



## SUBMISSION

to the

### SENATE STANDING COMMITTEE ON COMMUNITY AFFAIRS

*Violence, abuse and neglect against people with disability in institutional and residential settings, including the gender and age related dimensions, and the particular situation of Aboriginal and Torres Strait Islander people with disability, and culturally and linguistically diverse people with disability*

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## **About NAAJA**

### *The North Australian Aboriginal Justice Agency*

The North Australian Aboriginal Justice Agency was formed in 2006. It brought together three existing Aboriginal Legal Services across the Top End to ensure the provision of quality legal services for Aboriginal Australians. NAAJA has grown to employ over 100 staff across the Northern Territory, with offices in Darwin, Katherine and Nhulunbuy and is the largest law firm in the Northern Territory.

NAAJA provides high quality, culturally inclusive criminal, civil (including family law, child protection, tenancy and social security law) advice and assistance, community legal education and Throughcare prison support services. NAAJA attends community courts and holds regular advice clinics in remote communities across the Top End, from Groote Eylandt to Wadeye.

NAAJA advocates for the legal rights of Aboriginal Australians at a national level. In 2010 NAAJA received a Human Rights Award from the Australian Human Rights Commission and in 2014 NAAJA received a Northern Territory Human Rights Award for its commitment to bringing about long term change in the justice system through representation, law reform and education.

## **Executive Summary**

The North Australian Aboriginal Justice Agency welcomes the opportunity to assist the Senate Standing Committee for Community Affairs on the issue of violence, abuse and neglect against people with disability in institutional and residential settings, including the gender and age related dimensions, and the particular situation of Aboriginal and Torres Strait Islander people with disability, and culturally and linguistically diverse people with disability.

In this submission we highlight a number of key issues surrounding Indigenous Australians in the Northern Territory who suffer from a disability. These include the lack of appropriate services available to Indigenous Australians both in the community (including remote communities) and inside institutions (such as prisons and hospitals) and in the child protection, adult guardianship and social security systems. We argue that this amounts to systemic neglect.

## Background Demographics in the Northern Territory

Aboriginal people in the Northern Territory represent 30% of the population (compared to less than 5 % in all other states and territories of Australia)<sup>1</sup>. The Aboriginal population is young, with 42% of Aboriginal people in the NT being under 19.

Unique to the Territory is the fact that 79% of people live in remote to very remote areas.<sup>2</sup> The NT is also one of the most linguistically diverse areas of the world, with many Aboriginal people having English as their second, third or fourth language.<sup>3</sup>

The Northern Territory has the highest rate of homelessness in Australia. In 2011 one in 4 Aboriginal people in the Northern Territory was homeless and 90% of all homeless persons in the NT on Census night were Indigenous.<sup>4</sup> The majority of homeless Aboriginal people in the Northern Territory live in severely overcrowded conditions, at a rate 187 times higher than non-Aboriginal people.<sup>5</sup>

Aboriginal Australians are significantly overrepresented in the criminal justice system, in prison and as victims of crime. In Northern Territory prisons, as at 30 June 2014, Aboriginal people comprised approximately 86% of the prison population<sup>6</sup> and 98 % of those in juvenile detention.<sup>7</sup>

Overrepresentation of Aboriginal people is also found in children in the care and protection system with at 86% of the children in out of home care being Aboriginal<sup>8</sup> and the adult guardianship system with 50% of the people subject to guardianship orders being Aboriginal.<sup>9</sup>

Aboriginal people have higher rates of disability Australia wide and are 1.7 times more likely to be living with a disability than non indigenous Australia, and the rate of disability peaks earlier due to chronic disease (heart conditions and diabetes). Disability is particularly prevalent in Aboriginal children with prevalence rates at 14.2% compared to 6.6% of non indigenous population.<sup>10</sup> The First People's Disability Network also notes:

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<sup>1</sup> Australian Bureau of Statistics, *Estimates of Aboriginal and Torres Strait Islander Australians, June 2001*, Cat No 3238/0/55/001, ABS, Canberra

<sup>2</sup> *ibid*

<sup>3</sup> Northern Territory Government, *Aboriginal languages in the NT* (12 July 2013) Department of Local Government and Community Services

<[http://www.aish.gov.au/aboriginal\\_interpreter\\_services/aboriginal\\_languages\\_in\\_the\\_NT](http://www.aish.gov.au/aboriginal_interpreter_services/aboriginal_languages_in_the_NT)>

<sup>4</sup> AIHW *Homelessness among Indigenous Australians Report 2014*, table 2.1

<sup>5</sup> AIHW *Homelessness among Indigenous Australians Report 2014*, table 2.1.

<sup>6</sup> See Australian Bureau of Statistics, *Prisoner Characteristics, Australia*, Aboriginal and Torres Strait Islander Prisoners. Available at

<http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4517.0~2014~Main%20Features~Aboriginal%20&%20Torres%20Strait%20Islander%20prisoner%20characteristics~10007>.

<sup>7</sup> See Northern Territory Department of Justice, Northern Territory Quarterly Crime and Justice Statistics, Issue 35, March Quarter 2011, 94-95. Available at: [www.nt.gov.au/justice/policycoord/researchstats/index.shtml](http://www.nt.gov.au/justice/policycoord/researchstats/index.shtml).

<sup>8</sup> Office of the Children's Commissioner Annual Report 2013-2014 (Northern Territory Government (2014) 34

<sup>9</sup> WestWoodSpice "Final Report of the Review of Adult Guardianship within the Northern Territory for Department of Health and Community Services", May 2005 31

<sup>10</sup> COMPARISON OF DISABILITY PREVALENCE BETWEEN ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES AND NON-INDIGENOUS PEOPLES Australian Bureau of Statistics  
<http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/4429.0main+features100292009>

*The high prevalence of disability, approximately twice that of the non-indigenous population occurs in Aboriginal and Torres Strait Islander communities for a range of social reasons, including poor health care...and psychological trauma (eg arising from removal from family and community).<sup>11</sup>*

While it is possible that that overrepresentation in disability rates may be explained by taking into account the lower life expectancy and higher rates of physical and intellectual disability amongst Aboriginal people than in non indigenous communities<sup>12</sup>, other factors such as Aboriginal peoples' remote living (which affects access to health care, adequate housing, advocacy, legal and other community services), lack of English and literacy skills and cultural differences may also play a part.

### **Inadequate Support Services for Indigenous Australians with Cognitive, Mental or Physical Disabilities**

NAAJA wishes to highlight the impact upon Aboriginal people with disability and their families of the failure to provide appropriate support services in the community, particularly in remote Aboriginal communities.

It is NAAJA's consistent experience that an absence of supports for Aboriginal people with disability, such as access to mental health services or supported accommodation for people with cognitive impairment, leads to a range of serious problems. These include neglect, exploitation and violence towards people with disability and it also means that people are removed from their home community, losing the support of family and culture. It also leads to increased contact with the criminal justice system - often through their own violent conduct - and child protection system.

### **The Prison System**

It is not possible to measure exactly the over-representation of Indigenous Australians with disabilities in the NT criminal justice system – there being little comprehensive research about people with mental, cognitive or physical disabilities in prison. However the 2009 NSW Inmate Health Survey – Aboriginal Health Report<sup>13</sup> found that Aboriginal prison populations have higher rates of disability (including mental illness, cognitive impairments, intellectual disability) than the general population. We believe that the same situation applies to the Northern Territory.

NAAJA is often called upon to represent people with mental illnesses and cognitive impairments who have committed serious violent acts after a long history of escalating offending while their underlying cognitive/intellectual/mental health issues

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<sup>11</sup> Ibid.

<sup>12</sup> See WestWoodSpice Final Report op cit at 32; Australian Institute of Health and Welfare "The Health and Welfare of Australian Aboriginal and Torres Strait Islander peoples 2008 Chapter 5

<sup>13</sup> <http://www.justicehealth.nsw.gov.au/publications/inmate-health-survey-aboriginal-health-report.pdf>

have gone unaddressed. It is often the case that the family and community of the person have found themselves unable to cope with the support needs of the person.

Where people with cognitive impairment and mental illness find themselves before the courts for criminal matters, the absence of supports also often leads to their incarceration. This is because the person may be considered to be a danger to community safety without support and/or supervision in their community. This can see people remanded in custody and then subject to custodial supervision under the NT Criminal Code. In the absence of a forensic mental health facility in the NT, custodial supervision means imprisonment in a maximum security prison.

Transition to community from prison is also made more difficult by the lack of support services in the community. Once a person 'goes in', they are likely to face significant challenges 'getting out' because reducing the risk of their release requires options for supervision and support that are simply not available to Aboriginal people in the NT, particularly in remote communities.

### *Identification of Disabilities*

There is no comparable word in many Aboriginal languages to 'disability'. This adds a significant barrier in identifying the numbers of Indigenous Australians with a disability or combating any disadvantage suffered as a result of a disability.<sup>14</sup>

Further there is no standard practice for the assessment of prisoners to determine if they have a disability. Assessments can occur during a court process or if a client is already known to Disability Services. On rare occasions assessments are done of prisoners but there are no audits or other processes to ensure prisoners don't 'fall through the gaps'. For example, a grey area can be where a prisoner has a mental health issue and is known to Forensic Mental Health services but also has an undiagnosed and overlapping disability. Because the disability is not diagnosed the prisoner can potentially have less access to resources, including post-release from prison. There are also disputes between mental health services and disability services in relation to supports for clients with possible dual or overlapping diagnosis, and where the level of disability required to receive the support of either service is contested. There does not appear to be a clearly set out model or process where clients have a dual mental health/disability.

The assessment tools for people with a disability are not normed on (or validated by) Indigenous Australians, and particularly for the specific characteristics and profile of Indigenous Australians from the Northern Territory. For example, a client of NAAJA's was assessed using the KICA assessment tool (Kimberley Indigenous Cognitive Assessment). This tool is commonly used for senior people with possible dementia and memory issues, and it was noted that it was relevant in the circumstances applied. Whilst this tool was validated for Indigenous Australians, this particular prisoner passed the test because his memory was fine. It was other aspects of his cognitive thinking which lacked and were questionable. He was released full time from prison and returned to the community. Because there was a lack of disability services in his home community there was no incentive for him and his family to attempt to provide instructions to attempt to rectify this issue.

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<sup>14</sup> See First People's Disability Network Australia, About us. Available at <http://fpdn.org.au/about-us>.

In NAAJA's experience, there do not appear to be any resources available for ensuring disability assessment tools are normed on (or validated with) Indigenous Australians. Policy in Corrections avoids these matters and tends to focus on things such as employment for prisoners.

### *Prison Complex Behaviour Unit*

From about November 2014 prisoners were moved from the old Berrimah based Darwin Correctional Centre to the new Holtze based Darwin Correctional Precinct (DCP). The DCP is a modern correctional facility and provides a significant improvement in terms of environment and design for prisoners. We are aware of at least one client with a significant mental illness and possible disability who has benefited from the new DCP environment as compared to the very negative conditions of the old Berrimah based prison.

Notwithstanding this, the DCP has a designated area for people with a disability and mental health issues called the Complex Behaviour Unit (CBU). The CBU has not been opened, despite DCP being operational for more than 7 months. We understand the design of programs and delivery is being revisited. We have concerns that there will not be adequate funding and resources to provide a specialist disability and mental health service for prisoners as clients including those with high needs.

It also remains the case that the NT lacks a forensic mental health facility. While the CBU may ultimately offer a more appropriate place for the detention of people with mental illness who are considered unable to be safely accommodated in the community, it remains part of the prison and is no substitute for a designated forensic mental health facility.

### **The child protection system**

It is important to understand the impacts of the child protection system upon Aboriginal people with disabilities within the context of the significant systemic barriers in the child protection system in the NT that affect Aboriginal people generally. The barriers include no mediation provisions to enable and promote participatory decision making and open discussion between the Department of Children and Families (DCF) and families at risk; a lack of health and intensive family support services in remote communities and a lack of culturally appropriate services and practices within the existing services. We have written elsewhere about this.<sup>15</sup>

The consequences of removal must also be considered. Significantly, in the NT the likelihood of an Aboriginal child removed from family being placed with a non-Aboriginal foster family is far greater than in other states and territories across Australia. In the NT, 58.3% of Aboriginal children in care are placed with non-indigenous carers.<sup>16</sup>

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<sup>15</sup> Martin P "Glimmers of hope in a broken child protection system" Indigenous Law Bulletin 8 (17) 16

<sup>16</sup> Office of the Children's Commissioner Annual Report 2013-2014 (Northern Territory Government (2014) 63

### *Children with disabilities*

Our work representing parents in child protection matters has exposed us to a number of cases where Aboriginal children who live in remote communities and who have disabilities are being removed from their families, simply because they have special needs and those needs cannot be met in their community. Some of these children have complex physical and intellectual disabilities and need ongoing therapy, treatment and monitoring. They also require specialised schooling programs. It is clear that some children will need to move into Darwin or a regional town to get the care that they need.

However the decision to remove a child should always be the last resort and only after consideration of the child's and emotional and cultural needs, the family's ability to move with the child, the availability of services in the community and if there are none the possibility of travelling for those services. Family need to be involved in that decision making process. In our experience this does not happen and we are concerned that families are being broken up prematurely and/or unnecessarily.

### Case study Ms P

A primary school teacher from a remote Aboriginal community contacted NAAJA when Ms P's two young boys were removed from their family by Department of Children and Families (DCF). The boys had been displaying some behavioural issues and one had been recently diagnosed with autism. However the teacher and the school were assessing the boys and sourcing appropriate support services. DCF placed the boys, whose first language was not English, with the same non indigenous foster parents in Darwin. However those foster parents were unable to manage both of them in addition with the three other foster children in their care. The boys' behaviour was worsening and suggested distress at their strange circumstances. The boys were then separated and living with different foster parents, going to different schools, and only seeing their parents every 3-4 weeks.

Concerned about the boy's worsening condition and the time the court proceedings were likely to take, NAAJA worked with the extended family, the teacher and various support services and put forward a plan for the grandparents would care for the boys in their community and they would continue to have their behavioural issues assessed while DCF's application for two year protection order was being considered. The Court accepted this plan. NAAJA was then able to advocate for the parents to be brought into Darwin to attend a weekend workshop about children with autism.

The community had been shocked that two boys could be taken from the family just because of their disabilities and without any discussion with parents, teachers about what care can be provided in their community. It is disturbing to think that without NAAJA's intervention the boys would have remained away from their family and community while the Court was assessing what protection orders to make.



### *Parents with disabilities*

NAAJA represents parents who have intellectual and physical disabilities defend DCF's applications to remove their children. Again we have observed that not enough is being done to communicate with the parents and extended family, assess extended family supports to ensure that removal of the child is the last resort.

### Case study Ms T

Recently we helped Ms T a mother of two with an intellectual disability when DCF made applications for protection orders for her two children. Ms T's eldest child had been removed because he had intellectual and physical disabilities and could not get the care he needed in the remote community in which the family lives. Ms T agreed to those orders understanding that it was in his best interests for him to live in town. However Ms T did not agree to her daughter living away from her. The little girl was originally removed because she had swallowed some tablets. DCF took this incident together with Ms T's intellectual disability as a sign that the little girl was being neglected and removed the girl from her mother, her family and her community. The girl was placed in foster care with a non indigenous family.

NAAJA helped Ms T put together a plan to care for her daughter where she would live with her aunt in their community and jointly care for her. DCF fought this plan for almost a year during which time the little girl was in foster care and Ms T was only able to see her in supervised access visits and only once in her home community. When the application finally went to hearing the Court ordered that Ms T's aunt have 'parental responsibility' for the girl and returned the child to her family and community.

This is not an isolated case and in our view keeping our client away from her daughter is a form of systemic neglect. With more care and resources, DCF could have spent more time assessing the actual risks, talking with our client and her family, supporting them to get the extra services they need before taking the extreme step of removing the little girl from her family and community and commencing protracted and adversarial court proceedings.

### **The Adult guardianship system**

The number of people under guardianship in the NT is 8 times as many as the number of people under guardianship in the next highest Australian jurisdiction (NSW)<sup>17</sup>. A review of the Adult Guardianship system in 2005 suggested that because of this overrepresentation, Aboriginal peoples' particular circumstances and needs should be given special consideration within the adult guardianship system. That system:

*... must operate effectively for (Aboriginal people) and with all deliberate speed taking proper account of the fact that many of them continue to live on their traditional lands and in the places that their forebears have lived in for*

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<sup>17</sup> at p49

*tens of thousands of years but which are remote from the towns that developed in the NT in the 20<sup>th</sup> century.*<sup>18</sup>

### *Extreme vulnerability*

#### Case study Ms M

Ms M is a woman in her 40s with a noticeable intellectual disability and multiple medical conditions. She comes from a remote community and English is not her first language, although she can speak some English. She was suffering from some heart problems and was flown from her local clinic to Royal Darwin Hospital and then on to Royal Adelaide Hospital where she had an operation. As a result of this procedure Ms M has to take medication once a day for the rest of her life. She cannot return to her home community because she does not have the capacity to monitor her own medication intake and the clinic there does not have the resources to do this either. She has no family and nowhere to live outside her community and is now homeless.

NAAJA is assisting Ms M to complain to the South Australian Health and Community Services Complaints Commission about the fact that at no time during her stay in Adelaide did Ms M have a support person or an interpreter. Further we have been advised that Ms M does not have the capacity to give full consent to treatment which should have included discussion of all the options available to her. The treatment was not urgent and there were less invasive options for treatment which could have allowed Ms M to remain in her community. We consider that there are serious issue of 'trespass' – operating without consent - and well as failures to consider the most appropriate treatment given Ms M's personal circumstances.

Since her return to the NT, Ms M has had to stay in hospitals because there is no suitable and available supported accommodation. She is now under guardianship, her intellectual disability now formally assessed as 'moderate to severe' and the Public Guardian has been appointed to make decisions about where she lives and her day to day medical care. The current issues for Ms M are that the OPG does not have the resources to act as an advocate. Earlier this year Ms M had to travel to Darwin hospital for acute care. However on her own in the hospital, without an advocate or caseworker, she was neglected and vulnerable. At one point when she left the hospital to be with her partner it was assumed she was out drinking (she does not drink) and this lead to a misunderstanding that she was refusing treatment and 'non compliant'. At another point she was almost discharged back to a smaller hospital without having the operation required. Ms M has had this operation but is still in hospital waiting for a placement in supported accommodation.

NAAJA have notified the Health and Communities Services Complaints Commission about our concerns for two women with intellectual disabilities who were in hospitalised for almost two years before being placed in supported accommodation. While in hospital we understand that they were unable to get the care that was appropriate to their disabilities and at times had to be medically restrained. We

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<sup>18</sup> WestWoodSpice "Final Report of the Review of Adult Guardianship within the Northern Territory for Department of Health and Community Services", May 2005 at 33.

consider this to be neglect and abuse. For at least part of the time the women were in hospital the Public Guardian was joint guardian for both women.

### *Individual disability advocates*

We are also concerned that even when the Public Guardian is appointed there is no guarantee that a person is protected from financial or physical abuse. There is a clear need for an independent disability advocate for each person under guardianship and without such an advocate, there is a risk of that person suffering neglect and abuse.

### Case study Ms N

In February 2014 the NT Health and Community Services Complaints Commissioner tabled a report in Parliament detailing the prolonged, systematic institutional neglect of a very vulnerable woman, Ms N, for over 13 years<sup>19</sup>. The Public Guardian and two family members had been appointed as Ms N's guardian and there had been clear and consistent warnings about the neglect, physical and sexual abuse and ongoing suffering of Ms N that various government agencies had not acted upon.

The Commissioner found that the Public Guardian, the Department of Health and other health service providers (such as the local clinic) were aware that Ms N was vulnerable and unable to care for herself. It was also evident that her family was not coping with her high care needs and was not getting the support they needed. The Commissioner found that all services involved in Ms N's care and daily life 'failed to protect her, to ensure her safety, and to promote her wellbeing, her dignity and her place in the community' (p 63).

Although the case dates back to 2006, NAAJA is concerned that it is not an isolated case and the systemic problems remain. Intellectually disabled Aboriginal people in remote communities are particularly vulnerable to abuse and neglect because of a lack of services and support. There is a critical lack of disability services for Aboriginal people in remote communities and a lack of support and education for families and community members to assist them to care for disabled family members. The report also highlights the significant under-resourcing of the Office of the Public Guardian.

The Commissioner called for a 'comprehensive and independent' inquiry into the level of care that is being provided to people with disabilities in remote communities, to see whether 'their safety, well-being and dignity remains at serious risk as a result of the same systemic failures that had such a tragic impact on Ms N's life'<sup>20</sup> That inquiry has not taken place and there is no monitoring system to ensure that similar systemic failures are not continuing to affect people with intellectual and physical disabilities in the NT.

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<sup>19</sup> <http://www.hcsc.nt.gov.au/wp-content/uploads/2010/04/Report-of-Investigation-into-the-Care-Provided-to-Ms-N.pdf>

<sup>20</sup> *ibid* 3

### Case study Mr G

When we come across such failures we report them to the HCSCC. For example the case of Mr G. Mr G is from a remote community and around three years ago the Public Guardian was appointed as his financial manager. For the first two years of that order the PG did not take control of Mr G's finances and he continued to suffer financial exploitation. This included a well meaning non-indigenous community member unofficially assuming management of Mr G's finances – and having his Centrelink benefits deposited directly into her personal account. At the time the PG took control of Mr G's Centrelink payments he had no money in his bank account.

The financial statements provided with Mr G's next Court review indicated that in the first 3 months under the management of the PG, Mr G had saved \$7,529.97 (after expenses for accommodation, bank fees, food and personal spending had been deducted). It is arguable that had the PG taken control of his finances when the Court ordered it to, he would have saved an estimated \$65,000 (over the two years and two months from when the adult guardianship order began to when the PG assumed control of Mr G's finances). While Mr G's health, food and accommodation needs were being met in those two years, in our view this is still a case of institutional neglect.

### **The social security system - access to Disability Support Pension**

The Department of Human Services (DHS) is required to have regard to

- the special needs of disadvantaged groups in the community and
- the need to be responsive to the interests of Aboriginal and Torres Strait Islander communities and to cultural and linguistic diversity

when making decisions about peoples access to social security payments.<sup>21</sup>

However in decisions and processes around access to the Disability Support Pension (DSP), this appears to be being overlooked, particularly for claimants in remote communities.

We are often approached by people who have unsuccessfully attempted to claim the DSP a number of times before they ask for NAAJA's assistance. In some cases it is clear that they were eligible at the time of their first claim, but this is either not recognised by DHS staff, or the barriers in DHS processes do not allow for a full appreciation of the person's condition, as it affects their capacity to work in that person's community and social context. For example, doing a Job Capacity Assessment over the phone will often mask the seriousness of a person's injuries or disabilities because the assessor does not understand the community context – overcrowded housing, lack of public transport, dirt roads, access to medical and related services etc.

### Case study Ms P

Ms P from a remote community was the victim of a violent and brutal sexual assault. She suffered serious injuries requiring her to be fully dependent on a colostomy bag.

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<sup>21</sup> Social Security (Administration) Act 1999 subsection 8(b) and (c) respectively

She also had chronic medical conditions including Type 2 Diabetes, kidney disease (stage 3) and rheumatic heart disease but had been working up to the time of her rape.

Ms P lodged her first DSP claim three months after the sexual assault. That was rejected because her conditions were not assessed as 20 points or more on the impairment tables. A year later Ms P, notified DHS of her intention to claim, her doctor submitted a treating doctors report, but as she did not sign a claim form, the claim was never processed. She lodged another claim five months after that and that was rejected. NAAJA helped Ms P to appeal the decision to reject her DSP. We gathered the available medical reports and submitted them and four months after the appeal (22 months after the original claim) Ms P was granted the pension backdated to the date of the third claim. A month after this decision Ms P passed away.

#### Case study Mr B

Mr B lives in a remote community and had applied unsuccessfully for the DSP twice. He was in his 60s and had been diagnosed with cancer in his nasal cavity. Treatment for that cancer involved surgery removing one of his eyes, a large part of his nasal cavity and jaw, and applying a large skin graft. He also underwent chemotherapy and radiotherapy. Mr B's application for DSP was rejected on the basis that his injuries were not fully treated and stable, as his radiotherapy was ongoing and there were other rehabilitative procedures scheduled. This is despite the obvious fact that some aspects of his condition (for instance, the loss of one eye, part of his nose and jaw) would never improve. We lodged a detailed review application and submitted further medical material from Mr B's treating Doctor. The authorised review officer overturned the rejections and approved the client for DSP.

We consider it to be systemic neglect that DHS did not contact either Ms P or Mr B or follow up their claims in any other way. DHS was on notice of the claims, the extent of their injuries/conditions and their remote location. It is arguable that acting in accordance with their obligations under the Social Security (Administration) Act that DHS should have:

- Contacted Ms P about the problems with her form
- Consulted the Health Practitioners Advisory Unit at each stage of the claim
- Spoken with Ms P and Mr B's treating doctors
- Done a comprehensive assessment of the impact of the client's medical conditions on her ability to function

NAAJA is concerned that the recent changes to the DSP, in phasing out Treating Doctors Reports, and instead placing the onus on claimants to provide medical evidence to the Department will further reduce the accessibility of the system for vulnerable Aboriginal people.

## *Procedural barriers to access*

### Program of support requirements

Having participated in a 'program of support'<sup>22</sup> is a prerequisite for being granted the DSP for those people who do not have a 'severe impairment'. In remote communities, the job network provider (now the Remote Community Jobs Program (RJCP)) is usually the only 'program of support' and in many communities there is no full time job network provider. This means that the programs of support are only available when the job network provider travels to the remote community. We are concerned that current RJCP providers in the NT generally lack the specialist staff or capacity to undertake specialist support for people with disabilities or people who require a high level of employment assistance. As a consequence, these providers have extremely limited ability to provide any type of meaningful support for people assessed as needing the assistance of a Disability Employment Support Service.

### Case study Ms G

Ms G is a traditional Aboriginal woman who speaks English as a second language and lives in a small remote community. She has diabetes, a kidney disorder and rheumatic heart disease. Ms G gets short of breath after walking for about a minute. She has applied for the DSP a number of times. Her job capacity assessment was completed over the phone without an interpreter. She was given a baseline work capacity of 8 -14 hours a week. Ms G was told that she needed assistance with activities of daily living, disability management education, mobility assistance, job search skills, functional capacity assessment, occupational therapy assessment, cognitive assessment, post placement support, and vocational counselling. She was also told that any future workplace would need modifications in order to assist her. When the Program of Support provider was contacted about the assistance they could offer Ms G they stated: "It sounds tricky. Able bodied people are our priority to get into work. There is not a lot for people to do here; there are not many support services. The only activity we have is a commercial kitchen, but there is no supervisor. They can do craft activities or play on the computer. There are no specialist disability services we can provide. Maybe the health clinic can help her."

### *Job Capacity Assessments*

A Job Capacity Assessment (JCA) assessing how a person's medical conditions affect their capacity to work is required before each claimant will be granted the DSP. However unlike in the rest of Australia where face to face assessments are done, for many Aboriginal people in remote communities these assessments are done over the phone or on a simple file review. Assessing an Aboriginal person living in a remote community in the NT who is likely not to have English as their first language has obvious impacts on the reliability and robustness of the JCA report. Further the worker conducting the assessment is not able to assess how the person

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<sup>22</sup> a vocational, rehabilitation or employment program (usually through an Employment Service but can be through another program) tailored to address the person's impairment and other barriers to employment. (Basic Rights Queensland fact sheet "Centrelink and Disability Support Pension Language – definitions" <http://www.brq.org.au/assets/Uploads/Centrelink-DSP-Language-Definitions-BRQ.pdf>)

presents nor to gain an appreciation of their living conditions and other intangible factors that are barriers to employment. File reviews are also not adequate when a person has barriers to providing complete medical information as is the case in remote communities, where remote clinics are over stretched meeting the clinical demands of a population with acute and complex health needs.

Aboriginal DSP applicants in remote communities have to overcome significant hurdles in meeting the some of the eligibility and procedural requirements for the grant of the DSP. An unreliable or incomplete job capacity assessment will affect that person's claim for the DSP. Maintaining the current program of support requirements for all Disability Support Pension applicants where in many communities there is no Disability Employment Service provider with specialist staff that can provide an adequate level of service, is unreasonable. DHS needs to take a more proactive approach to ensure that it is meeting its legislative obligations but also provide a full, fair, flexible and appropriate level of service and income support to disabled Aboriginal people in the NT.