Alice's story highlights a common practice experience VLA sees, namely that cultures and practices within male dominated workplaces and workplaces that do not provide adequate support to workers must be addressed in order to reduce the prevalence of sexual harassment in Australian workplaces.

¹⁰ Paula McDonald, Sara Charlesworth, Tina Graham, 'Developing a framework of effective prevention and response strategies in workplace sexual harassment', 53 Asia Pacific Journal of Human Resources (2015) pages 41 and 45-46.

1.1.3 Insecure work

There is a heightened risk of sexual harassment for employees who are in an insecure work arrangement. In our experience migrant workers are particularly vulnerable to exploitation because of their reluctance to complain for fear of deportation, the lack of alternative employment options, and unfamiliarity with workplace laws and entitlements. We have also had multiple clients who are unable to continue a complaint because they were forced to leave Australia after losing their employment.

Labour hire and other forms of insecure work arrangements, including contracting arrangements, heighten this risk. Our clients report examples of labour hire arrangements being used by employers to evade workplace laws and other legal obligations. Many of our clients report being told that they are no longer required by the host company, without being provided with any reason, after they have raised a complaint about their treatment. While the labour hire agency may know the true reason, it has a stronger commercial interest in maintaining good relations with the host company than with the individual worker. This leaves the worker, who is often unskilled and has limited employment options, in a particularly vulnerable position.

1.2 Impact of sexual harassment

Sexual harassment has ongoing impacts on victims in various aspects of their life including an impact on financial security, mental and physical health, job security and the victim's relationships at work and in their family. These impacts are illustrated in the client stories throughout this submission, including the story of Alice, above, who suffered depression and relationship breakdown as a result of her experiences of sexual harassment.

These impacts can be short term but in many cases of sexual harassment, the impacts can be significant and long lasting.

Sexual harassment can have a major impact on an individual's ability to participate in the workforce. Individuals who are sexually harassed often decide to resign from their work due to feeling unsupported or because they face workplace exclusion. For example, we have seen clients who have experienced sexual harassment not receive further shifts, or experience social isolation from colleagues, or need time off work due to the impacts of the sexual harassment on their health.

People who experience sexual harassment along with other forms of discrimination can have their experiences compounded and the impacts on them can therefore be significant.

In Emily's story, we see that the trauma she experienced as a result of being raped by a colleague was exacerbated by her being subjected to other forms of sexual harassment and discriminatory conduct on the basis of her gender.

Impact on mental health and personal relationships: Emily's story

I worked in a large male-dominated organisation for many years. During my career I was raped by another employee. I also experienced sexual advances from colleagues and was subject to discriminatory comments and behaviour based on my gender.

I did not receive any support when I reported the rape and was asked to consider the ramifications of going ahead with the complaint. I was never treated like a victim and had to seek my own support. I was told that I shouldn't have reported my colleague. I was ostracised as a result of reporting. I did not make a complaint about this conduct as I did not know who to report it to and was afraid of further repercussions.

The culture at my workplace never varied or changed during my service. The sexual harassment, victimisation, unwanted comments about the rape and other conduct resulted in me not being able to cope as these issues were a constant reminder. As a result, I resigned from my employment as I had reached the point of no return.

The traumatic incidents that I dealt with impacted on my ability to succeed in a personal relationship. My employer failed to support me in the traumatic incidents that I experienced, as I was expected to deal with whatever came my way.

If I had received support and psychological counselling I would not have resigned and would have been able to work through to my retirement age. My employer prevented me from reaching my potential by not providing a safe work environment for me.

Eventually I sought medical attention as I felt that I was on the verge of a breakdown. This led to me being diagnosed with post-traumatic stress disorder. What happened to me had and continues to have a detrimental impact on my mental health and everyday life.

Emily's story also highlights a common experience of our clients who describe that the mental health impacts of the sexual harassment can be exacerbated due to inadequate access to medical treatment or targeted counselling support. In Emily's story, the lack of initial medical and psychological support combined with an unsupportive employer not only had a severe impact on her health and career but also on her ability to maintain personal relationships.

PART 2: PREVENTING SEXUAL HARASSMENT

2.1 Primary prevention measures needed to address the drivers of sexual harassment

The drivers of sexual harassment cannot be effectively addressed by focusing on workplaces and the actions of duty holders alone; a holistic approach aimed at the broader community is required. Australia needs a strong primary prevention strategy to change gendered attitudes that lead to sexual harassment, integrating sexual harassment into existing funding, programs and initiatives that address violence against women. We note Our Watch's submission to the National Inquiry recommends that as part of these strategies for primary prevention there be 'significant investment in the development of an expert primary prevention workforce to lead, support and embed efforts in a range of settings including workplaces' and that this could include identification of workplaces as key settings for primary prevention work¹¹. We also note that Our Watch recommends that work should begin on the development of a second *National Action Plan to Reduce Violence against Women and their Children* with a particular emphasis on primary prevention including on strategies to achieve cultural change and structural changes to address the drivers of sexual harassment.¹² We support these recommendations and believe that, if we address these gendered drivers of sexual harassment it will be less likely that people like our clients, Nomusa, Chloe, Jessica, Emily and Alice, will be subjected to sexual harassment in the future.

Recommendation 1: Funding should be granted to dedicated prevention efforts to address the underlying gendered drivers of sexual harassment, which should be part of a holistic strategy to prevent violence against women and promote gender equality in line with *Change the story: A shared framework for the prevention of violence against women and their children in Australia*.

2.2 A stronger regulatory framework and response to prevent sexual harassment

The greatest flaw in our current regulatory approach to sexual harassment in Australia is the reliance on individuals to fix what is a cultural and systemic problem. This approach isn't working effectively in preventing and/or addressing sexual harassment when it occurs. Despite being unlawful for over 25 years, we continue to see concerning high numbers of sexual harassment occurring across all industries and jobs.

We recommend that there be stronger and clearer legal duties on employers to take proactive steps to prevent sexual harassment at work, and strong and effective regulators

¹¹ Our Watch (2018) *Submission to the Australian Human Rights National Inquiry into Sexual Harassment in Australian Workplaces*, page 5.

¹² Ibid, page 6. See also Our Watch, Australia's National Research Organisation for Women's Safety and VicHealth (2015) *Change the Story: A shared framework for the primary prevention of violence against women and their children in Australia*, accessed online on 2 February 2019 at <https://www.ourwatch.org.au/getmedia/0aa0109b-6b03-43f2-85fe-a9f5ec92ae4e/Change-the-story-framework-prevent-violence-women-children-AA-new.pdf.aspx>

that have the full suite of regulatory tools and resources necessary to effectively tackle sexual harassment, including as a cultural, systemic, and health and safety issue.

It is our view that, subject to our recommendations further below, the regulators best suited to preventing sexual harassment as a systemic and cultural problem are work health and safety agencies. There are two main reasons for this. First, we consider that the existing positive general duty in work health and safety legislation already covers sexual harassment, which undoubtedly causes psychological and physical harm and is therefore a workplace health and safety hazard. Second, as discussed further below, work health and safety regulatory schemes also have the full suite of regulatory powers necessary to effectively prevent sexual harassment as a cultural and systemic issue.

It is important to note that in modern workplaces protection needs to be provided to the full spectrum of employment relationships and not just to the traditional employer and employee relationship. When we refer to “employers” in this submission we mean it in the fullest sense of the word including but not limited to principal and contractor relationships and labour hire relationships.

Why our reliance on individual complaints is not working

2.2.1 People who experience sexual harassment do not complain

Reform is needed to address the fact that our laws and agencies currently place the burden on the individual who has experienced sexual harassment to bring a legal claim to enforce their rights and change their workplace. Our regulatory agencies responsible for addressing sexual harassment either have not been given powers to enforce compliance with the law (i.e. human rights commissions) or do not commonly use their existing powers to do so (i.e. work health and safety agencies).

This reliance on individual complaints means that employers are rarely made aware that sexual harassment is occurring and there are rarely consequences for perpetrators and workplaces in which sexual harassment occurs. As the 2018 Australian Human Rights Commission’s (AHRC) Fourth National Survey on Sexual Harassment in Australian Workplaces (AHRC Survey) confirmed, less than 1 in 5 people who experience harassment take action, and only 1 in 100 make a legal complaint to the AHRC or equivalent State or Territory agency.¹³ There are many reasons why victims are reluctant to make a complaint, including the strain it has on their mental health and fears that it will have a negative impact on their reputation and career. This fear is not unfounded, as the 2018 AHRC Survey found that ‘almost one in five people who made a formal report were labelled as a trouble-maker, victimised, ostracised or resigned.’¹⁴

Even when people do make a complaint or come forward and seek advice we often see complainants decide not to proceed with their claim for fear of the consequences to their career and reputation, as evidenced by Lydia’s story below.

¹³ Australian Human Rights Commission (2018) Everyone’s Business: Fourth national survey on sexual harassment in Australian Workplaces, page 9.

¹⁴ Ibid, pages 73-75.

Fear of reprisals for making complaints: Lydia's story

I worked for a sole proprietor who subjected me to sexual harassment. He touched my bottom, sexually propositioned me, made comments about my appearance and invited me to his home. He also behaved this way to other female employees. There was nobody to complain to about the behaviour. I spoke up and my position was made redundant.

I received legal advice that I had a strong claim but decided not to pursue the complaint. I was worried about my reputation and the risk of defamation.

The boss is very connected in my industry and I knew if I complained that I would have a black mark next to my name.

This experience has set me back in my career and I almost left the industry I am passionate about.

When people like Lydia are deterred from enforcing their rights nothing is done to stop the conduct from happening again. Often the employer is not even aware that sexual harassment has occurred in their workplace.

2.2.2 Sexual harassment complaints do not prevent future sexual harassment

In our practice experience another key flaw in the current reliance on individual complaints is that when an outcome is obtained as a result of a sexual harassment complaint, it rarely requires the employer to take preventative systemic action (such as conducting proper training or staff consultation about preventing sexual harassment, or implementing a policy to prevent harassment occurring again in the future).¹⁵ Further, any consequences are rarely visible as the vast majority of claims resolve with a confidential settlement agreement. This means that sexual harassment claims rarely act as a visible warning or example to others and rarely result in steps being taken to reduce the risk of sexual harassment occurring again in future.

2.2.3 Employers are not required to prevent sexual harassment occurring

In our practice we see many employers who have failed to put any policies or training in place to attempt to prevent sexual harassment. We also see employers who have failed to address the risk of ongoing sexual harassment in the workplace even after becoming aware that it has occurred, as Fiona's story highlights.

Employers' failures to take action on sexual harassment: Fiona's story

I was subjected to sexual harassment by my manager in my employment. This person would make lewd jokes, call me by sexual nicknames and discuss his

¹⁵ These kinds of outcomes are very rarely obtained at hearing, and despite Victoria Legal Aid pushing for these outcomes in settlements we are only able to obtain them approximately 25% of the time.

sexual fantasies with me at work. He would also sit very close to me and other female staff.

It was common knowledge in the workplace that he regularly behaved in this way to female staff, but it was never addressed. I initially spoke with the HR manager about the sexual harassment I was experiencing and nothing happened. There were six other women in my area who made complaints. It took six-months for the company to do anything.

The manager only left when the complaints against him became overwhelming as me and the other women were reporting more incidents. When he left the company the HR manager sent an office-wide email thanking him for his service and explaining that he is pursuing a new adventure. That email felt like the company telling us that we weren't valued.

I was treated unfavourably as a result of my internal complaint. I felt I had no choice afterwards but to resign.

I then lodged a legal complaint and I found the conciliation process to be very adversarial and intimidating. The organisation responded to my complaint by attacking my work ethic rather than by acknowledging any wrongdoing or responsibility for what happened. I felt like the process was a battle and afterwards I didn't have anything left in me to keep pursuing my rights. I felt depleted. I was unable to obtain any outcome and in the end I just let the matter go. My manager was never really punished for his behaviour. I ended up feeling like the system favours the perpetrator.

A key reason why employers are failing to prevent sexual harassment is that our regulatory system does not require them to do so.

Anti-discrimination laws

The focus of anti-discrimination law on individual instances of sexual harassment means that employers are not required to consider the broader workplace conditions that increase the risk of sexual harassment occurring and take proactive steps to address them. Our Commonwealth, State and Territory anti-discrimination laws do not require employers to take preventative steps to provide a working environment free from sexual harassment or discrimination.¹⁶ An employer is only prompted to consider whether they took all reasonable steps to prevent the sexual harassment if they seek to avoid vicarious liability for a legal claim made by an employee who was subjected to harassment.¹⁷ This approach means that employers are only held accountable for the steps they took to reduce the likelihood of

¹⁶ Our *Sex Discrimination Act 1984* (Cth) does not impose a positive duty on employers, and while Victoria's *Equal Opportunity Act 2010* (Vic) does impose a positive duty it is not enforceable by direct action, though it can be the subject of a review or investigation by the Victorian Equal Opportunity and Human Rights Commission.

¹⁷ See for example the *Sex Discrimination Act 1984* (Cth) section 106.

sexual harassment occurring after an incident of sexual harassment has already occurred. Given the low number of employees who come forward about sexual harassment this is not an effective mechanism to ensure preventative steps are taken.

Work health and safety laws and agencies

In addition to our anti-discrimination laws failing to require employers to prevent sexual harassment, our work health and safety agencies have failed to ensure employers take preventative steps to address sexual harassment. While our Commonwealth, State and Territory work health and safety laws already require employers to provide a safe working environment so far as is reasonably practicable,¹⁸ this has not resulted in regulations, codes of practice, or significant enforcement activity regarding sexual harassment.¹⁹ Further, our work health and safety agencies have not prioritised sexual harassment as a psychosocial and physical hazard in the workplace.²⁰ This is despite clear evidence of the significant health impacts for people who are sexually harassed, including psychological harm,²¹ indicating that sexual harassment should be treated as a hazard to workplace health and safety.

As a result of the lack of relevant work health and safety regulations, codes of practice, guidance notes or enforcement activity, there is very little guidance for employers as to how they can effectively prevent sexual harassment (as opposed to simply preventing liability for sexual harassment), and little impetus for employers to prioritise sexual harassment prevention over other competing concerns.

From our practice experience the mere existence of a policy and training is not enough to prevent sexual harassment in a workplace. We have assisted clients to bring claims against many employers who try and avoid vicarious liability for the claim by pointing to a policy that is in place. It is often very brief and not accompanied by more than a mention during induction training.

There is significant evidence of the link between gender inequality and violence against women and the need to address it as a cultural issue.²² Yet there is no framework to ensure that these gendered drivers of sexual harassment are addressed by employers in relation to workplace culture, or to ensure they are addressed at a wider societal level.

¹⁸ See for example the *Model Work Health and Safety Bill 2016* (Cth) section 19 and the *Occupational Health and Safety Act 2004* (Vic) section 21.

¹⁹ The *Model Work Health and Safety Bill 2016* (Cth) does not define sexual harassment, the *Model Work Health and Safety Regulations 2019* (Cth) do not set out detailed requirements for how employers can comply with their duties in relation to sexual harassment, and there is no model code of practice to provide practical guidance to employers as to how they can comply with their duties regarding sexual harassment.

²⁰ For example there is no content on the Comcare website about sexual harassment: <https://www.comcare.gov.au/preventing/hazards> accessed 2 February 2019, nor is there any content on the Victorian Work Safe website about sexual harassment other than to note workers can get advice from a human rights commission: <https://www.worksafe.vic.gov.au/topics> accessed 2 February 2019.

²¹ See for example, Adrienne O'Neil, Victor Sojo, Bianca Fileborn, Anna Scovelle, Allison Milner, 'The #MeToo movement: an opportunity in public health?' (2018) 391 *The Lancet* 2587. O'Neil et al state that, '[v]ictims, witnesses, or bystanders of sexual harassment can have adverse psychological consequences, including depression, anxiety, and post-traumatic stress-disorder (PTSD) – all risk factors for various chronic diseases.' See also, LM Cortina and JL Berdahl, 'Sexual Harassment in Organizations: A Decade of Research in Review', *The SAGE Handbook of Organisational Behaviour: Volume 1, Micro Approaches*, J Barling and CL Cooper (Eds), 469-497 (2008), 481 and LF Fitzgerald, C Hulin, F Drasgow, 'The Antecedents and Consequences of Sexual Harassment in Organizations: An Integrated Model', in GP Keita and JJ Hurrell (eds), *Job Stress in a Changing Workplace: Investigating Gender, Diversity, and Family Issues* (1995) 55-73, 55.

²² See for example Kim Webster and Michael Flood (2015), *Framework foundations 1: A review of the evidence on correlates of violence against women and what works to prevent it*. Companion document to Our Watch, Australia's National Research Organisation for Women's Safety and VicHealth, above note 12.

How our regulatory system can protect us all from sexual harassment

2.2.4 A clear positive duty that is effective at preventing sexual harassment

It is not enough to tell employers that they have a duty to provide a sexual harassment free workplace, we must tell them how to do so effectively. As outlined above, there is currently no framework around what is required of employers under work health and safety laws in Australia in order to provide a safe workplace in relation to sexual harassment. Further, in anti-discrimination law there is no enforceable positive duty to prevent sexual harassment at all.

As a result of our direct practice experience of a legal system that is ineffective at addressing or preventing sexual harassment, and organisational responses to sexual harassment that are likewise ineffective, we have looked to comparative jurisdictions to better inform our legal services and client advocacy. If we look to comparable jurisdictions overseas we can see examples of positive duties that require specific preventative steps be taken.

In Sweden, anti-discrimination law requires active measures to prevent discrimination and harassment including:

- continually investigating the existence and analysing the causes of discrimination and obstacles to equal opportunity in the workplace
- establishing guidelines and routines to prevent sexual harassment and victimisation and evaluating their effectiveness,
- promoting gender balance in their workplace through education, training, skills development and other appropriate measures, and
- annually documenting and evaluating the measures taken.²³

These requirements are all enforced by the Equality Ombudsman which can conduct reviews, require access and information, and order compliance subject to financial penalties.

For an example of a positive duty in work health and safety law, we can look to Ontario, Canada where the law requires specific steps be taken by employers in order to comply with their duty to take every precaution reasonable to prevent sexual harassment including:

- developing a policy that is reviewed at least annually and posted at a conspicuous place in the workplace,
- developing a program to implement the policy which covers a range of things including measures and procedures for workers to make complaints and how they will be conducted, and
- providing instruction to employees about the content of the policy and program.²⁴

These requirements are enforced by the Ministry of Labour's inspectors who can require access and information, issue compliance orders, and require compliance plans in addition to prosecuting breaches.²⁵

²³ *Discrimination Act 2008* (Sweden) chapter 3, sections 1 to 13.

²⁴ *Occupational Health and Safety Act 1990* (Ontario, Canada) sections 32.01 to 32.08.

²⁵ *Ibid*, sections 55-57.

While these international models are important context, in considering what kind of requirements to place on employers in Australia it is necessary to have regard to the available evidence about what preventative measures are actually effective. A recent taskforce conducted by the United States Equal Employment Opportunity Commission (EEOC) completed a comprehensive interdisciplinary review of the current evidence for what works at preventing sexual harassment in the workplace.²⁶

Sexual harassment policies

The EEOC found that there is evidence that the existence of a sexual harassment policy is effective at reducing the incidence of workplace sexual harassment,²⁷ and made recommendations as to what the policy should cover and how it should be communicated to employees. Based on its research the EEOC recommended that a policy generally include:

- “A clear explanation of prohibited conduct, including examples;
- Clear assurance that employees who make complaints or provide information related to complaints, witnesses, and others who participate in the investigation will be protected against retaliation;
- A clearly described complaint process that provides multiple, accessible avenues of complaint;
- Assurance that the employer will protect the confidentiality of harassment complaints to the extent possible;
- A complaint process that provides a prompt, thorough, and impartial investigation; and
- Assurance that the employer will take immediate and proportionate corrective action when it determines that harassment has occurred, and respond appropriately to behavior which may not be legally-actionable "harassment" but which, left unchecked, may lead to same.”²⁸

The EEOC also recommended that the policy be regularly communicated to staff in a variety of forms and methods.²⁹

Sexual harassment training

In addition to policies, a common measure to prevent sexual harassment is training. The EEOC established that there was no clear empirical study that proved the effectiveness of sexual harassment training.³⁰ However there was evidence that training at least increased understanding as to what kind of conduct is unacceptable at work,³¹ and can result in employees feeling more confident to make complaints.³²

Based on evidence from those with experience on the ground, including lawyers, investigators and employers, the EEOC concluded that training is an essential component of

²⁶ Chai Feldblum and Victoria Lipnic (2016) *Report of the Co-Chairs of the Select Task Force on the Study of Harassment in the Workplace*, accessed online on 2 February 2019: https://www.eeoc.gov/eeoc/task_force/harassment/upload/report.pdf

²⁷ Chai Feldblum and Victoria Lipnic, above footnote 26, page 38.

²⁸ *Ibid*, page 38.

²⁹ *Ibid*, page 38.

³⁰ *Ibid*, page 45.

³¹ *Ibid*, page 46.

³² *Ibid*, page 48.

sexual harassment prevention so long as it is part of a holistic effort and has certain content and structural elements. That is, the training should be:³³

- focused on behaviours not legal standards,
- tailored to the particular workplace using realistic scenarios for that workplace,
- cover how to make a complaint and what the process will be,
- expressly supported by senior leadership, with additional training for managers and supervisors about how to deal with sexual harassment, and
- conducted more than once a year by a live, qualified instructor.³⁴

Importantly, the EEOC found evidence that the kind of training currently provided by employers in the US has little impact on attitudes towards sexual harassment.³⁵ The EEOC recommended that employers consider other forms of training such as bystander intervention training.³⁶

Incorporating primary prevention into a positive duty

Given the evidence that the primary driver of sexual harassment is gender inequality,³⁷ we need to address gender inequality to reduce the prevalence of sexual harassment.

Utilising primary prevention in workplaces has already been the subject of two research-based resources which provide valuable examples of best practice:

1. Our Watch and the Victorian Government have developed the *Workplace Equality and Respect Standards* which outline how workplaces can promote and embed gender equality and respect in the workplace through a comprehensive organisational change process.³⁸
2. Women's Health Victoria has developed *Working with Workplaces* which outlines some challenges and opportunities for workplace violence prevention and bystander programs.³⁹

Any reforms implementing a positive duty that incorporates a prevention framework should take these primary prevention resources into account.

2.2.5 Clearer guidance for employers and other duty holders

Reform is urgently needed to incorporate the above best practice into our work health and safety and anti-discrimination laws to ensure there is an effective positive duty on employers to prevent sexual harassment.

³³ Chai Feldblum and Victoria Lipnic, above footnote 26, page 49.

³⁴ Ibid, pages 50-52.

³⁵ Ibid, page 47.

³⁶ Ibid, page 59.

³⁷ Kim Webster and Michael Flood, above note 22

³⁸ See the *Workplace Equality and Respect Standards* available online at: <https://www.ourwatch.org.au/Workplace-Equality-Respect-Hub/Workplace-Equality-And-Respect-Category>.

³⁹ See the Women's Health Victoria *Working with Workplaces* knowledge paper online at: https://whv.org.au/static/files/assets/0b102585/Working_With_Workplaces_May_2018_Knowledge_Paper_Issue_1_reformat.pdf.

Work health and safety laws

Experience shows that even clear empirical evidence about the drivers of sexual harassment has failed to permeate broader societal understanding or organisational practice.⁴⁰ It is likely that the evidence-based prevention measures described above will likewise remain largely in the realm of academia and specialised organisations (such as Women’s Health Victoria and Our Watch) without a plan and a framework to implement these measures on a large, mainstream scale.

The work health and safety framework must make it clear that the general duty on employers to provide a work environment that is safe and without risks to health includes an obligation to provide a work environment that is free from sexual harassment. Work health and safety agencies must clearly communicate evidence-based measures, such as those described above, that employers and duty holders are required to implement in order to meet this legal obligation. There must also be for a framework for work health and safety agencies to assess and enforce compliance in relation to sexual harassment prevention. We refer to the ‘Stop Gendered Violence at Work’ report by the Victorian Trades Hall Council which addresses workplace sexual harassment in the context of gendered violence and suggests steps that can be taken within the work health and safety framework for this to occur.⁴¹ If these measures were in place, people like our client Fiona above may never have been subjected to sexual harassment as their employer would have taken action before it was too late.

In order to provide greater guidance for employers the general duty in the *Model Work Health and Safety Bill 2016* (Cth) should be supplemented by:

- Amending the *Model Work Health and Safety Regulations 2019* (Cth) to map out specific procedural requirements for addressing sexual harassment as a workplace hazard including policies and training that draw on best practice.
- Developing a sexual harassment code of practice which draws on best practice to provide practical guidance to employers as to how to comply with their obligations and which must be taken into account in determining whether a duty has been breached.

We note that Victoria and Western Australia have not adopted the model work health and safety laws however we consider these reforms can be applied to their laws in the same manner.⁴²

While it is noted that the *Model Work Health and Safety Bill 2016* (Cth), the *Occupational Health and Safety Act 2004* (Vic) and the *Occupational Safety and Health Act 1984* (WA) do not expressly address sexual harassment, it is not necessary to amend the general duty in

⁴⁰ For example, see Vicki J. Magley, Taylor D. Barr, Ragan E. Decker, and Courtney J. Pfeifer, ‘3.3 Appraisal and coping with sexual harassment: Existing and Needed Research’, in edited by Ronald J. Burke, and Cary L. Cooper (eds), *Violence and Abuse in and Around Organisations*, (2018): ‘Although there is clear empirical evidence that sexual harassment, even at fairly low levels, exacts a negative impact on its targets (c.f., Cortina & Berdahl, 2008) and that it is more likely to occur under three conditions: in male-dominated workplaces, with tolerant supervisors, and in overall tolerant climates (c.f., Fitzgerald, Drasgow, Hulin, Gelfand, & Magley, 1997), this research does not seem to have permeated much beyond the academic realm into a broader societal understanding.’

⁴¹ Victorian Trades Hall Council (2017) *Stop Gendered Violence at Work: Women’s Rights at Work Report*.

⁴² These jurisdictions also have a general duty supplemented by regulations (see *Occupational Safety and Health Regulations 1996* (WA) and *Occupational Health and Safety Regulations 2017* (Vic)) and codes of practice or compliance codes (see section 57 of the *Occupational Safety and Health Act 1984* (WA), and section 149 of the *Occupational Health and Safety Act 2004* (Vic).

these Acts because it is already broad enough to cover sexual harassment.⁴³ Further there is a risk that the duty will be inadvertently limited in its application to other forms of harmful discrimination in the workplace if sexual harassment alone is highlighted in this way.

Recommendation 2: The Model Work Health and Safety Regulations and Codes of Practice should be amended to create an effective framework to prevent and address sexual harassment, and these amendments should be adopted by all jurisdictions that have adopted the model laws. Victoria and Western Australia should likewise incorporate any necessary amendments into their work health and safety laws to effectively prevent and address sexual harassment.

Anti-discrimination laws

Our Commonwealth, State and Territory anti-discrimination laws also have a key role to play in protecting workers from sexual harassment, and in addressing sexual harassment outside the workplace. The Victorian *Equal Opportunity Act 2010* imposes a positive duty on employers and other duty holders to take reasonable and proportionate measures to eliminate sexual harassment as far as possible.⁴⁴ Unfortunately this positive duty is currently only enforceable through an investigation by the Victorian Equal Opportunity and Human Rights Commission (**Victorian Commission**) which does not currently have the powers to compel compliance.

Commonwealth, State and Territory anti-discrimination laws should be amended to:

- Impose a positive duty on employers to eliminate sexual harassment as far as possible.
- Empower human rights commissions to make guidelines for compliance which must be taken into account in any application under the law and must be reviewed regularly.⁴⁵
- Enable the positive duty to be enforced by the relevant human rights commission with the suite of powers discussed below.

Recommendation 3: Commonwealth, State and Territory anti-discrimination laws should impose an enforceable positive duty on employers to prevent sexual harassment, supplemented by guidelines for compliance.

2.2.6 Regulators empowered and resourced to utilise a full suite of powers to enforce compliance with the law

In addition to having clear positive duties in place for employers to prevent sexual harassment, we need a framework to ensure that these duties are enforced. The well-established concept of a regulatory pyramid (see Table 1. below) is based on the idea that efforts to persuade compliance with the law are more effective if they are backed by the

⁴³ See section 19 of the *Work Health and Safety Bill 2006* (Cth), section 19 of the *Occupational Safety and Health Act 1984* (WA), and section 21 of the *Occupational Health and Safety Act 2004* (Vic).

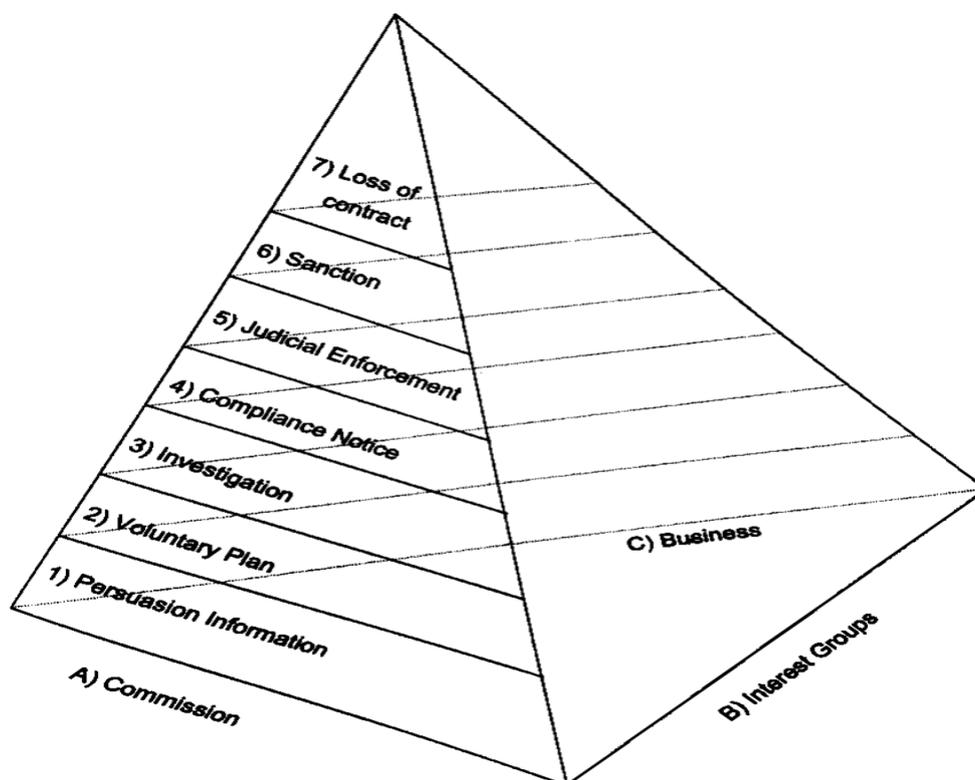
⁴⁴ *Equal Opportunity Act 2010* (Vic) section 15.

⁴⁵ The Australian Human Rights Commission currently has the power to make guidelines under both the *Sex Discrimination Act 1984* (Cth) and the *Australian Human Rights Commission Act 1986* (Cth) but they are not enforceable. The AHRC's guidelines regarding workplace sexual harassment, *Effectively preventing and responding to sexual harassment: A code of practice for employers*, were last updated in 2008.

threat of punishment for non-compliance.⁴⁶ British academics Hepple, Coussey and Choudhury developed an enforcement pyramid for regulating discrimination and sexual harassment laws:

- At the base of the pyramid is persuasion, including education and training, followed by voluntary action plans.
- Next is an investigation by a Commission which can enter into enforceable undertakings or issue compliance notices.
- At the top of the pyramid is prosecution and sanctions.⁴⁷

Table 1. Regulatory pyramid:⁴⁸



Recent research on the deterrence impact of the activities of the Fair Work Ombudsman supports the need for a full suite of enforcement powers, finding that a greater emphasis on concentrated and sustained enforcement activity can increase compliance with employment standards.⁴⁹

Work health and safety agencies

While our work health and safety agencies already have the full suite of powers in the regulatory pyramid above, they have not utilised these powers to address sexual

⁴⁶ See Ian Ayres and John Braithwaite (1992) *Responsive Regulation: Transcending the Deregulation Debate*, Oxford University Press.

⁴⁷ Bob Hepple, Mary Coussey and Tufyal Choudhury (2000) *Equality: A New Framework: Report of the Independent Review of the Enforcement of UK Anti-Discrimination Legislation*, Hart Publishing, page 58-59.

⁴⁸ Ibid, page 59. Note the “loss of contract” category at the top of the pyramid represents an additional sanction on government contractors who are found to be liable for persistent non-compliance.

⁴⁹ Tess Hary and John Howe (2017) *Creating ripples, making waves? Assessing the general deterrence effects of enforcement activities of the Fair Work Ombudsman*, Sydney Law Review, volume 39, page 502.

harassment in a regular or systemic way. Given work health and safety agencies have the existing legal powers and investigations framework needed to be effective, it is our view that they must take the lead in addressing sexual harassment in Australian workplaces.

Increased resourcing is required to enable work health and safety agencies to address sexual harassment, and training is required for staff of these agencies as to what constitutes sexual harassment and how to undertake their functions in relation to it.

Human rights commissions

Human rights commissions have a key role to play alongside work health and safety agencies in addressing sexual harassment:

- Work health and safety agencies can only address sexual harassment within workplaces, however sexual harassment is prohibited in other areas of life such as goods and services and education. Approximately 15% of our sexual harassment advice at Victoria Legal Aid is in relation to sexual harassment outside the workplace. Similarly, approximately 18% of complaints under the *Sex Discrimination Act 1984* (Cth) to the AHRC relate to sexual harassment outside the workplace.⁵⁰
- Last year the AHRC received over 14,000 enquiries,⁵¹ which gives it the opportunity to identify systemic issues and repeat offenders. The AHRC and State and Territory human rights commissions should be granted powers to address the systemic issues they identify through their functions under anti-discrimination laws.
- The AHRC and State and Territory human rights commissions have a key role to play in public education. We encounter many employers that do not understand what their obligations are under anti-discrimination law, and many employees do not understand what constitutes sexual harassment. The AHRC National Prevalence survey found that half of participants who said they hadn't been sexually harassed based on the legal definition of sexual harassment did report being subjected to behaviours that constitute sexual harassment.⁵²

Our Commonwealth, State and Territory human rights commissions lack the powers that form the top of the regulatory pyramid outlined above. The AHRC and State and Territory Commissions have education and dispute resolution functions, and varying investigation powers, but no power to compel compliance with anti-discrimination laws. Reforms in the original *Equal Opportunity Act 2010* in Victoria would have enabled the Victorian Commission to enter into enforceable undertakings and issue compliance notices, however these reforms were pulled back in 2011 before coming into force.

Our Commonwealth, State and Territory anti-discrimination laws should be amended to:

- Ensure all human rights commissions have the power to investigate acts or practices of their own motion that may be inconsistent with anti-discrimination law, without additional procedural requirements such as those present under section 127 of the *Victorian Equal Opportunity Act 2010*.

⁵⁰ Australian Human Rights Commission 2017-2018 Complaint statistics, accessed online on 2 February 2019 at https://www.humanrights.gov.au/sites/default/files/AHRC_Complaints_AR_Stats_Tables_2017-18.pdf.

⁵¹ Ibid.

⁵² Australian Human Rights Commission, above footnote 13, page 24.

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- Enable all human rights commissions to enforce compliance with anti-discrimination law following an investigation, including entering into enforceable undertakings with employers and issuing compliance notices.

It is essential that increased resourcing be provided to human rights commissions to make these enforcement powers meaningful and to increase the commissions' abilities to undertake their public education and inquiries functions.

Regulatory overlap

While the degree of overlap of regulatory functions of human rights commissions and work health and safety agencies would potentially increase as a result of the above recommendations. In practice, individual victims of sexual harassment would have the option of pursuing both a complaint through a human rights commission and reporting the incident to a work health and safety agency for investigation and potential enforcement or prosecutorial action. This can be managed by memoranda of understanding between the regulators to ensure they share data and coordinate their activities.⁵³ According to our recommendations, both human rights commissions and work health and safety agencies would have research and educative functions, powers to issue guidance materials, investigative powers, and power to issue enforceable undertakings and compliance notices, and seek court enforcement of such notices. However, only work health and safety agencies would have the power to prosecute and seek penalties for sexual harassment-related contraventions. As indicated above, this limit on the regulatory pyramid of powers of human rights commissions may limit the effectiveness of their other regulatory powers, which lack the ultimate threat of prosecution and penalty. For this reason, we reiterate that work health and safety agencies should play the lead role in addressing workplace sexual harassment.

Recommendation 4: Commonwealth, State and Territory work health and safety agencies should be resourced and trained to effectively address sexual harassment.

Recommendation 5: Commonwealth, State and Territory human rights commissions should be granted increased powers and resources to effectively address sexual harassment including greater investigation powers, the power to enter into enforceable undertakings, and the power to issue compliance notices.

⁵³ For an example of this in practice, see US Equal Employment Opportunity Commission, Memoranda of Understanding, accessed at <https://www.eeoc.gov/laws/mous/index.cfm> - on 10 February 2019, which contains a list of Memoranda of Understanding between the EEOC and other State agencies, which "explain how two or more agencies will cooperate and interact when their enforcement responsibilities overlap."

PART 3: REDRESS AND SUPPORT FOR VICTIMS OF SEXUAL HARASSMENT

The sections and recommendations above have largely focussed on systemic measures to address sexual harassment as a cultural problem, including as a significant workplace health and safety issue. It is equally important that the individual complaints-based framework operates as fairly and effectively as possible. Everyone has the right to be safe and healthy at work. When this right is infringed and workers experience workplace harassment and discrimination they are entitled to fair and accessible redress. Further, while limited, there is some scope for individual complaints processes to contribute to systemic change, as discussed below.

Given the harm and distress caused by sexual harassment it is also critical that there are accessible specialist services available to support victims of sexual harassment. This is necessary in order to provide victims of sexual harassment the support necessary to both recover and continue to participate fully in life and work, and also to pursue any avenues for regulatory action or legal redress that are available to them.

3.1 Increasing the impact of individual complaints

Until sexual harassment is eliminated from Australian workplaces individual complaints will always be a key feature of our regulatory system. In jurisdictions that have a positive duty to address sexual harassment and a regulatory body with a range of enforcement powers, such as Sweden, the vast majority of individual claims still settle without enforcement activity from the regulator.⁵⁴ Any reforms to our anti-discrimination laws should consider ways in which our individual complaints system can better prevent and address sexual harassment. This should include reforms directed at encouraging systemic outcomes in dispute resolution processes, and improving access to information and data about the nature of sexual harassment complaints that are initiated, and outcomes achieved.

3.1.1 Use of standard form settlement agreements to encourage systemic outcomes

Sexual harassment complaints commonly resolve prior to a final hearing on terms that seek to address the loss or harm caused to the complainant, often through financial compensation. While complaints may also resolve on terms requiring some preventative organisational change on the part of employers, such as undertaking to implement training or policy updates, in our experience these outcomes are infrequent.

The AHRC's 2017-18 annual report notes that 31% of conciliation agreements included 'terms that benefit the community', although it's not clear what proportion of these agreements related to sexual harassment. In the 2017-18 financial year 25% of the matters where VLA assisted complainants to negotiate an outcome by agreement with their employer included terms requiring the employer to make systemic organisational changes aimed at preventing future sexual harassment.

⁵⁴ In 2017 in Sweden the Equality Ombudsman received 2,475 complaints and investigated only 204 of them, see Paul Lappalainen (2017) *Country Report: Non-Discrimination, Sweden*, European Commission, page 117.

In our experience of settlement negotiations, employers and their representatives are often taken aback by settlement proposals that require systemic or organisational change and are unwilling to consider such proposals. In one instance, a Respondent expressed surprise that such outcomes were being sought and remarked that this must be ‘just a legal aid thing’. Remedies of this nature are also rarely ordered by courts and tribunals. The infrequency of these outcomes severely limits the systemic change that is generated from the individualised complaints process.

One solution is to amend the standard form settlement agreements used by human rights commissions and the Fair Work Commission to include terms aimed at preventing and addressing any future harassment. This could prompt complainants to consider seeking such outcomes and normalise these requests, whilst ultimately leaving the final terms of any agreement to the parties’ discretion. Ideally, commission processes would also be appropriately updated to prepare parties to consider these terms, including resources and training for mediators/conciliators. Standard terms relating to release and enforcement should be likewise amended to ensure compliance with these obligations, together with payment of financial compensation.

Recommendation 6: Standard form settlement agreements for sexual harassment complaints should include terms requiring duty holders to implement systemic measures to prevent and address sexual harassment.

3.1.2 Improved access to information and data

There is limited publicly available data and information about complaints of sexual harassment that are initiated. This is due in part to:

- The low numbers of legal complaints that proceed to final hearing, with most settling out of court on the basis that the details of the complaint remain confidential. In our practice experience, these settlement clauses are routine.
- An absence of consistent recording and reporting of deidentified complaints outcome data from relevant statutory commissions. Although the AHRC publishes some deidentified details of complaints proceeding to conciliation, including settlement outcomes, these records are ad-hoc and are not consistently updated.⁵⁵

The impact of this is that the extent of sexual harassment as a wide-spread problem is obscured from the public, employers, governments and regulators. Were this data available it could inform strategies to address systemic sexual harassment by identifying drivers, patterns of abuse and industry trends. It would also provide a resource to evaluate the effectiveness of the current laws and regulatory regime.⁵⁶

Further, this lack of transparency acts as an inhibitor for would-be complainants. Significant wins that might demonstrate the effectiveness and accessibility of the individualised complaints system are not visible to those subjected to sexual harassment. Deidentified information, including the nature of the complaint and settlement outcomes could encourage victims to more readily initiate complaints and provide them with guidance on fair settlement

⁵⁵ McDonald, P and Charlesworth, S (2013), ‘Settlement outcomes in sexual harassment complaints’, *Australasian Dispute Resolution Journal*, vol.24, no.4, pages 259 – 269.

⁵⁶ *Ibid.*

outcomes. Equally, the reporting of settlement outcomes could act as a deterrent to perpetrators and employers.

Resourcing statutory commissions to consistently record and report publicly on sexual harassment complaints data would address this issue. Ideally both aggregate and disaggregated data would be made available. Kingsford Legal Centre's report 'Having my voice heard: fair practices in discrimination conciliation', recommends available disaggregated data include:

- The nature of the complaint.
- Outcomes achieved.
- How many parties were legally represented.
- The number of complaints accepted, terminated, withdrawn or settled.⁵⁷

Any reforms to the individual complaints process should draw on the findings of the Kingsford Legal Centre's survey of vulnerable applicants' experience of conciliation processes and subsequent report.

We are also of the view that aggregated data on settlement outcomes, both financial and non-financial, would also be a valuable resource for potential complainants. In addition, any reporting and recording mechanism would also ideally capture matters resolved prior to final hearing at the Victorian Civil and Administrative Tribunal, the Federal Court and Federal Circuit Court.

We are aware that internationally there have been moves to regulate confidentiality clauses in settlement agreements to identify repeat offenders and provide for greater transparency.⁵⁸ We would urge that this measure be approached with caution. In our experience, confidentiality clauses often serve the complainant's interest by encouraging the early resolution of claims and allowing complainants to avoid the trauma of a public hearing. In some instances, complainants will also have valid reputational concerns, for instance that they may be labelled as litigious. These clauses are often actively sought by our clients and we would be concerned that complainants may be deterred if an early and/or confidential resolution was no longer available.

Recommendation 7: The Commonwealth, State and Territory human rights commissions should be required to regularly record and report deidentified complaint data and information.

⁵⁷ Maria Nawaz, Anna Cody & Emma Golledge, 'Having my voice heard – Fair practices in discrimination conciliation' (Report), Kingsford Legal Centre (2018) 37.

⁵⁸ See for example Cal Civ Code §1001 (2019), and Wash Rev Code § 49.44.210 (2018).

3.2 Complaint processes must be fairer and more accessible

3.2.1 Include in the Fair Work Act explicit protection against sexual harassment

Unlike discrimination protections, sexual harassment protections are not explicitly included in the *Fair Work Act 2009* (Cth) (**FW Act**).⁵⁹

We recommend that the FW Act be amended to expressly protect employees from sexual harassment for a number of reasons:

- In our practice experience employers have a much stronger understanding of their obligations under the FW Act than they do of their obligations under anti-discrimination law.
- As outlined above sexual harassment often goes hand in hand with other forms of discrimination and unlawful conduct. Incorporating sexual harassment into the FW Act also removes the necessity for employees to bring multiple claims if aspects of their employer's conduct are captured by the FW Act but there is a sexual harassment aspect that falls outside the protection of the FW Act.
- As highlighted below, a significant benefit to claims under the FW Act is the speedy process at the Fair Work Commission. Incorporating sexual harassment protections in the FW Act would enable employees to take advantage of this process where it suits their interests.
- Finally, the Fair Work Ombudsman (**FWO**) has a key role to play in enforcing employment regulations. When the FWO is investigating a workplace it should have the ability to consider the full range of unlawful workplace conduct including sexual harassment.

A stand-alone civil remedy provision in the FW Act would provide clear protection from sexual harassment in the FW Act jurisdiction.

While an alternative would be to clarify that sexual harassment can constitute sex discrimination under section 351 this approach is not recommended because:

- It would not provide a clear outline of what kind of conduct is unlawful, and
- It would be an unnecessarily legally complex protection requiring the victim to prove that the sexual harassment was "because of" the victim's sex, and that the conduct fit into the categories of adverse action.⁶⁰

We appreciate that there may be concerns about complainants duplicating proceedings, however there are already mechanisms in the FW Act to ensure that claims of the same nature are not brought in multiple jurisdictions.⁶¹ Further, the overlap of regulatory functions between the Fair Work Ombudsman, work health and safety agencies and human rights commissions can be managed by memoranda of understanding between the regulators to

⁵⁹ Discrimination is prohibited under section 351 of the *Fair Work Act 2009* (Cth).

⁶⁰ See *Fair Work Act 2009* (Cth) sections 342 and 351.

⁶¹ See *Fair Work Act 2009* (Cth) sections 725 to 732.

ensure they share data and coordinate their activities. While having multiple avenues available for complaints may be confusing for complainants, this is already the case for discrimination claims and as a result, human rights commissions and the Fair Work Commission already have processes in place to provide information to people with multiple legal options, and identify and respond to people who have lodged multiple complaints.⁶² We consider that the existence of funded specialist legal services can also significantly assist complainants to navigate their legal options.

Recommendation 8: The Fair Work Act should be amended to protect workers from sexual harassment with a stand-alone civil remedy provision to enable the Fair Work Commission to receive complaints and the Fair Work Ombudsman to tackle sexual harassment.

3.2.2 Extend the coverage of protections against sexual harassment

In our practice experience the limitation of sexual harassment protections to certain areas of public life can leave employees without protection in circumstances related to their employment. For example, we have seen more than one client who has been sexually harassed by their boss's husband in a workplace context. Because the boss's husband was not an employee or other workplace participant captured by the SDA, it was not possible for these clients to bring a sexual harassment claim in relation to conduct which they found incredibly distressing.

Queensland has extended protection from sexual harassment to all areas of public life, making it unlawful for any person to sexually harass another person.⁶³ The vicarious liability provision remains and ensures employers would only be held responsible for conduct of their employees or agents while acting as an agent.⁶⁴

Recommendation 9: Commonwealth, State and Territory anti-discrimination laws should be amended to expand protection from sexual harassment to all areas of public life.

3.2.3 Share the burden of proving sexual harassment

Under Commonwealth, State and Territory anti-discrimination laws the burden of proving sexual harassment rests solely with the applicant.⁶⁵ This means that our sexual harassment laws do not start from the position of believing victims of sexual harassment, rather the victim must prove that they are telling the truth. In our practice experience many people are deterred from taking legal action about sexual harassment due to difficulties proving the conduct, including due to lack of access to documents and other information held by the employer,

⁶² For example, the complaint form of the Australian Human Rights Commission asks whether a complaint has already been made to another organisation (<https://www.humanrights.gov.au/complaints/make-complaint/complaint-form>), and section 46PH of the Australian Human Rights Commission Act 1986 (Cth) enables a complaint to be terminated if it has already been or could be adequately dealt with by another statutory authority.

⁶³ *Anti-Discrimination Act 1991* (QLD) section 118.

⁶⁴ *Ibid*, section 133.

⁶⁵ For example, under the *Sex Discrimination Act 1984* (Cth) the onus lies with the applicant and only shifts to the respondent to prove that a requirement, condition or practice is reasonable under section 7C.

and witness reluctance to give evidence. These problems have been referred to as the employer's 'monopoly on knowledge'.⁶⁶

The significant power imbalance resulting from the respondent's monopoly on knowledge is recognised by the General Protections provisions in the FW Act. Under section 361 of the FW Act an employer has the burden of proving a non-discriminatory reason for an action taken if a General Protections claim is lodged. The Explanatory Memorandum to the Fair Work Bill 2008 (Cth) outlines that this section "recognises that, in the absence of such a clause, it would often be extremely difficult, if not impossible, for a complainant to establish that a person acted for an unlawful reason". The Courts have held that this first requires the applicant to establish a prima facie case that the discriminatory conduct occurred before the burden of proof shifts to the respondent. This approach is in line with the approach of comparative jurisdictions such as the United Kingdom.

Our experience in FW Act discrimination claims is that shifting the burden of proof to the employer improves the prospect of the matter resolving by agreement at a mediation as well as at hearing. This is because an employee can shift the focus of a mediation to what evidence the employer has that its actions were lawful, rather than focusing solely on the limited evidence available to the employee. We need to amend anti-discrimination laws to ease the evidentiary burden on victims of sexual harassment and remove this barrier to victims pursuing complaints.

Recommendation 10: Commonwealth, State and Territory anti-discrimination legislation should be amended to shift the burden of proof to the employer once the employee has established a prima facie case.

3.2.4 Extend the time limits for making a legal complaint

In our practice experience it is difficult for many people who have experienced sexual harassment to seek advice and take action within the current 6 month time limit under the *Australian Human Rights Commission Act 1986* (Cth). There are many reasons for this including the mental health impacts of sexual harassment which can be severe, and reluctance of some employees to report complaints while they are still employed. The case study of Penny below illustrates this, where Penny needed time to make sense of what happened and work through feelings of shame and guilt before she could take action. For some clients the knowledge that their claim may be rejected because it is outside the time limit is enough to prevent them from making a claim at all. Further, the time delay can be used by employers responding to a claim to delay proceedings and increase costs with interlocutory jurisdictional proceedings.

If we look to overseas jurisdictions for comparison Ontario, Canada has recognized the barriers to early reporting and completely removed the limitation period for civil sexual harassment lawsuits.⁶⁷

⁶⁶ Margaret Thornton, *The Liberal Promise: Anti-Discrimination Legislation in Australia* (1990) 180 and Laurence Lustgarten, 'Problems of Proof in Employment Discrimination Cases' (1977) 6 *Industrial Law Journal* 212, 213. See also Dominique Allen, 'Reducing the Burden of Proving Discrimination in Australia' [2009] 31 *Sydney Law Review* 579, 583.

⁶⁷ CBC Radio (2018) *Civil cases for sexual harassment — a new avenue for women seeking justice?* Accessed online on 1 February 2019: <https://www.cbc.ca/radio/thecurrent/the-current-for-january-08-2017-1.4475517/civil-cases-for-sexual-harassment-a-new-avenue-for-women-seeking-justice-1.4475519>.

Comparing to other employment related rights of action in Australia the time limit for all non-dismissal related civil remedy provision protections in the *Fair Work Act 2009* (Cth) is 6 years.⁶⁸ This represents a much fairer time limit on claims than 6 or 12 months and would enable more people who have experienced sexual harassment to come forward and hold perpetrators to account.

Recommendation 11: Commonwealth, State and Territory anti-discrimination legislation should be amended to extend the time limit for bringing a complaint to 6 years.

3.2.5 Reduce the risk of prohibitive costs orders

As indicated above, many clients are deterred from pursuing a meritorious legal complaint as a result of the evidentiary burden of proving their claim and the employers 'monopoly on knowledge'. This deterrent effect is significantly compounded by the risk of incurring an adverse costs order in the event that they lose their case. The principle that 'costs follow the event' acts as a strong disincentive against taking legal action, particularly given the economic power imbalance between most complainants and perpetrators in the area of employment.

While there is discretion to not award costs under the SDA, Courts have not considered claims arising under other Federal discrimination legislation to warrant any departure from the ordinary rule in that jurisdiction that costs will follow the event.⁶⁹ The approach to costs is contrary to the approach to legal costs in the relevant provisions of the FWA and State and Territory laws. Under the Victorian *Equal Opportunity Act 2010* (Vic), for example, costs may be ordered at the Tribunal stage but only where one party has unreasonably caused the other to incur unnecessary costs. The Victorian Civil and Administrative Tribunal has ruled that costs orders should not be made lightly in the human rights jurisdiction so as not to deter applicants from using the method of redress provided by the law.⁷⁰ Unfortunately, however, the reality is that the failure to reward successful applicants with a favourable costs order is having the opposite effect due to the risk that their own legal costs will be equal or greater than the compensation awarded.

The deterrent effect of the current costs rule could be ameliorated by allowing costs orders against an unsuccessful defendant, but limiting costs orders against unsuccessful applicants to instances where the application is frivolous, vexatious or without foundation. This is the approach taken in discrimination cases in the United States.⁷¹ The US Supreme Court has held that there are at least two strong equitable considerations favouring this approach, being that discrimination law is a law that Congress considered of the highest priority, and when a district court awards counsel fees to a prevailing plaintiff, it is awarding them against a violator of federal law. Under section 43 of the *Federal Court of Australia Act 1976* (Cth) and section 79 of the *Federal Circuit Court of Australia Act 1999* (Cth) the Courts' costs powers are subject to any restrictions placed by other Acts. The *Australian Human Rights Commission Act 1986* (Cth) could be amended to insert a provision adopting this approach.

⁶⁸ *Fair Work Act 2009* (Cth) section 544.

⁶⁹ *Hollingdale v North Coast Area Health Service (No.2)* [2006] FMCA 585 per Driver FM.

⁷⁰ *Tan v Xenos* [2008] VCAT 1273 per Judge Harbison VP.

⁷¹ *Christianberg Garment Co v EEOC* 434 US 4012 (1978).

Recommendation 12: Commonwealth, State and Territory anti-discrimination laws should be amended to include a costs rule which provides that costs orders against an unsuccessful defendant are allowed, but costs orders against unsuccessful applicants are limited to instances where the application is frivolous, vexatious or without foundation.

3.2.6 Increase resourcing of human rights commissions to enable the early resolution of sexual harassment complaints

The reported average time from receipt to finalisation of a complaint at the AHRC in 2017-18 was approximately 4.6 months, indicating a delay between the lodgement of a complaint and the conciliation.⁷² This delay prolongs the dispute as well as the stress associated with the dispute. This is particularly concerning for complainants who remain employed in the workplace where the harassment occurred and wish to maintain harmonious working relationships and retain their employment.

The AHRC should be properly resourced to provide a more timely complaints process, with consideration of more ambitious targets for the time between the initiation of a complaint and a conciliation. The Fair Work Commission sets a target of providing a conciliation for unfair dismissal applications within 34 days of a complaint being lodged,⁷³ and in 2017-18 the median time between lodgement and conciliation of general protections claims involving dismissal was 40 days.⁷⁴ By comparison, the AHRC aims to finalise 85% of complaints within 12 months.⁷⁵

We appreciate that there will be circumstances where it is appropriate to take a slower approach to resolution, such as when either party is experiencing ill-health. However, most parties desire a resolution of their dispute as soon as possible, and for some people a swift resolution will mean that they can save their working relationship and stay employed.

Recommendation 13: The Commonwealth, State and Territory human rights commissions should be resourced to reduce the current wait times for conciliations.

3.2.7 Improved alternative dispute resolution processes

We routinely represent clients with complaints of sexual harassment and discrimination in alternative dispute resolution processes (**ADR**) across various jurisdictions, including the Fair Work Commission, the AHRC, the Victorian Commission, as well as Courts and Tribunals. These processes include mediations, conciliations and compulsory conferences in the Victorian Civil and Administrative Tribunal (overseen by a member of the Tribunal).

Our experience of these processes reflect the findings of Kingsford Legal Centre's recent survey; that there is a lack of consistency within and between jurisdictions.⁷⁶ There are some discernible differences in the models of dispute resolution adopted by the commissions⁷⁷ that

⁷² While the date when a complaint is finalised does not necessarily coincide with the conciliation date, in our experience most matters that finalise do so on the day of conciliation or shortly thereafter.

⁷³ Fair Work Commission annual report 2017-18 online, Fair Work Commission: <https://www.fwc.gov.au/annual-report-2017-18>

⁷⁴ Fair Work Commission, above footnote 73

⁷⁵ Australian Human Rights Commission (2018) *Annual Report 2017-2018*, page 27.

⁷⁶ Maria Nawaz, Anna Cody & Emma Golledge, above note 57, page 45.

⁷⁷ See the discussion of models of ADR in Maria Nawaz, Anna Cody & Emma Golledge, above footnote 57, page 6.

we have identified through practice experience. For instance, the Fair Work Commission has minimal wait times between lodgement and conciliation, although its ADR processes are generally outcomes focussed.

In many instances, however, our clients want the opportunity to explain to the respondent their experience of the harassment and its impact on them. When not provided with this opportunity clients often leave feeling that their dispute and related feelings remain unresolved, even though the parties may have reached a settlement agreement. In some cases, an outcomes focussed process can impede resolution because a party is unwilling to agree to settle their dispute in the absence of feeling heard.

In our experience, the ADR processes across jurisdictions will not always provide a forum for this and the process often turns heavily on the individual style of the mediator or conciliator. In particular, some mediators will be engaged with the issues and informed of the relevant legislative provisions, whilst others will take a hands-off approach and allow the process to be driven by the legal representatives. Inconsistencies in these processes makes it difficult for us to prepare clients for what to expect and can compound their distress. In many cases, clients will feel pressured to resolve their claim on terms that do not meet their interests.

The Kingsford Legal Centre recommends that ‘a basic framework for conciliation procedures should be provided to the parties and any representatives prior to conciliation, similar to the conciliation agenda provided by AHRC to parties’.⁷⁸ We agree and consider that a key part of the framework should include providing the parties with an opportunity to speak about their experience. It is our view that providing a clear structure and framework for conciliations would reduce inconsistencies in individual conciliator or mediator styles and clarify the expectation of everyone involved, including the expectation that conciliations and mediations are a restorative process.

Recommendation 14: A basic framework for alternative dispute resolution procedures in courts, tribunals and commissions that deal with sexual harassment complaints should be provided to the parties and any representatives prior to a conciliation or mediation, and should include specific time for individuals to speak about their experience and the impact of the harassment on them.

Recommendation 15: Conciliators and mediators should receive consistent training in alternative dispute resolution theory and techniques from experts in the field, including in how to mitigate power imbalances.

⁷⁸ Maria Nawaz, Anna Cody & Emma Golledge, above footnote 57, pages 45-46.

3.3 Better support for victims of sexual harassment

3.3.1 Better protections of complainants within their employment

We have seen many clients suffer punitive consequences at work as a result of making a complaint about sexual harassment, echoing the AHRC Survey findings.⁷⁹ These consequences include “being labelled a troublemaker, being victimised or ignored by colleagues, being disciplined or resigning.”⁸⁰

While there is some legal protection if the negative consequences amount to unlawful victimisation under anti-discrimination law⁸¹ or adverse action under the *Fair Work Act 2009* (Cth),⁸² there are no explicit legislative standards regulating employer responses to complaints of sexual harassment. Employers will avoid liability for a claim of sexual harassment if they can show they took reasonable precautions,⁸³ or all reasonable steps to prevent the conduct. However, this will not necessarily include responding appropriately to the complaint that precipitated the legal claim.

As a result, our clients have experienced the following detriment without any legal redress:⁸⁴

- deeply flawed workplace investigations, for example investigations that:
 - lacked procedural fairness,
 - inappropriately applied a criminal standard of proof, or
 - failed to communicate the outcome of the investigation to the complainant;and
- unacceptable employer responses to their complaint, for example:
 - inaction or long delays,
 - conduct deterring the complainant from making a formal complaint,
 - isolating the complainant,
 - requiring the complainant to work in close proximity to the perpetrator, or
 - standing the complainant down.

The result is that complainants feel demoralised, perpetrators of sexual harassment may not face appropriate sanction and ongoing employees may be deterred from speaking up.

There is also a lack of regulation of external workplace investigators who are often engaged by employers to investigate complaints of sexual harassment, with no requirements to undertake specific training or hold a particular license.⁸⁵

Although complaint handling processes and investigations will always cause some degree of tension or stress, there should be a mechanism for individuals to hold employers and

⁷⁹ Australian Human Rights Commission, above footnote 13.

⁸⁰ *Ibid.*

⁸¹ Section 103 *Equal Opportunity Act 2010* (Vic), Section 93 *Sex Discrimination Act 1984* (Cth).

⁸² Section 342, *Fair Work Act 2009* (Cth).

⁸³ Section 110, *Equal Opportunity Act 2010* (Vic).

⁸⁴ Case law demonstrates that the requirement to show that the punitive conduct was taken *because of* the complaint in order to prove a claim of victimisation has proved insurmountable for complainants in many instances, with Courts and Tribunals unwilling to make a finding of victimisation: *Lazos v Australians Workers Union & Anor* [1999] VCAT 635, *Besley v National Aikido Association Inc* [2005] VCAT 245. Similarly, attempts to frame onerous requirements imposed in investigation processes as claims of indirect discrimination on the basis of sex have failed: *Richardson v Oracle Corporation Australia Pty Ltd* (2014) 223 FCR 334, 376.

⁸⁵ Although statutes regulating the private security industry, such as the *Private Security Act 2004* (Vic) may apply to workplace investigators, but this has not been judicially considered: see Adriana Orifici, *Workplace Investigations and Regulation: A Preliminary Map*, Presentation at the Australian Labour Lawyers Association Conference (9 November 2018).

investigators accountable for conduct that falls well below an agreed standard, such as in the examples outlined above. This issue could be addressed by amending the law to provide a legal claim for complainants subjected to an inadequate employer response to their complaint.

Providing complainants with the option to initiate an action against employers for such conduct would allow the individualised complaints system to do more to incentivise employers to take appropriate action to respond to sexual harassment, as well as encouraging more complainants to come forward.

Recommendation 16: Consideration should be given to reforming Commonwealth, State and Territory anti-discrimination laws and the Fair Work Act to improve protection and redress for people who complain of sexual harassment and suffer detriment because the employer or other duty holder fails to respond reasonably or handles an investigation badly.

3.3.2 Confidential online reporting tool for victims of sexual harassment

As outlined above, there are a number of barriers to people who have experienced sexual harassment coming forward and only 1 in 5 people make a complaint about sexual harassment. In our experience many victims of sexual harassment who do seek advice decide not to take the matter further. This is for many reasons including fear that they will not be believed, concerns about retaliation and fear about the impact on their career and reputation. It is important to look at a range of ways in which we can support people to come forward about their experiences.

Over the last few years a range of online reporting tools have been developed informed by the barriers to reporting sexual assault. Project Callisto in the United States targets sexual assault on University Campuses and provides an online trauma informed platform for students to document and report their sexual assault.⁸⁶ Its three year report confirms that it significantly increases the chances that a victim of sexual assault will report it, increases access to support services, and enables schools to detect repeat offenders.⁸⁷ There are a variety of models for online reporting tools that can:

- Provide information about legal protections and options for addressing problem behaviour;
- Notify the employer and/or regulator when a report is made;
- Link victims of the same perpetrator;
- Link victims with support services; and/or
- Enable identification and reporting on trends.

In Australia, South Eastern CASA has developed the Sexual Assault Report Anonymously (**SARA**) mobile website.⁸⁸ SARA enables victims to report what happened to them and elect if they would like to be contacted by a sexual assault counsellor. Anonymous data is provided to police to help identify trends. Clients are also given the option to make a supported report to the police. SARA has been a user centred, trauma informed design pilot

⁸⁶ Project Callisto 2017-2018 Academic Year Report, accessed online on 4 February 2019 at: http://www.projectcallisto.org/Callisto_Year_3_final.pdf

⁸⁷ Ibid page 3.

⁸⁸ See <https://www.sara.org.au/>

which has grown substantially, receiving 604 reports last financial year.⁸⁹ While this tool has not yet been officially evaluated, it is our view that it creates a framework aimed at providing a safe and supportive space to encourage people to share experiences they otherwise wouldn't share.

A similar tool could be developed for victims of sexual harassment. We consider that, like SARA, such a tool should also commence as a small user centred design pilot that can be scaled following iterative development. We would urge careful consideration of various factors required for a successful online reporting tool and management of that tool, such as:

- the ownership, use and sharing of data collected through the tool;
- accessibility, including for people with a disability and people who cannot read or write well in English due to language or literacy skills;
- confidentiality and privacy needs of those reporting sensitive information;
- the skills, sensitivity and training required to communicate safely and effectively with people who have experienced sexual harassment and assault, and may be traumatised by their experience;
- the training and support required to ensure the safety of staff who manage the tool and provide support to victims; and
- protocols for referrals to service providers and agencies.

We note that a victim-centric confidential online reporting tool is quite different to other anonymous online reporting tools that are marketed towards employer organisations and aimed primarily at assisting those organisations to identify problem 'hot-spots' and patterns.

Recommendation 17: Funding should be granted to pilot an accessible and confidential online reporting tool that (a) assists people to report and address problem behaviour and seek support, and (b) identifies trends to assist with prevention and enforcement

3.3.3 Accessible support for victims of sexual harassment

In our practice experience it can be very difficult for our clients to access appropriate and affordable counselling support. There is no free and widely accessible counselling service tailored to the needs of people who have experienced sexual harassment. While the Victorian Centres Against Sexual Assault do provide counselling for sexual harassment they prioritise their waiting lists based on the severity of the sexual assault. As a result the primary option for psychological support for victims of sexual harassment is to be granted a mental health care plan and find a psychologist who is willing to bulk bill for sessions and has availability within an accessible distance. Unfortunately it is often the case that our clients struggle to access support within this system with few psychologists who bulk bill and significant wait times for those who do.

Victims of sexual harassment should have access to appropriate and timely specialist support when they need it, including access to information and counselling that is

⁸⁹ South Eastern Centre Against Sexual Assault (2018) *Annual Report 2017-2018*, accessed online on 4 February 2019 at: <https://www.secasa.com.au/assets/Documents/annual-report-2017-2018.pdf>

appropriately resourced and coordinated. Penny's story below highlights how difficult it can be to take action about sexual harassment without the necessary supports.

Lack of appropriate counselling support for victims: Penny's story

I worked as a retail assistant at a clothing store. I was sexually assaulted by my manager after work hours. He also sent me text messages containing sexual comments that were quite controlling and confronting.

I complained, and my employer investigated the conduct. I felt that at the time I was not supported as I had to tell the story a few times to different people. It felt like an interrogation. I told them that I was anxious and unwell as a result. I said I hadn't asked for anything, I just didn't want him to work there anymore.

They came back with a decision that there wasn't enough evidence to support my complaint, but they would relocate him. I knew I would still have contact with him through the work phone and email. I told them that they haven't provided me with a safe workplace and I put in a letter of resignation as I could no longer work here.

The way that management handled the situation highlighted that the workplace did not have the framework to handle complaints as I felt dehumanised from the investigation process and it turned me off wanting to pursue legal matters further. It was all too much, even living at that point was a struggle. Nothing that I said was believed.

If there wasn't a timeframe on sexual harassment complaints I would probably do something about it now. At the time I was trying to make sense of what happened. I felt a lot of shame and guilt.

It would be good if, after speaking to a lawyer, there was an option to be transferred through to a counsellor to debrief about it afterwards. This would've helped me as it was triggering speaking about it and I felt alone after hanging up on the phone. I would have liked to have someone tell me that I haven't done anything wrong and to let me know what I could have done for self-care and referral to some doctors. Kind words are appreciated as it was hard to survive.

We need to make sure that people like Penny are supported in the future to minimise the ongoing harm caused by speaking up about sexual harassment.

Recommendation 18: Specialist support services should be funded to assist people who have experienced sexual harassment.

Annexure 7

Power to Prevent: Urgent Actions Needed to Stop Sexual Harassment at Work

Joint statement

We are a group of diverse organisations, unions, researchers, peak bodies, health professionals and lawyers who have come together to say we need to do more to stop sexual harassment in workplaces. Our organisations and research efforts see the effects of sexual harassment on people around Australia every day and how our systems are not working to respond to the issues.

Everyone deserves to be safe at work and in their community. Yet the rates of sexual harassment in Australia are alarming, particularly for women, with 85% having experienced it in their lifetime. Sexual harassment is about more than just individual behaviour. It is a problem that is deeply entrenched within our society and occurs because gender inequality is ingrained in our social and cultural norms, structures and practices.

It's time that employers and workplaces stamp out sexual harassment. Sexual harassment causes significant harm to individuals, workplaces and society. We know what the solutions are, but we need governments and employers to implement them. We need strong action to prevent and respond to sexual harassment, and we need it now.

We call on State, Territory and Federal Governments across Australia to take urgent and coordinated action to implement the following solutions.

1. **Dedicated prevention efforts to address the underlying gendered drivers of sexual harassment**, which should be part of a holistic strategy to prevent violence against women and promote gender equality in line with *Change the story: A shared framework for the primary prevention of violence against women and their children in Australia*.
2. **Stronger and clearer legal duties** on employers to take proactive steps to prevent sexual harassment at work, and strong and effective regulators that have the full suite of regulatory tools and resources necessary to effectively tackle sexual harassment, including as a cultural, a systemic and a health and safety issue.
3. **Access to fair, effective and efficient complaints processes**, including a new right of action under the Fair Work Act, extended time limits, increased transparency of conciliation outcomes where appropriate, and other amendments and resources necessary to address the unique barriers that currently prevent workers who experience sexual harassment from taking effective legal action.
4. **Appropriate advocacy and support for workers** who experience sexual harassment, including access to information, counselling and legal services that are appropriately resourced and coordinated.
5. **Accessible reporting tools**, including piloting an online reporting tool that assists people to report and address problem behaviour and seek support, and identifies trends to assist with prevention and enforcement efforts.

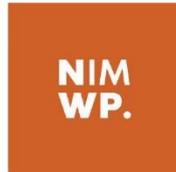
We stand together to call for change to create sexual harassment free workplaces.

List of Signatories (as at 28 February 2019)

Alice Springs Women's Shelter
Annie North Inc
Australasian Meat Industry Employees Union - Victoria Branch
Australian Council for International Development
Australian Council of Social Service
Australian Council of Trade Unions (ACTU)
Australian Discrimination Law Experts Group, Academic forum
Australian Education Union - Victoria
Australian Lawyers' Alliance
Australian Manufacturing Worker's Union Victorian Branch
Australian Services Union Victorian and Tasmanian Authorities & Services Branch
Australian Women Against Violence Alliance
Basic Rights Queensland
Centres Against Sexual Assault Forum
CFMEU Construction and General Division Victoria and Tasmanian Branch
Community and Public Sector Union - PSU Group
Community Legal Centres' NSW
Disability Discrimination Legal Service
Djirra
Domestic Violence NSW
Domestic Violence Victoria
Dr Alysia Blackham, Academic
Dr Belinda Smith, Associate Professor of Sydney Law School, University of Sydney
Dr Cristy Clark, Legal Academic
Dr Dominique Allen, Legal Academic
Dr Karen O'Connell, Associate Professor of Faculty of Law, University of Technology, Sydney
Dr Paula McDonald, Legal Academic
Dr Sara Charlesworth, Legal Academic
Drummond Street Services
Emeritus Professor Margaret Thornton of Australian National University College of Law
Emma Coetsee, Human Rights Consultant
Equality Rights Alliance
Fair Agenda
Federation of Community Legal Centres
Finance Sector Union of Victoria

Fitted for Work
Gender Equity Victoria (GEN VIC)
Gippsland Sexual and Reproductive Health Alliance
Gippsland Women's Health
Good Shepherd Australia New Zealand
Gordon Legal
Health and Community Services Union
Human Rights Law Centre
Independent Education Union Victoria and Tasmania
International Women's Development Agency
Job Watch
Jumbunna Institute for Indigenous Education and Research, UTS
Justice Connect
Karen Willis, Executive Officer, Rape and Domestic Violence Services Australia
Kingsford Legal Centre
Liam Elphick, Legal Academic
Maritime Union of Australia
Maurice Blackburn
Media Entertainment and Arts Alliance
Minus18
National Association of Community Legal Centres (NACLC)
National Working Women's Centres
Not in My Workplace
NOW Australia
NT Working Women's Centre
Professor Beth Gaze, Academic
Public Health Association of Australia
Public Interest Advocacy Centre
Rail Bus and Tram Union
Redfern Legal Centre
RMIT Centre for People, Organisation & Work (CPOW)
Ruby Gaea Darwin Centre Against Sexual Violence
Sexual Assault Support Service Inc
Shop Distributive and Allied Employees' Association (SDA) National
St Kilda Legal Service
Switchboard Victoria
Thorne Harbour Health

Unions NSW
United Voice
University of Melbourne Students Union
Victoria Legal Aid
Victorian Aboriginal Legal Service
Victorian Council of Social Service
Victorian Trades Hall Council (VTHC)
Victorian Women's Lawyers
Victorian Women's Trust
Villamanta Disability Rights Legal Service Inc.
WestJustice
Women in Adult and Vocational Education (WAVE)
Women with Disabilities Victoria
Women's Electoral Lobby
Women's Health and Wellbeing Barwon South West
Women's Health Goulburn North East
Women's Health in the South East (WHISE)
Women's Health NSW
Women's Health Victoria
Women's Health West
Women's Legal Service NSW
Women's Legal Service Victoria
Women's Legal Services Australia
Women's Property Initiatives
Working Women Queensland
Working Women's Centre South Australia Inc
Youth Affairs Council Victoria
YWCA Australia
Northern Territory Legal Aid Commission



NT Working Women's Centre





AUSTRALIAN COUNCIL FOR INTERNATIONAL DEVELOPMENT



Lawyers for the People



AUSTRALIAN SERVICES UNION
Victorian and Tasmanian Authorities & Services Branch



fitted for work



GIPPSLAND
Sexual and Reproductive Health Alliance



Good Shepherd
Australia New Zealand



Gordon
Legal
IT'S PERSONAL



INDEPENDENT EDUCATION UNION
IEU
VICTORIA TASMANIA



jobwatch
Employment Rights Legal Centre



Jumbunna
Institute for Indigenous
Education and Research



justice
connect



MEDIA ENTERTAINMENT & ARTS
ALLIANCE



MINUS18



RAIL TRAM
RTBU
OF UNION



Rape &
Domestic Violence
Services Australia



Centre for People,
Organisation and Work | RMIT
UNIVERSITY



RUBY GAEA



Sexual
Assault
Support
Service



sda
at work with you



st kilda legal service



Q switchboard



thorneharbour
health*



united
voice



UMSU
UNIVERSITY OF MELBOURNE
STUDENT UNION



vwl
VICTORIAN
WOMEN
LAWYERS



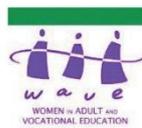
VICTORIAN
WOMEN'S TRUST



Villamanta Disability Rights
Legal Service Inc.



WEstjustice



WAVE
WOMEN IN ADULT AND
VOCATIONAL EDUCATION



WEL
Women's
Electoral
Lobby



WOMEN'S HEALTH
AND WELLBEING
Barwon South West Inc.



women's health
goulburn north east
challenging inequity, embracing diversity



Whise
Women's Health in the South East



women's health west



wpi
WOMEN'S PROPERTY
INITIATIVES



WwQ
WORKING WOMEN
QUEENSLAND



YACVIC
Youth Affairs
Council Victoria



YWCA
Australia