C O R R E C T E D V E R S I O N

LAW REFORM COMMITTEE

Inquiry into access to and interaction with the justice system by people with an intellectual disability and their families and carers

Bendigo — 28 May 2012

Members

Mr A. Carbines
Ms J. Garrett
Mr C. Newton-Brown
Mr R. Northe
Mrs D. Petrovich

Chair: Mr C. Newton-Brown
Deputy Chair: Ms J. Garrett

Staff

Executive Officer: Dr V. Koops
Research Officer: Ms V. Shivanandan

Witness

Ms E. Oates, Chief Executive Officer, Loddon Campaspe Centre Against Sexual Assault.

Ms OATES — Because I have been unwell for a couple of weeks, I do not have any written document.

The CHAIR — That is okay. We prefer people to give oral evidence.

Ms OATES — I am happy to submit it afterwards.

The CHAIR — That is great.

Ms OATES — I will refer to it if that is okay.

The CHAIR — Just to kick it off, we are a cross-party committee set up by Parliament to inquire into various issues to do with law reform. This is our second inquiry. We take evidence from people and call for submissions and then we write a report which goes to Parliament, and then the government will respond to that and perhaps take up some of our recommendations. You have parliamentary privilege while you are giving evidence in this room. We are recording everything and you will get a copy of the transcript within a week or two. If you could start with your name, professional address and who you represent for the transcript and then talk us through your submission, that would be great.

Ms OATES — I apologise, because I know that as I speak I will cough. My name is Eileen Oates, and I am the Chief Executive Officer of the Loddon Campaspe Centre Against Sexual Assault. We are based in Bendigo as a regional service, but we do not advertise widely where we operate from. Mainly everything is provided with our post office box for the confidentiality of our clients in greater Bendigo.

The CHAIR — You do not have an office where people come to see you?

Ms OATES — Yes, we do, but we do not have a big sign out the front.

The CHAIR — Right. Okay.

Ms OATES — We are transitioning to how we best address that to meet the needs of clients. That would be a barrier to the service for some clients; they would not come if there was a big sign out the front. Others have different opinions about that.

As a regional CASA we are particularly pleased to be able to speak about the experiences of the clients who access our services who do have an intellectual disability. They are small in number, and that is worrying, because what we do know in terms of the needs of clients with an intellectual disability is that they are particularly vulnerable in terms of assault and abuse and sexual assault and sexual abuse, particularly. I would like to say also that what I am saying probably complements and just gives a local and rural perspective to the submission by the Victorian CASA — Centres Against Sexual Assault — forum, the written submission that we have provided to the inquiry.

Mr NORTHE — Yes, we have that with us, thanks, Eileen.

Ms OATES — Just taking the key issues and themes and the participants' knowledge of their rights, the small number who do access our service indicate that they do have a knowledge of their rights, and they know that their right is to live safely and that if their right is breached they have a right to report the assault and to be believed and heard. They seem to be the really important steps for our clients. However, the number of clients we see is small; we can only speculate about the knowledge of the others who may experience assault and do not access our service. Is it because they are aware that if they disclose it there are some ramifications, in terms of ongoing care, perhaps, or some problem at the facility where they may reside? Or it might be in terms of a family carer. Or is it that they do not know what it is to live safely and what that safety means for them? I think we are left with a lot of very difficult and confronting concerns about how we best meet the needs of clients with an intellectual disability if they are experiencing sexual assault. There is strong evidence that their responses both in terms of their fear or their lack of knowledge is evident. That is well researched.

But the positive response I can, I suppose, provide here in terms of our service is that the clients who come to see us appear to present very positively and very confidently that they will be heard, that they will be respected and that they will be believed. They are the really important ingredients in terms of taking what is often a giant leap of faith to talk about a really awful experience for them, perhaps, sometimes.

The CHAIR — That is the case even with the numbers who have mental impairment?

Ms OATES — Yes, it is.

The CHAIR — You do not notice any difference in that presentation?

Ms OATES — No, absolutely not. Our experience in terms of our clients with intellectual disability is that they present with either a family member as a carer or a carer, and those people are very positive advocates for them and a support for them. Perhaps we could argue that they have already gone through and encouraged them and built up that level of confidence, but because the numbers are so low, I have faces in my memory of the different clients we have in our service who have an intellectual disability, and it is really very rewarding to see the level of comfort they have in coming to the service.

Often they may have communication difficulties, which mean that they present differently to the way our clients with full capacity may present. But once that is understood and known, there are things that you can read and understand about their presentation. To be believed is extraordinarily important for all our clients, but to have that level of confidence for our clients with an intellectual disability is extremely important, because they are difficult conversations. They are difficult things to be talking about, and our experience is that for some of these clients they do not only experience one episode or one particular abuser; they are extraordinarily vulnerable, and for that reason it is quite complex for them.

That is a positive, I think, in terms of being able to provide a response that does, in a way, validate how they feel and giving them somewhere to go to be able to talk about how that might be. So that becomes very important.

Mostly our clients come because they are referred by their carer or somebody at a facility, and some come because they have reported to police. Of those who come who have not reported to the police already, some are keen to do that, but there are many who do not want to go down that route at all. They simply want to talk to somebody and learn how to manage the trauma they are currently experiencing or how they are feeling about a recent episode. That is, sort of in a nutshell, a little bit about how it is for clients who come. As I say, the worrying thing is the low numbers.

To address some of this we are currently working on a project that you have probably heard about already, and that is the one with Golden City Support Services called Living Safer Sexual Lives. It is a project that is a peer education model, and we are working with co-facilitators and other professionals. We are already in this and are halfway through the project now. Through that project it would be hoped that people with an intellectual disability will learn about their rights, what they can do and how to go about living safer sexual lives. That is a very positive outcome. Patsie Frawley, who has been involved in the development of that, is highly skilled, and there is a very strong evidence base for this work. We are very pleased to be involved in that.

Mrs PETROVICH — On that point, if I may, Chair, this course, I presume, will help define what is a safe and appropriate sexual relationship and when it is a welcome sexual relationship for some of these people?

Ms OATES — Yes, exactly. I think that is some of the confusion for some. But also I think it is a confusion in the broader community as to how we perceive and understand the needs of people with intellectual or any disability. I think it is an ongoing and challenging area of the lives of clients with disabilities.

Mrs PETROVICH — Where there is inappropriate sexual interference, it will assist those people to make that definition and feel much more comfortable in coming forward?

Ms OATES — Yes, you would hope so. You would hope that a level of understanding would develop and then an understanding of where they can go, who they can talk to and how they can go about reporting or disclosing anything that is happening for them that they are not comfortable with.

Mrs PETROVICH — In your experience is it difficult for someone who has been assaulted to then prosecute a case because of that lack of knowledge currently?

Ms OATES — Absolutely, yes. There is another whole layer of vulnerability around the prosecuting of a case if the client has an intellectual disability.

In terms of availability of services our local response is that — I would hope when we become aware of an incident of sexual assault that involves a client with an intellectual disability that we would provide an appropriate response. We have a priority system always for our clients, in a very busy service with a waiting list and increasing demand. Certainly clients with a disability are prioritised, simply because of the fact that often there needs to be an immediate response to see what is in place for that client, given the fact that there might be extenuating circumstances that might need to be addressed in the shorter term.

We provide a rural service, so we go out to the major towns in the six local government areas of Loddon Campaspe. I would have to say that I think another layer of vulnerability, probably, for clients with intellectual disability is residing in a rural community where there is limited access to some services, an increased feeling of being exposed and a lack of privacy. So there are those circumstances that are particular to being rural, if you have the vulnerability of a disability as well. That does make it more complex for clients.

It has been our experience broadly that with the clients we do see, their carers and their family members are extraordinarily brave and very, very strong as advocates for those they care for, in the cases where the abuse has been believed and acted upon. There would be the other side of that argument, of course, that there are many who do not respond appropriately, or respond negatively and do not believe, or have reasons why it might be just too difficult to take a case to its full fruition because of the problems it creates for small services. I think we can only speculate about that, though, because we never actually know, which is difficult. When I have been considering this I have been thinking a lot about what I do not know, and I think I do not know an awful lot, and I know a little bit about the good outcomes.

Mrs PETROVICH — Many of us are in the same position on many occasions.

Ms OATES — Yes. Unfortunately I have been lying in bed thinking about this while nursing my virus, so it has given me a chance to think about it and how we could look at doing it differently. I believe Living Safer Sexual Lives is an awfully important starting point, but once again that is for clients who have that access to that service and who are connected into that service, and there would be a lot who are not.

I think one of the key things that would ensure that we all do this better would be to develop strong partnerships between particularly residential care workers, residential care facilities and community support agencies. As we do develop what is needed, which is that trust about the service that we provide and that linkage with understanding about the work that we all do, I think that certainly in terms of the availability of services that would go a long way to providing an improvement at least for clients with a disability.

One of the key things of course in all of that is about providing training in an ongoing way that is robust and is maintained with an understanding that what we all need to learn is the same language. We all come with our own particular disciplines and languages, and we assume knowledge and understanding from that. It might be like I am speaking to you now — you might not find me very helpful because I might divert into jargon occasionally.

Mr NORTHE — You are talking to members of Parliament, Eileen!

Ms OATES — Look, I know. I am a sociolinguist. I have a great love of all this — you know, the assumptions we make about our understanding. I think we have a responsibility as providers to make sure that we do understand and we do train. I am in the lucky position as a CEO to be able to drive our commitment to training, so it is key, I think, to our service provision that we continue to fill all those gaps as they continually become exposed in our service.

One of the things in terms of the availability of services that I wanted to speak to you about, but I thought may not have been spoken about much in terms of sexual assault, is the development of multidisciplinary centres. Has that been brought up yet as a new model of service provision in Victoria?

Mr NORTHE — I am well aware of it, but I do not think it has been brought up at this point.

Ms OATES — I think this is one of the areas of service provision that would be greatly enhanced in the setting of MDC, simply because of the fact that co-location with the key players — so the police being located and child protection being co-located with the CASA — means that there is an easier way to collaborate. You would be forced to be, and if there were critical aspects to a case, it would come up of course, and it would be

easier to address. Also, there would hopefully be the outcome of the ease of access for a client, that they are coming to the one facility, they are being seen at one place, they are becoming familiar and comfortable at it, and their needs can be best addressed in that.

That is to me a very strong aspect of a multidisciplinary centre, one of which is coming to Bendigo. I can see so many aspects of how this service will be able to be improved. I think that also then allows that we could engage more strongly with inviting in carers, support people and services who provide support for disability services, and then also organise training in a way they are all easily able to be engaged. You cannot not turn up if you are in the one building. It is very hard to get us all together when we are spread all over the place. When we look at one, I would think a training room will be very important as part of what we do.

Moving on to dealing with police; would you like me to do that? Responses are mixed in terms of this.

The CHAIR — Excuse me for a moment. Donna has to excuse herself in the next few moments. She will just slip out when she needs to.

Mrs PETROVICH — I have another commitment that I need to go to. If I may, I would like to say how wonderful your submission has been thus far, and I am very disappointed I cannot stay.

Ms OATES — You will get the printed version.

The CHAIR — The committee has empowered me to take evidence.

Ms OATES — I could preface this by saying that I consider that we are in a very fortunate position in our region to have always experienced fairly positive relations with the local police, particularly the SOCA, the sexual offences unit, which is now called SOCIT. They have transitioned into a new thing. They are full of jargon and movement at the moment, but it is all positive and good.

The positive experiences have always been the cases where clients are taken and treated respectfully. They are heard, and great lengths are gone to to ensure understanding. If that happens, it already puts a very positive tick above the experience for the client. But the ongoing experience and the thing that we most frequently need to address with the clients is the fact that most of these cases do not go on to become cases that are heard in court. This is because of the problems of communication and credible evidence; the problem that it is usually an incident that has happened without witnesses, and it is always about the disparity in power and the ability of the alleged perpetrator to basically deny anything has occurred. When there is a lack of forensic evidence or a lack of anything that can be drawn upon in terms of providing some other evidence, it is often the case that while the client is well heard and feels understood, there is not a lot of progress in terms of the cases.

Sometimes this can be okay for clients. They understand that. Once again they feel if the audience has been careful with them and has understood what they believe has happened, it is an okay outcome. But for those who find it really difficult and who have had great difficulty coming forward and speaking about what has happened, it can be quite distressing for them to find that there is to be no progress. We have a mixture of responses in terms of that. I am not sure, but I think very much wiser people than I would be able to work out ways to think about how that could be rectified for many clients.

The importance of police being well trained in working with clients with intellectual disability is a baseline need, the same as they require all the other training. I know it is like anything; it is a very big ask. But it is awfully important that that happens and that they do feel confident to work with them. Part of the experience is if there is confidence there, it is a better experience anyway for the client. I have become aware of the role of the independent third party. The south-east CASA in Melbourne has now developed up their team where they are all trained to be able to take on that role, which seems to be a practical and probably a productive way of being able to support clients. Certainly that is something that all our CASAs could be looking at being able to provide.

Mr NORTHE — Eileen, if I can interrupt you on that point, you were talking earlier about maybe some of those proceedings not occurring. In your experience or in your evidence would you know if that is as a result of a lack of skills in the ITP or not having an ITP in the room or otherwise?

Ms OATES — As in every case, it is usually based on the careful consideration of the police involved in the reporting and investigation of the case as to what chance there is of it getting up. It is usually around, 'Is the

witness able to give credible evidence or make a credible VATE so it can be used in the court?', or it might be the need for an appropriate communicator, somebody who is able to be there and communicate with and advocate for the client. But it can also be about the perception of independence as well. It is rather difficult to speculate as to what the reasons are.

We have had one very good outcome where a client's VATE evidence was given in court. She was not required to be in court based on that and the perpetrator was convicted — he pleaded guilty — and that was a very positive outcome. I would say that employment of the recent reforms in how the cases can progress is positive but that is not usual in our experience. When I reflect on this I think in our experience most of our clients are not exactly dying to get to court. They like to be heard, they like to be believed and validated for how they feel. Their feelings are very broad: they can be very, very angry, and they can also feel very let down by the service that they live in or those around them. They can also be let down by the perpetrator, who has usually groomed them to get to the point where they are assaulted in a way that they hope they do not get found out. Grooming of them is part of that.

It is really difficult to generalise as to why or how things progress as they do. If ever my staff are not happy with how they think things are progressing, I always follow up with the head of our SOCIT unit and we talk about the case. To me it always feels like they are doing what they can, given the tools they are given to work with, in that case. It is not an outcome of disrespect, it is not an outcome of disbelief, I do not think. It is an outcome of the reality of law and what that might mean. But we know that the conviction rates, particularly for women who experience sexual assault, are extraordinarily low where there is an intellectual disability. That needs to be changed. We need to look at ways to ensure that there are just outcomes when they are required. I am not sure how that can happen. I do not feel as though it will be in my time.

I will move on to the operations of the court. We have very limited experience of clients going to court. We have quite regular experience of clients going to make reports to police. As I say, broadly that is fairly positive. But the experiences that I know of in court have not been particularly positive, and there is a real lack of the sorts of facilities that are required in some rural courts. The further out you get from a big court, the stronger the disability and the fact that the access is problematic. But, as I say, the one episode that we know of where the VATE was used, the client did not need to go to court. She was told about the conviction, and the fact that this fellow wisely moved away from the area was all very positive for her. She felt safe, and that is the important thing.

I am going to move right through now into the measure within Australia and internationally to improve access to and interaction with the justice system. I think there are obvious barriers to justice when there is an intellectual disability. Identifying what those barriers are, finding ways to address them and taking a more specialist approach to working with clients with an intellectual disability is going to be key to all that.

I think there are models that could be employed that would be well known to those in the justice system who are able to do that. The south-east CASA has the Making Rights Reality project that you may be aware of. It was part of the submission by CASA. That hopefully will start to do quite a lot of work with working with women and men with intellectual disability to engage in a way that is meaningful and provides a just outcome for them.

I think there is a lot of need for further research into all aspects of reporting of sexual assault by people with a disability and their experiences within the justice system. There is a bit of a dearth in terms of recent research. As is always the case, there was a period of quite a lot of activity, but it seems to have dropped off a bit lately when I was researching this.

What we do know is that the ongoing characterisation of the experience of clients with an intellectual disability is that perpetrators target these clients because of their vulnerability, because they are aware that the impairment means that there is less likelihood of being found out, less likelihood certainly then of being convicted, so that it becomes very complex. Really, it just in a way disenfranchises those people in terms of their rights to safety.

We know that often people with an intellectual disability are not believed, and that is one of the key things broadly for all our clients at CASA. That is key, that the starting point of recovery is when they are able to talk about what has happened and to feel believed, and to feel that somebody is believing what they are telling them. It may well be that not everything that is disclosed is factual at the initial conversation because of the trauma and the circumstances around an assault, but the reality is that if the assault feels like it happened, something has

happened for that client and they need to be believed for that. The evidence is very low of mischievous reports around sexual assault internationally, in spite of what is sometimes considered to be the case.

It is obvious that the collaboration and coordinated approaches across government departments and agencies is going to be key to the improvement of response to clients with intellectual disability. DHS has a structure in place in terms of any sexual assault that occurs on a facility funded by them that that is a category 1 and it must be reported. It must be followed up with a referral to the CASA in the region. I feel a bit concerned about that, because we do not seem to be getting those reports or those referrals. I am not naive enough to believe that assaults are not occurring. So they must be being categorised differently if they are, and yet it is very clear under the new critical incident framework that DHS has reviewed recently that it is considered a category 1 incident. When I went to the briefing about that I thought, ' Oh, dear. Here we go'.

Mr NORTHE — You are going to be inundated?

Ms OATES — Yes.

Mr NORTHE — But it has not happened?

Ms OATES — No, it is not the case. I think possibly part of that could be that processes are in place and procedures are in place but perhaps there is not a rigorous enough approach to evaluating and just looking at what is happening, how it is being responded to and if the procedures that are being followed are correct given that.

In terms of just having a small reflection on the needs of those who perpetrate sexual assaults who may also themselves have an intellectual disability, that can be the scenario that both the perpetrator and the victim survivor have an intellectual disability. There are very few programs that have been effectively developed, evaluated and put in place for alleged offenders or offenders, let alone those with cognitive impairments, so I think that is a lot of work that needs to be considered broadly. Certainly the family violence sector has a stronger response to the behaviour that needs to change for working with perpetrators of violence. It is not the case in the sexual assault sector at this point, for whatever reason. But for me, I think this response requires — the expertise for how that should happen and what it might look like probably comes from the disability sector itself. They would best know how to — it must be extraordinarily challenging to operate a facility where you have clients with matching disabilities perhaps but where the power is being exerted by one over another. I am not quite sure how they would manage that at all. I think it is very challenging work.

That last question that was posed in the terms of reference around those with acquired brain injuries or other neurological conditions, I would consider that whatever you are doing needs to encompass all those clients, because their needs would be similar in terms of what the outcome needs to be for them, although the lived experience of disability will have been different depending on the circumstances prior to actually acquiring the disabilities or injuries.

Mr NORTHE — Yes, we have heard lots of evidence on acquired brain injuries and other forms of disability throughout, so no doubt that will form part of our deliberations.

Ms OATES — It seems like it would be an important part to include that, from our perspective certainly. That in a nutshell is basically my thoughts, rather jumbled.

The CHAIR — Thank you very much for that. That was very helpful.

Mr NORTHE — You have done well to get yourself out of bed.

Ms OATES — Yes, dragged myself out of bed.

Mr NORTHE — To come and present, Eileen; well done!

Ms OATES — We are a very small service. You will have noticed St Luke's had three staff — ah, if only! — but they are a very large service in our region. We are a small service that does a lot of outreach. There was no-one else to call on today; put it that way. But we thought it was important to put probably a bit of a rural lens on what we see in terms of our clients' needs. Certainly it is my impression that the outcome is not all bad; it is just very complex when there is a disability, because it is already an area that is fraught with complexities

anyway in terms of looking for just outcomes for clients broadly in terms of sexual assault. I am loath to generalise about the needs of clients, because they all have very particular and individual responses to what they want to happen for themselves. I am very careful not to assume I know how to speak for them all.

The CHAIR — Do you have any comments in relation to perpetrators of sexual crimes who have mental disabilities?

Ms OATES — Yes. Can I give you an example of how difficult this area is?

The CHAIR — Yes.

Ms OATES — We have a program that we have funded called the Sexually Abusive Behaviour Treatment Services. That is working with young ones aged up to 15 who are engaging in problematic sexualised behaviours or abusive behaviours. They can be quite young and already exhibiting lots of behaviours that are very worrying. Some of those clients have either developmental delays or they experience autism on the spectrum of Asperger's or some areas of autism. It is very difficult, because often it is around them not appearing to know how to appropriately respond to sexual urges they may now be experiencing or because they have been exposed to things they do not understand and do not have those normal boundaries that other young ones might. I have seen that, but that is not okay.

Certainly some — quite a lot — of our clients in the SABTS program have Asperger's syndrome. I think that is a prime example of picking them up quite early. They can present when they are adults as having an intellectual disability because of the various behaviour traits or characterisations of their disability. I do not have the skills knowledge or expertise around that, but I am very concerned as to how we respond to those clients because of the fact that they do live with a disability that is probably something that is going to need a lot of support throughout their lives and they need particular intervention at puberty to ensure that they get the best chance possible to understand what is okay and how to live with that. But it is very complex, and it is extraordinarily important. That is why I think an integrated response is so important. We need to be drawing on the skills and expertise of those who work with their disability, and then we take our skills to work with them therapeutically. I think that would translate into how it is for older clients as well who are perpetrating sexual assault who have a disability.

I think there are surely and obviously gaps in knowledge and understanding for some clients, but there would be others who are just very cunning and smart and are aware of the opportunities that may present. Once again, how do we get an ideal circumstance given the very broad range of what the experience might be for that perpetrator?

With our SABTS clients, I consider they are abusers because they are often exposed to things like pornography or other inappropriate images or films or whatever. But the thing is that some of them have also been victims of abuse themselves, so they are acting out in a way. It may well be the case for adults as well that there might be some latent anger and trauma around experiences they have had, so they could be responding to that as well. It is very complex.

The CHAIR — All right. Thank you very much. That is great.

Mr NORTHE — Yes. Well done, Eileen.

Witness withdrew.