



SUBMISSION

Senate Community Affairs References Committee

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

“Words have no power to impress the mind without the exquisite horror of their reality.”

Edgar Allan Poe

Queensland Advocacy Incorporated is an independent, community-based systems and individual advocacy organisation and a community legal service for people with disability.

Our mission is to promote, protect and defend, through systems and individual advocacy, the fundamental needs and rights and lives of the most vulnerable people with disability in Queensland.

QAI does this by engaging in systems advocacy work through campaigns directed to attitudinal, law and policy change, and by supporting the development of a range of advocacy initiatives in this state.

We have campaigned for the closure of institutional and congregate care arrangements since our inception in 1988, and have worked collaboratively with people with disability, family members, other advocacy groups and allies to successfully close down a number of such places.

The experiences of people directly or indirectly affected by violence, abuse and neglect perpetrated against people with disability in institutional and residential contexts

Vulnerable people with disability experience violence, abuse and/or neglect in a variety of situations, support arrangements and living circumstances. People who are 'placed' in group living arrangements have reported to our organisation abuse by co-tenants and staff. These kinds of abuses include punching, biting, hitting, hair pulling, rape, verbal and emotional abuse, ridicule and vilification.

Others have told their stories of hunger; being left in bathrooms unattended for over an hour; being given food that is unfit for human consumption; being fed meals in the shortest possible time – “bird feeding” that results in choking, asphyxiation, and respiratory problems and sometimes eventuates in death; not having access to privacy; not being allowed visitors; having possessions and money stolen; neglected health, hygiene and personal care matters; inattention to significant injuries; disregard for personal dignity; verbal and emotional abuse by staff; not being supported to leave the residence or hospital – ever; being charged for support services that are not delivered; not having any choice about where, with whom, or how they live or how they are supported.

Case examples provided throughout this submission are evidence of the societal devaluation of people with disability that lead to abuse, neglect, and disregard for personal autonomy, and the imposition of practices that would otherwise constitute criminal offences if applied to people without disability.

The impact of violence, abuse and neglect on people with disability, their families, advocates, support persons, current and former staff and Australian society as a whole

People with disability in Australia are a highly vulnerable and marginalised group. They experience higher rates of unemployment, homelessness, imprisonment and substandard educational and inadequate healthcare as compared with people without disability.

People with disability also experience significantly elevated rates of violence, abuse and neglect. This is particularly disturbing, given that this group already experiences disproportionate hardship and is denied equitable opportunities across a broad spectrum of areas. It is also deeply distressing that those perpetrating this abuse and violence in an institutional setting are often those in positions of authority and trust, who are charged with responsibility for the care of the person with disability and should be supporting the people in their care to reach their full potential. That vulnerable people are being harmed by those entrusted with their care is untenable and a grave misuse of power.

Abuse can take many forms – it can be overt or subtle; random and isolated or recurrent; physical or verbal. As an example of the latter, the language used in reference to people with disability is often itself inappropriate and as well as constituting abuse, it can reinforce negative stereotypes and act as a barrier to a more inclusive and supportive approach. Mindsets and preconceptions about people with disability and their behaviour can also significantly affect the way in which people with disability are treated. This has been a common problem in the disability services system that requires addressing as an urgent priority.

Abuse can be coercion, silencing the person, or deliberate withholding of information or skewing what information is available or how it is provided. This kind of abuse of power is difficult to prove, but can have tremendous effect on a vulnerable person who is beholden to those providing fundamental supports, accommodation or services.

Abusive practices can become embedded if they are not immediately addressed. When subtle forms of abuse are viewed as harmless, more overt and serious issues are more likely to occur and be ignored. People who are systematically abused can normalise this behaviour and unwittingly perpetuate the abuse upon others. Other people who normalise abusive behaviour can become perpetual victims.

The marginalisation and inequitable treatment of one group affects Australian society as a whole. It challenges our egalitarian and humanitarian ethos and increases the hierarchy and divisiveness between different sections of society. We need to take proactive steps to embrace an approach of respect, autonomy and enablement toward people with disability.

The incidence and prevalence of all forms of violence, abuse and neglect perpetrated against people with disability in institutional and residential settings

It is important to recognise that the environment of any living arrangement is often a portrayal of blatant or subtle value judgements about the people who live in congregate care situations. For example people with intellectual impairment who reside in Baillie Henderson Hospital in Toowoomba until recently lived in wards with four beds to a cluster separated only by beaded curtains. People who still reside in Jacana Rehabilitation Hospital in the Brisbane suburb of Bracken Ridge live in a similar situation with only a small cupboard to house all of their possessions. Residents of group homes with four or more residents are often required to share the only bathroom in the house, or where there are two bathrooms one is often designated for staff.

Boarding houses and hostels share a terrible history of abuse and neglect of vulnerable people with disability. People are required to pay 85% of their disability support pension for support, accommodation and meals. Medication is often administered by staff, and paltry allowances dispensed as well. There are reports of exorbitant charges for laundry and other housekeeping incidentals.

Other large residential institutions have been fitted with huge open bathrooms with no doors on toilets or shower recesses, and large, flat bottomed stainless steel troughs in which residents were hosed down.

With these design flaws it is not surprising that the treatment sometimes meted out to people with disability is often appalling, cruel, inhuman and degrading.

Incidence of Sexual Abuse or Assault

- Sobsey and Varnhagen suggest that most people with disabilities will experience some form of sexual assault or abuse.¹ Sobsey estimates up to 80% of people with a disability are sexually abused.²
- Muccigrosso suggests that the incidence of sexual assault against people with an intellectual disability is at least four times higher than in the general population.³
- The incidence of sexual abuse (regardless of age) among people with developmental disabilities was estimated in 1985 by the California State Department of Developmental Services to be 70%.⁴

Queensland, like every other state in Australia, has a history of abuse in institutional settings such as hospitals and large and small congregate residential arrangements. It is difficult to collate accurate data as many cases are un-reported or confidential. However the dark chronicles of abuse have been echoed through the halls of several institutions, as the following case studies exemplify.

Case study: Maryborough Disabled Persons' Ward

Maryborough Disabled Persons' Ward operated from 1973 to 1997. Over its 24 years of operation, it was home to approximately 60 people, mostly those with severe and multiple

¹ 'Sexual abuse and exploitation of people with disabilities: Toward prevention and treatment'. In M. Csapo and L. Gougen (eds) *Special Education Across Canada* (pp.199-218). Vancouver: Vancouver Centre for Human Development and Research.

² Sobsey, D. 1994. *Violence and abuse in the lives of people with disabilities: the end of silent acceptance?* Baltimore, MD: Brooks Publishing.

³ Muccigrosso, L. 1991. 'Sexual Abuse Prevention Strategies and Programs for Persons with Developmental Disabilities'. *Sexuality and Disability*; Vol. 9. Pp. 261-272.

⁴ Abuse Prevention Strategies in Specialist Disability Services Commissioned by National Disability Administrators on behalf of Commonwealth, State and Territory Ministers responsible for disability services in Australia. 2002; Baladerian, N. 1991. 'Sexual abuse of people with developmental disabilities'. *Sexuality and Disability*, 9(4), 323-335.

disabilities. Some people lived there for their entire lives. Twenty-four people died there.

“The Council held hearings in Maryborough and visited the Disabled Persons’ Ward in local hospital where we saw residents with intellectual disability, wasting away their lives in hospital beds or in bean bags. At council hearings we heard evidence of residents’ treatment, of the lack of meaningful daily activities, and of some people staying in bed most of the day. We heard of bathing without any privacy, again in large stainless steel troughs, and staff competing against each other to see how quickly they could “feed” the residents. We learnt that the Public Trustee, appointed as financial manager for all residents, had pooled the residents’ trust funds to pay for a hospital swimming pool which residents rarely used but which hospital staff no doubt enjoyed.”⁵

Case study: Cootharinga Nursing Home, Townsville

Notorious Cootharinga Nursing Home in Townsville was at the centre of controversy during the 1990’s. An investigation followed numerous complaints from three males and a female - all former clients or residents of the old Cootharinga nursing home. 110 people were interviewed including former residents their friends and families.

A 68 year old man was charged with 18 sexual offences allegedly committed at the Cootharinga Society of North Qld.

Police said the charges were developed followed a major investigation into 17 “unexplained deaths” which began in October the previous year. Claims of torture and abuse by former society staff and clients were part of the investigation. The discovery of the abuse and neglect at this facility came after an independent report in 1997 into the operation of the facility, offering a ‘clean bill of health’. The 61 page document outlined the findings of a six-week internal investigation carried out by Ron Joachim Consulting. The independent report was commissioned by Families, Youth & Community Care Minister Kev Lingard after police started their probe in 1997.

Case study: Halwyn Centre, Royal Brisbane and Women’s Hospital

Complaints of abuse, medical and individual neglect were recorded against the **Halwyn Centre**. The following complaints are from just one family:

- Misappropriation of taxi vouchers (eg Resident’s taxi vouchers went missing, parent offered cash reimbursement)
- Misappropriation of birthday money (eg American father overseas, sent money to his son for his birthday but it was spent on furnishings)
- CNC told registered staff that in the case of a registered nurse making a clinical

⁵ Jeremy Ward. Presentation at QAI’s Renaissance – Now Or? Forum. 8 August 2014.

decision to give oxygen, they were not to give oxygen unless the doctor ordered to do so (Time delays could be serious here)

- Drug errors
- Visitors and various entertainment invitations turned down because there is not enough staff to get residents ready.
- Adults in their night attire by 3 o'clock in the afternoon
- The more disabled clients are, the more they will be ignored by staff
- Continued cases of broken and fractured bones.

The issue of poor dietary standards is a further indicator of poor medical care. As the complaints attest, lack of a proper diet contributes significantly to cases of constipation, ulcers, impacted bowels, poor teeth, and weakened face muscles and jaws, which in turn affect the ability to verbally communicate.

Case study: Basic Stafford Centre and Challinor Centre

The infamous Basil Stafford Centre and Challinor Centre have a documented history of abuse and neglect. The sensational story of the teenager held in 12 hour back-to-back seclusion in Basil Stafford is indicative of the endemic treatment of people in congregated and segregated settings. The teen was denied face-to-face contact with residential care officer support workers for up to days at a time.

"They put food in to his unit through a slot, or they buzz him out of the unit into the backyard pen, while they put the food in," one source said. "There is no therapy and his only outing is a once-a-week drive when they bring a high-security van up from The Park (mental health centre), reverse it up to the cage at the back of the unit, he then climbs into the van which is then padlocked and driven around. "He is on no medication – the only treatment he's getting is solitude."⁶

According to the Victorian Public Advocate, reports of abuse inside residential facilities and hospitals for the disabled and mentally ill surged 37% with 287 reported incidents last financial year, up from 209 the previous year⁷. However it is thought that these cases represent the "tip of the iceberg" because many residents, patients and staff are incapable of reporting such incidents or too frightened to do so.

The 287 cases, reported by "Community Visitors" who inspect facilities for the Public Advocate, include a frail, non-verbal elderly person having their leg and knee cap broken in two separate attacks by a staff member in a group home, and a mentally ill man being punched in the head by a nurse at a hospital because he was suspected of smoking in his room.

⁶ <http://www.couriermail.com.au/news/queensland/troubled-teen-still-held/story-e6freoof-111113078047>

⁷ Community Visitors Annual Report 2013-2014 (Victoria)

The report also highlighted concerns about restraint tactics used on mentally ill patients causing injuries and sexual assaults occurring when mentally ill women and men are housed together in psychiatric units. In one case, a female patient was placed in the male section of a unit despite reporting she had been sexually assaulted there on a previous admission.⁸

The responses to violence, abuse and neglect against people with disability, as well as to whistleblowers, by every organisational level of institutions and residential settings, including governance, risk management and reporting practices

People with disability who experience abuse particularly when living in congregate settings will often tell someone who is part of the support service if they have no family connections. The very nature of dependency upon paid supports will increase a person's vulnerability to abuse, and in many situations their complaints are unheeded. The denial of the validity of their complaint or lack of immediate investigation or response by the service provider or family member undermines a person's confidence in their supports and will increase feelings of fear, abandonment and isolation.

In 2011 in South Australia three counts of indecent assault and one count of assault were dropped against a 57-year-old bus driver. It has amplified calls for urgent reform to laws that inhibit intellectually disabled people from giving evidence.

People with cognitive impairment are not afforded credibility by police and considered to be unreliable witnesses because of difficulties in cross-examination. Many allegations of abuse do not proceed to trial. The lack of support to assist people to progress complaints results in people feeling intimidated and humiliated by the investigative and court processes. The mere ordeal of enduring the repeated articulation of their experiences can produce serious emotional trauma, devastating blows to self-confidence and self-esteem and, at times, cause family rifts if the person is not believed or supported by their family members.

When victims with disabilities did report incidents of abuse to authorities, in 52.9% of cases nothing happened. Alleged perpetrators were arrested in only 9.8% of cases where abuse was reported to authorities.⁹

Case study:

Ghislaine, who did not want to use her full name, is legally blind and has a cognitive impairment and mobility issues. She said when she reported a sexual assault the police response was "offensive".

The perpetrator, a taxi driver she regularly used, arrived at her house saying he was there to help with her computer problems.

"He came in and I sat beside him on a stool as he sat at the computer. Then he turned around to me and said, 'For some reason I've always liked you.' And I thought, oh no, I was

⁸<http://www.publicadvocate.vic.gov.au/file/file/Report/2014/Community%20Visitors%20Annual%20Report%202013-14.pdf>

⁹ A Report on the 2012 National Survey on Abuse of People with Disabilities Nora J. Baladerian, Ph.D. Thomas F. Coleman Jim Stream

trapped. Then he stood up, and down went his pants and he started touching himself and wanted me to touch him but I refused and pushed him away."

Later that day when Ghislaine's carer arrived she realised something was wrong and the incident was reported to police. But when the officers arrived - one male and one female - Ghislaine said the policeman was insensitive and patronising, taking her carer into another room to ask questions about the incident.

"I found that very offensive, they were trying to find out if I had all my marbles and whether I knew what I was doing. Later, police said they couldn't follow up my case because it was my fault for letting the man into my home," the 60-year-old said. "Now, I don't go out on my own any more. I'm basically locked up in the house seven days a week. I think that the police should know that when a person with a disability is traumatised, the way the police handle the complaint can make that worse."¹⁰

Case study:

"Kimberley may be intellectually impaired but she knew what you were doing was wrong and she did not want you to touch her. She had pulled her hand away when you first exposed your penis to her and tried to grab her hand. She said that when you penetrated her vagina, that she had wanted to swear at you and tell you to "fuck off", but it is a measure of her level of cognitive functioning that she felt unable to say that because there was a rule against swearing in the residence...

The team leader appeared to accept your story, because she immediately went and remonstrated with Kimberley for swearing in breach of the house rules. Kimberley was crying when she went into her room, but the team leader did not ask her why before she remonstrated with her, and told her that her behaviour with a staff member had been inappropriate. It is a measure of Kimberley's strength, or maybe of the impact that your behaviour had had on her, that despite the unfairness of the team leader reprimanding her without first ascertaining her side of the story, that Kimberly immediately responded to the remonstrations by alleging that you had touched her private parts and exposed yourself to her....unfortunately for Kimberley, the Yooralla response was less than adequate. Kimberley's complaint was described in a client incident report as "a sexual harassment allegation made by Kimberley against casual staff member Johnny Kumar."¹¹

There are significant problems marring the efficacy of the governance, risk management and reporting practices of institutions providing care for people with disability. This flows, to a large degree, from the predominant culture of institutions, which are traditionally hierarchically structured, paternalistic and lack transparency and accountability.

¹⁰ Victorian Equal Opportunity and Human Rights Commission report Beyond Doubt

¹¹ Court transcript: <http://www.nationaldisabilityabuseinquiry.com/the-evidence.html>.

In 2014 support workers in Victoria were fearful of reprisals for reporting abuse of a frail non-verbal elderly person, but when they finally did so, they were disciplined by the Department of Human Services for not speaking up sooner. In a separate case, staff at another group home delayed reporting that a worker had kicked, choked and pinned down a resident in front of other staff, because they were intimidated by the perpetrator.

In Queensland, statutory protection of whistleblowers is provided by the *Public Interest Disclosure Act 2010* (Qld). This legislation replaces the *Whistleblower Protection Act 1994* (Qld), which was introduced in the post-Fitzgerald Inquiry climate. Recently, the Federal Government has introduced equivalent protection at a commonwealth level: *Public Interest Disclosure Act 2013* (Cth).

Under the state legislative regime, any person can disclose information about a substantial and specific danger to the health or safety of a person with a disability, a substantial and specific danger to the environment (as set out in the Act) or a reprisal action following a public interest disclosure.

A public sector officer may also disclose information about corrupt conduct by another person, maladministration that adversely affects someone's interests in a substantial and specific way, a substantial misuse of public resources, a substantial and specific danger to public health or safety or a substantial and specific danger to the environment.

The new legislative regime extends the scope of the former Act, in that a person may make a public interest disclosure to a journalist in circumstances where they have already made essentially the same disclosure to an appropriate public sector entity and that entity has decided not to investigate or deal with the disclosure, did not recommend taking any action, or failed to report the results of the investigation to the discloser within the prescribed six month timeframe. This extension of whistleblowing power to the media is a significant one, and was enacted following recommendations from leading academics.¹²

Yet while the new legislative framework offers some improvement on the old model, some major issues remain. Of particular relevance for people with disability who have experienced violence, abuse or neglect within a residential or institutional setting is the power imbalance that exists and the fear of informal reprisal. Recent concerns about the misuse of executive power and lack of accountability under the Newman government have reignited concerns about the proliferation of inappropriate conduct and the potential for reprisals in Queensland, notwithstanding the public interest disclosure protective legislation. There remains in Queensland a climate of fear and reluctance to report official misconduct, particularly by vulnerable persons.

To put these concerns in context, we will offer a brief overview of some of the key problems reported on the previous legislative scheme which remain relevant to a consideration of these issues (due to the relative newness of the public interest protection legislation, there has not yet been the opportunity for detailed analysis or reporting under its provisions).

¹² See for example: AJ Brown, 'Restoring the Sunshine to the Sunshine State Priorities for Whistleblowing Law Reform in Queensland' *Griffith Law Review* (2009) 18(3) 666.

A recent conceptual study comparing the statutory protection offered to whistleblowers in four common law countries (Australia, New Zealand, South Africa and the UK) found that these countries have a significantly inadequate regime, with serious structural deficiencies particularly as regards the scope of protection and the construction of corruption. De Maria notes: 'The concern is that whistleblowers seeking protection under these inadequate programs will be hurt and there will be negligible impact on the profile of corruption.' The study called for an urgent review of whistleblower protection legislation to improve disclosure protection and reduce corruption.¹³

A separate paper reporting the findings of the largest study of whistleblowers in Australia revealed a 'crisis of competence in the official capacity of government structures to respond effectively to disclosures made in the public interest'.¹⁴ This concern remains relevant despite the enactment of the public interest disclosure legislative framework.

A further Australian study found that, despite the enactment of the former Queensland act, all of the factors that dissuaded whistleblowing prior to the passage of the act remained – informal sanctions for whistleblowers, a culture of secrecy and fear and authoritarian management practices. It concluded that the terms 'accountable', 'ethical', and 'workplace democracy' were 'powerful markers in a false geography of consensus and care'.¹⁵

A different perspective is presented by Brown. He begins from the premise that, notwithstanding the significant positive effects whistleblowing can have for organisations and for society in general, whistleblowing is generally seen as a rare 'crisis' event for an organisation, with the act of triggering allegations of corruption involving significant adverse personal reprisals for the whistleblower.¹⁶ However, Brown notes that the advent of whistleblowing amongst Australian public sector organisations is increasingly common and that this is leading to increasing acceptance of the validity of whistleblowing and that this has correlated with a decrease in the incidents of reprisals, although there is a significant degree of variation in this regard between different organisations.¹⁷ For the reasons explained below, people with disability are likely to be those who are disproportionately concentrated within organisations that may not embrace this move towards accountability and may instead use the significant power imbalance between service provider and recipient to fail to acknowledge or respond to allegations of violence, abuse and neglect.

¹³ William De Maria, 'Common law – common mistakes?: Protecting whistleblowers in Australia, New Zealand, South Africa and the United Kingdom', *International Journal of Public Sector Management* (2006) 19(7):643-658.

¹⁴ William De Maria & Cyrelle Jan, 'Behold the shut-eyed sentry!', *Crime, Law and Social Change* (1995/96) 24(2): 151-166.

¹⁵ William De Maria and C Jan, 'Eating its Own: The Whistleblower's Organization in Vendetta Mode' *Australian Journal of Social Issues* (1997) 32(1):37-59, 38-39, 55.

¹⁶ Alexander Jonathan Brown (2008) *Whistleblowing in the Australian Public Sector: Enhancing the Theory and Practice of Internal Witness Management in Public Sector Organisations* (ANU E Press).

¹⁷ Alexander Jonathan Brown (2008) *Whistleblowing in the Australian Public Sector: Enhancing the Theory and Practice of Internal Witness Management in Public Sector Organisations* (ANU E Press).

Dawson emphasises:¹⁸

Whistleblower protection is first and foremost a public policy issue, and more effective measures to protect those who blow the whistle on malpractice than exist at present are required. A three part strategy is called for. In the first place, Australia-wide legislation is needed to standardise whistleblower protection, commencing with the public sector where there is no question that a public interest case exists. Second, it will be necessary to change the often secretive and subtly authoritarian culture of much of the public sector. Third, it will be necessary to encourage a cultural change within the private sector in respect of whistle-blowing, and to consider seriously the possibility of legislation in this regard.

The call for cultural change and transparency are particularly pertinent for this consideration of institutional violence, abuse and neglect, as the closed-off practices of institutions with responsibility for the care of people with disability have been aided by the difficulties experienced by some people with disability to communicate their concerns and experiences and the disbelief and distrust with which those who are able to communicate such concerns are met.

People with disability who experience adverse treatment in an institutional setting are a particularly vulnerable group. There are a number of reasons for this, including:

1. Many people within this group have difficulty communicating their concerns or experiences and require the provision of appropriate support to do so.
2. Many people within this group have experienced a history of institutionalisation, or of violence, abuse or neglect, which can exacerbate their concerns with identifying and communicating inappropriate conduct by those in positions of power.
3. Many people within this group lack a supportive familial and friendship network that offers a buffer of support and thus experience feelings of isolation and fear about the withdrawal of services.
4. The limited options in terms of accommodation and services for people with disability mean that the fear of reprisal is particularly significant and may be a disproportionately powerful disincentive to report misconduct when compared with other groups.
5. The prescribed avenues for reporting abuse and inappropriate treatment are often difficult or impossible for a person with disability to access, due to the nature of their disability and their disempowerment and lack of appropriate support.

For these reasons, we consider that there is the need for additional and separate safeguards and supports to protect and defend the rights of people with disability who may be subject to violence, abuse or neglect within an institutional environment.

¹⁸ Stuart Dawson, *Whistleblowing: a broad definition and some issues for Australia*, Working Paper 3/2000, Victoria University of Technology.

In 1995 the Honourable D J Stewart reported on the allegations of official misconduct at the Basil Stafford Centre and made 20 recommendations, the primary one being that the problems at the Basil Stafford Centre were of such a nature that the only practical solution was to close the facility. The very terms 'official misconduct' seem to diminish the abuse and neglect that was inflicted upon the residents, many of whom had lived there since childhood. Despite the recommendations, and the removal of the residents of the day, other people (including the teen held in seclusion around the clock) were moved into the facility as the media attention waned.

Following this report, Justice W Carter QC reviewed the implementation of the findings in "Challenging Behaviour and Disability: A Targeted Response" (Carter Report), tabled in Parliament on 22 May 2007. The Carter Report led to the subsequent development of legislation regulating the use of Restrictive Practices.

While the intention was to safeguard practices (which if used on people with disabilities would constitute criminal offences), the Act has been reviewed three times with an erosion of protections for people with disability and resultant ease of use for service providers. Some of the changes include doubling the term of short term approvals from three months to six months, extending decision-making from the Queensland Civil and Administration Tribunal to the Public Advocate (now Public Guardian) and the Executive Officer of the Department of Disability Services as well and offering immunity from criminal prosecution to service providers.

QAI maintains that the use of Restrictive Practices constitute cruel, inhumane and degrading treatment under the Convention Against Torture.

The different legal, regulatory, policy, governance and data collection frameworks and practices across the Commonwealth, states and territories to address and prevent violence, abuse and neglect against people with disability

Existing frameworks, practices and safeguards

In Australia, there are some statutory, governmental and strategic initiatives that purport to address and prevent violence, abuse and neglect against people with disability. However, the measures presently in place, at both a state and federal level, are more reactive than preventative. They have proved largely ineffective in the face of the deeply ingrained and systemic roots of the problem of violence, abuse and neglect of people with disability.

We will briefly outline some of the more notable measures that are in existence in Australia, before turning to consider some examples of measures from other jurisdictions that have been successful in targeting and violence, abuse and neglect against people with disability, and exploring the reasons for this.

The following safeguards have been adopted at a Commonwealth level:

- *Disability Discrimination Act 1992* (Cth) – the Australian Human Rights Commission is vested with power to investigate and resolve complaints in relation to discrimination, harassment and bullying based on disability

- *National Disability Strategy (NDS)* – sets out a ten year national plan for improving life for Australians with disability, their families and carers, drawing on the findings of consultation conducted in 2008-9 by the National people with Disabilities and Carer Council.¹⁹ Policy Direction 4 of the NDS states that people with disability are to be safe from violence, exploitation and neglect. Areas identified for future action include developing strategies to reduce violence, abuse and neglect of people and to improve the reach and effectiveness of all complaints mechanisms.
- *National Disability Insurance Scheme (NDIS)* - establishes statutory quality assurance and safeguards frameworks. Relevant state and territory legislation vests relevant government agencies with responsibility for the administration of quality assurance and safeguards including responding to abuse, neglect and exploitation.
- *National Disability Insurance Agency* - The NDIA recognises the importance of ensuring staff are suitable to work with people with disability:
 - The NDIA has a system in place to maintain up to date and appropriate checks on staff in the NDIA including police checks on commencing employment and the requirement to declare any current or potential conflict of interest or criminal charges.
 - The NDIA investigates all allegations that a staff member is involved, or may be involved, in abuse, neglect or exploitation of any person. Whenever a staff member obtains information which may indicate that an NDIA staff member is involved, or may be involved, in abuse, neglect or exploitation of any person, the staff member who obtains the information is immediately report the information to their senior executive manager who will report to the NDIA's Chief Financial Officer in accordance with the NDIA's complaints management policy.
 - Staff members are required to document clearly all information and be careful not to compromise any investigation by the NDIA, police or external agencies.
- *National Disability Abuse and Neglect Hotline* – established as a means of reporting abuse and neglect of people with disability. The Hotline works with callers to find appropriate ways of dealing with allegations of abuse. However, the Hotline lacks any systemic investigation, inquiry, review or independent public reporting powers and is unable to initiate action on its own motion. Thus, the indicators are that it is a weak safeguard and requires significant strengthening to be of any real effect.²⁰

The following measures are in place in Queensland:

- *Disability Services Act 2006 (Qld)* – Part 5 of the Act provides for the screening of, *inter alia*, the criminal history of persons engaged by department or funded non-

¹⁹ Reported in *Shut Out: The Experience of People with Disabilities and their Families in Australia*. 2009. National Disability Strategy, 8.

²⁰ People with Disability Australia. *Response to the National Human Rights Action Plan Baseline Study Consultation*. 9 September 2011, 28-9.

government service providers for the purpose of protecting people with disability from abuse, neglect or exploitation. Part 2 of this Act covers disability rights and section 28 provides: “No single service provider to exercise control over the life of person with disability²¹”. However, the significant issues that arise when the service provider is both the landlord and the provider of supports and services often produces serious conflicts of relinquishment of care or non-reporting of abuse either by other co-tenants or staff members.

- *Public Guardian Act 2014* (Qld) – the Public Guardian is empowered to protect adults with impaired capacity from neglect, exploitation or abuse and can investigate any complaint or allegation that an adult with impaired capacity is being, or has been, neglected, exploited or abused. However, the investigative function is dependent upon allegations of abuse being reported to the OPG, and is not a pro-active investigative power – this means that the initiation of an investigative process relies upon families or carers, or others involved in the person’s life, to identify that the person is at risk of abuse. The risk is that some cases of abuse, neglect or exploitation of persons with impaired capacity, particularly those who are socially isolated, may remain unreported. Further, the OPG has limited powers when determining neglect, exploitation and abuse and does not have the power to prosecute cases of abuse. The primary focus of an investigation is to determine whether the decision-making support or care is deficient and amounts to neglect, exploitation or abuse, and then help the person with impaired capacity obtain better arrangements for their support and care.²²
- *Department of Communities, Child Safety and Disability Services* – published information on indicators and signs to assist service providers identify abuse, neglect and exploitation of people with disability and the steps to take in responding to identified signs.

Gaps and deficits in existing framework, practices and safeguards

As noted above, Australia has historically taken a reactive, rather than proactive or preventative, approach to cases of violence, neglect and abuse against people with disabilities, in contrast to some other jurisdictions.

In Australia, there has been growing recognition of the high incidence of domestic and institutional violence against people with disability. In February 2011, the *National Plan to Reduce Violence against Women and their Children 2010–2022* was endorsed by the Commonwealth and State and Territory Governments.²³ The *Second Action Plan: Moving*

²¹ *Disability Services Act 2006* (Qld), s 28.

²² The OPG does recognise that a person being harmed may not be able to report it, or be in a position to report it. In such circumstances, the OPG works with carers, support providers and family members to immediately report suspicions of abuse to the agencies involved with the person’s care, and also to report the matter to the OPG or the police directly where a criminal offence is suspected. See section 36 of the *Public Guardian Act 2014* which empowers the Public Guardian to apply to QCAT under section 148 of the *Guardianship and Administration Act 2000* for a warrant to enter and remove the adult with impaired capacity.

²³ Commonwealth of Australia. 2011. *National Human Rights Action Plan: Baseline Study*, 127.

Ahead 2013-2016, released on 27 June 2014, built upon the *National Plan*, and specifically focuses on, *inter alia*, women with disability and their children who experience violence. However, this framework is largely inadequate in the face of the endemic abusive cultures and practices that pervade institutions charged with the care of people with disability and fails to incorporate adequate human rights recognitions and protections.²⁴

The research literature documents the significant gaps in research, policy and practice as regards the abuse and neglect of people with disability.²⁵ Current arrangements for the detection, reporting, investigation and prosecution of abuse, neglect and exploitation of people with disability in Australia – particularly those with cognitive impairment – are inadequate. This is largely due to the fact that there is no specific legal and institutional framework for the investigation and prosecution of abuse, neglect and exploitation of ‘vulnerable’ adults in Australia. At the core of the problem is the lack of a Human Rights Charter or Bill of Rights which could offer a baseline level of human rights protection for vulnerable and marginalised groups including people with disability. Australia is presently an outlier as the only liberal democracy and common law legal system without a federal Human Rights Act. While there are Human Rights Acts in Victoria and the Australian Capital Territory, there is also no Queensland Human Rights Act.

This omission is compounded by the continuing overwhelming evidence which demonstrates that mainstream law and institutional arrangements fail to protect persons with cognitive impairment from harm²⁶.

It is well documented that legal frameworks and enforcement processes play an important role in the protection of people with disability by enshrining rights and safeguards in legislation and by providing avenues for persons with disability to seek redress. Many other jurisdictions, including the United Kingdom and the United States, have already implemented frameworks around vulnerable adult prevention and response, which Australia can learn from.²⁷

On 11 February 2015, the Senate referred the following matter to the Senate Community Affairs References Committee for inquiry and report: Violence, abuse and neglect against people with disability in institutional and residential settings, including the gender and age

²⁴ This point has been made by PWDA in its response to the National Plan: see People with Disability Australia (PWD) Response to the National Human Rights Action Plan Baseline Study consultation, 9 September 2011.

²⁵ See for example Sally Robinson & Centre for Children and Young People, South Cross University. 2012. *Proactive approaches to addressing the abuse and neglect of children and young people with disability*.

²⁶ French, P., Dardel, J., & Price-Kelly, S., *Rights denied: Towards a national policy agenda about abuse, neglect and exploitation of persons with cognitive impairment*, People with Disability Australia, 2009, 106-109.

²⁷ Council of Europe (2003) *Safeguarding adults and children with disabilities against abuse*. Council of Europe Publishing; Fitzsimons, N (2010) *Preventing Abuse and Neglect: New Approaches to Stopping Harm*

<http://www.griffith.edu.au/health/school-human-services-social-work/news-events/international-symposium>; Brown, H (2010) How can we better understand and respond to abuse and neglect of people with learning disabilities, <http://www.griffith.edu.au/health/school-human-services-social-work/news-events/international-symposium> .

related dimensions, and the particular situation of Aboriginal and Torres Strait Islander people with disability, and culturally and linguistically diverse people with disability.²⁸

One area of concern is the present dearth in protections against violence, abuse and neglect for children with disability. As Robinson notes, the responses to the abuse and neglect of children and young people with disability fall between national and state jurisdictions. This is compounded by the inconsistencies between state- and federally-based legal and policy responses to this issue.²⁹ The 2012 shadow report “Disability Rights Now” on the *Convention on the Rights of Persons with Disability* identified many areas in which children with disability are facing considerable barriers around both a disproportionate experience of harm and in systemic responses to that harm. Importantly, this report found that Australia lacks a specific legal, administrative or policy framework for the protection, investigation and prosecution of exploitation, violence and abuse of people with disability.³⁰

QAI submits that protection mechanisms should include recognition and reporting mechanisms at the individual, service and Government levels and that all health care and support staff within residential and institutional settings should have a professional and legislatively entrenched responsibility to speak out and report suspected abuse. Furthermore as noted later in this submission, QAI asserts that the NDIA must reconsider the position regarding people who live under the imposition of Restrictive Practices and the opportunity to self-direct their supports and services.

Finally, we note the important finding by Robinson and Chenoweth that ‘the views of people with intellectual disability about their experiences of emotional and psychological abuse and neglect feature very little in either the disability studies or abuse literatures’.³¹ This is clearly inappropriate. It is now widely recognised that any initiatives aimed at addressing the plight of vulnerable people with disability in our society must heed their views and recognise that this group is in the best position to speak on their own behalf – ‘nothing about us without us’.³²

Other jurisdictions

New Zealand:

New Zealand is one jurisdiction to which Australia can look for examples of successful initiatives in addressing violence, abuse and neglect against people with disability. Two broad pieces of legislation establish a protective framework – the *Human Rights Act 1993*

²⁸

http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Violence_abuse_neglect.

²⁹ Sally Robinson & Centre for Children and Young People, South Cross University. 2012. *Proactive approaches to addressing the abuse and neglect of children and young people with disability*.

³⁰ Sally Robinson & Centre for Children and Young People, South Cross University. 2012. *Proactive approaches to addressing the abuse and neglect of children and young people with disability*.

³¹ Sally Robinson and Lesley Chenoweth. ‘Understanding emotional and psychological harm of people with intellectual disability: an evolving framework’ (2012) *Journal of Adult Protection* (2012) 14(3): 110-122.

³² James I Charlton. 2010. *Nothing About Us Without Us: Disability Oppression and Empowerment*. University of California Press.

(NZ), which prohibits discriminatory treatment and establishes the Human Rights Commission, and the *New Zealand Bill of Rights Act 1990*, which affirms, protects and promotes human rights and freedoms and provides additional safeguards for fundamental rights and freedoms by making the government accountable to a set of objective standards.³³

Within this legislative framework, the Disability Action Plan 2014-2018 specifically recognises relevant articles of the *Convention on the Rights of Persons with Disability* and seeks to ensure personal safety and reduce incidence of violence, abuse and neglect for adults and children with disability. One important component of the Action Plan is educating people about their rights not to be abused and what abuse entails and this component is led by Disabled People's Organisations (DPOs). The Action Plan also requires investigation of funding of DPO partnered programmes that support disabled people to speak up for themselves to ensure this is linked with victims of crime work and focuses on increasing safeguards for people with disability who are socially isolated and developing initiatives to remove barriers to social inclusion.³⁴

Canada

In Canada, the *Adult Protection Act 1989* and the *Family Services Act 1980* offer protection for adults, including adults with a disability, who are experiencing abuse and neglect. The latter involves proactive involvement by a social worker where the Department has reason to believe there is an occurrence of abuse or neglect.

Australia's compliance with its international obligations as they apply to the rights of people with disability

While state and federal governments attempt to placate people with disability and their families, advocates and allies by inserting references to the *Convention on the Rights of Persons with Disabilities* (CRPD) and other international conventions, there is little to no reflection of this in practice or policy implementation. Our organisation is responsible for the development of the Human Rights Indicators (attached) relating to the implementation of the CRPD. QAI was also involved with the civil society 'shadow report' "Disability Rights Now" that analysed and assessed Australia's accordance with the CRPD. It is clear from the comprehensive report that Australia and its states are far from compliant.

As both a community legal centre and systems advocacy organisation, QAI regularly cites breaches of the CRPD in both individual cases as well as systemic legislative and policy areas.

As noted above, the lack of a human rights charter at either a state or federal level increases the marginalisation and vulnerability of groups such as people with disability. While the ratification of international humanitarian instruments such as the CRPD provide a theoretical basis for the understanding and interpretation of human rights for people with disability, in the

³³ See: <http://www.ccsdisabilityaction.org.nz/advocacy-and-your-rights/disability-laws-and-rights>.

³⁴ See: <http://www.odi.govt.nz/documents/what-we-do/ministerial-committee-on-disability-issues/disability-action-plan-2014-2018-a3-image.pdf>.

lack of domestic legislation implementing such treaties as laws of Australia, the respect for and translation of these rights into practice is not assured or enforceable.

Such concerns are heightened by the repeated violations of the human rights of people with disability in a multitude of ways, notwithstanding the existence of the CRPD. The use of Restrictive Practices on people with disability, the indefinite detention of people with disability who have not been convicted of an offence within the Forensic Disability Service, the failure to take proactive steps to ensure the provision of appropriate accommodation for people with disability within the community and the failure to ensure appropriate employment opportunities for people with disability are but a few examples of blatant violations of the rights prescribed by the CRPD. As the terms of the CRPD are not directly enforceable by state or federal courts, these flagrant breaches of the human rights of people with disability are difficult to prosecute. The Australian government has shown scant regard for the impact of such abuses on its human rights record and international disapproval of Australian human rights breaches have not resulted in the imposition of trade sanctions or other more concrete means of censure.

RESTRICTIVE PRACTICES

The following case studies highlight the inappropriate and abusive application of Restrictive Practices on vulnerable people with disability:

Case study: Tina, a 23 year old female

Tina was being supported by a service provider who regularly sought to increase the range of Restrictive Practices they could use. As a baseline, Tina was contained for 16 hours per day and secluded for eight hours overnight. During the day she would also be placed in seclusion or have chemical restraint applied in order to control her behaviour.

Tina's behaviour arose because neither she nor her family were listened to. Tina was bored, had little meaningful activity in her life and had been isolated from the community in which she lived. The service provider showed little interest in addressing these issues when they were raised by the family. Instead, they attempted to restrict Tina's access to her family and on several occasions applied to QCAT to have the public guardian appointed, as opposed to the family member. The service provider refused to acknowledge that Tina's behaviour was a form of communication (expressing dissatisfaction) and labelled Tina as difficult and prone to 'challenging behaviours'.

Tina really wanted to move to her own place and be closer to her family. The service provider discouraged this dream. Rather, they made application to QCAT submitting that Tina could never live on her own, was unsafe to be in the community and needed high level use of Restrictive Practices. The family continued their strong advocacy for Tina and contacted QAI for assistance.

Eventually Tina was moved into her own residence, closer to her family and to a service provider who has never used any form of Restrictive Practices. Tina now has a part-time job and has become part of her local community. Not only have the challenging behaviours

reduced, but also the level of support Tina requires.

Case study: Frances, a 22 year old female

Frances was living in the community, however due to inadequate funding and inappropriate supports Frances' needs were unmet. As a result she started to display behaviours which were seen by the service provider as challenging, so much so that they withdrew from providing support. A decision was made by Disability Services to place Frances in a secure facility, contrary to the appointed guardian's requests. This meant that Frances was contained 24 hours per day, seven days a week.

Subsequent to the move all activities that Frances had previously enjoyed were ceased, as was her personal mobility and freedom. Due to boredom and an inability to move around freely, Frances began to self-harm and strike out at staff. Additional Restrictive Practices such as seclusion and chemical restraint were applied yet, unfortunately, positive strategies were not as rigorously applied. Frances began to spend large amounts of time in seclusion.

It was 18 months before activities pleasurable to Frances were re-introduced into her daily routine. This was only achieved through the strong advocacy of her family and QAI's involvement. Some 12 months later Frances remains at this facility and continues to have Restrictive Practices applied, albeit the frequency of use is decreasing.

The question to be pondered is: would any of this have occurred if appropriate funding and supports were available to Frances in the first instance?

INVOLUNTARY TREATMENT

The following case studies highlight the abusive and neglectful operation of involuntary treatment orders on vulnerable people with disability:

Case study: Tom, a 34 year old male

Tom is a 34 year old male with diagnoses of pervasive developmental disorder and intellectual disability.

Tom has a Forensic Order – Mental Health which was applied to him approx. 14 years ago. This was recently converted to a forensic order – disability. He was placed on the order because he was found to be of unsound mind. Later he was found to be permanently unfit for trial and the charges against him have never been tested in Court.

In 2011 Tom was moved from a mental health facility out to the newly established Forensic Disability Service. The purpose of this service is to provide habilitation and rehabilitation programs and to integrate the person back into the community.

Since moving to the service Tom's only form of leave has been to attend health appointments outside of the facility. This is despite community access leave being approved

by the Mental Health Review Tribunal (MHRT). The reason given by the treating team for not allowing this leave is that Tom has failed to progress appropriately. When this reason was explored the treating team said that Tom did not participate fully in the rehabilitation program, was constantly challenging staff and the rules of the facility. Therefore until he complied with the program he would not have any leave as he would be a risk to the community. He is effectively punished for his disability.

When challenged about this approach the staff stated that they had tried everything to help Tom but nothing was working. QAI pointed out that in fact they had not tried everything because Tom was not allowed to do what he wanted to most, which was to be able to leave the facility to go shopping or to visit his parents.

It is nearly four years since Tom moved to this service which was supposed to improve his quality of life; however the opposite has happened.

Case study – Peter, a 28 year old male

Peter subject to a Forensic Order and has been detained in the High Dependency Unit of an acute mental health service without leave since April 2014.

Peter does not have access to reading material, iPod, TV etc. Peter's family and private psychologist visit him at the acute facility. He is allowed to ride an exercise bike for half an hour per day and this bike was physically brought in by a nursing staff member who didn't ask for permission to relocate the exercise bike.

QAI attended an MHRT hearing, argued to have a stakeholders meeting, had the Community Visitor see Peter and wrote to the Director Mental Health, with no improvement in the situation.

During this time no one was reviewing the ongoing restrictive environment Peter was detained in and no one could provide any clear evidence as to why Peter was not allowed to access leave approved by the MHRT.

From QAI's understanding the treating team felt Peter needed to accept a particular type of medication (with significant side effects) however Peter, his family and private psychologist refused to accept any new form of medication because he had been stable in his mental health for several months. It seemed to be that the treating team would not progress Peter's recovery unless he accepted a particular medication.

However the treating team finally developed a treatment plan to progress his recovery even though he has not accepted the new medication.

Role and challenges of formal and informal disability advocacy in preventing and responding to violence, abuse and neglect against people with disability

It is within this climate of disregard for the tenets of international humanitarian law insofar as they protect the rights of this vulnerable group of people with disability, discussed above, that disability advocates work.

Bureaucratic processes also exclude informal advocates and family members from guardianship status (by which they can formally participate and have a voice in proceedings affecting a person with disability). In particular, in guardianship proceedings before the Queensland Civil and Administrative Tribunal, service providers are often successful in arguing for the formal removal of a person's familial or supportive network from the guardianship role. A significant humanitarian concern is that the theoretical regime established by the *Guardianship and Administration Act 2000* (Qld) is not authentically translated into practice, both in terms of the circumstances in which guardians are appointed pursuant to the GAA and in the actions of those guardians to the persons then subject to their control. This can obviously have significant adverse consequences, including infringing the autonomy of, and determining or otherwise restricting the choices available to, people with a disability. QAI acknowledges the significant value of informal supports for a person with a disability and calls for informal supporters to be accorded greater respect and status, as well as formal recognition within bureaucratic guardianship processes.

Disability rights advocates take the position that the appointment of statutory officials, or adult guardians, should be a measure of last resort.³⁵ Bach likens a declaration of guardianship to a '[s]tate-sanctioned removal of personhood from an individual with respect to one or more or all areas of personal decision-making'³⁶ and Perlin characterises the imposition of guardianship as a form of 'civil death'.³⁷ Disability advocates are generally in a superior position to an independently appointed guardian to properly understand and help to articulate the needs and preferences of a person with disability.

What should be done to eliminate barriers for responding to violence, abuse and neglect perpetrated against people with disability in institutional and residential settings, including addressing failures in, and barriers to, reporting, investigating and responding to allegations and incidents of violence and abuse

While the recent changes in the whistleblower protection legislative scheme, discussed above, are welcomed, they are unlikely to have significant impact on either the fears or actual experiences of people with disability who experience abuse from a service provider. People with disability are a highly marginalised group. They require additional protections, above the

³⁵ Shih-Ning Then, 'Evolution and Innovation in Guardianship Laws: Assisted Decision-Making' (2013) 35 *Sydney Law Review* 133, 141; Lawrence Frolik, 'Plenary Guardianship: An Analysis, a Critique and a Proposal for Reform' (1981) 23 *Arizona Law Review* 599, 642-3.

³⁶ Michael Bach, Legal Capacity, *Personhood and Supported Decision-Making*, Canadian Association for Community Living (UN Enable Working Group, Jan 2006), <http://www.un.org/esa/socdev/enable/rights/ahc7docs/ahc7ii3.ppt>.

³⁷ Michael L Perlin, "Striking for the Guardians and Protectors of the Mind": The Convention on the Rights of Persons with Mental Disabilities and the Future of Guardianship Law' (2013) 117 *Penn State Law Review* 1159, 1162.

baseline protections offered to other groups, to empower them to assert and defend their rights.

There is a pressing need for significant cultural change across key areas and institutions with which people with disability interact. At present, the general experience of people with disability living in institutions is largely one of significant disempowerment, which is heightened in correlation with the length of institutionalisation. This experience is often not substantially different in residential care settings, as autonomy and control is often denied to people with disability over many facets of their daily lives.

QAI submits that a first step would be for a supported decision-making approach to be properly embraced in Australia. This would transform many presently disempowering experiences for people with disability into events over which they can begin to exercise choice and autonomy. This would help to instil and develop confidence and the ability to make choice and expect to be treated with respect and dignity and to have their human rights acknowledged and protected.

Further, we submit that service providers should be under a positive duty to record any incidents that suggest there may be a problem – the onus should be on the service provider to report suspected breaches of rights, not on the person with disability to report the breach. Each service provider should be required to develop and maintain a set of core indicators that flag potential issues. This must be accompanied by a shift in mindset whereby attention is paid to behaviours that may seek to communicate problems and action taken accordingly (rather than the present approach of responding to communicative behaviours in a punitive way).

What needs to be done to protect people with disability from violence, abuse and neglect in institutional and residential settings in the future, including best practice in regards to prevention, effective reporting and responses

QAI submits that the greatest protection for people with disability will come from the cultural change discussed in the previous response.

With the introduction of the National Disability Insurance Scheme, there is the potential for a fresh approach to be adopted, where people with disability are seen as consumers whose choice is respected in the marketplace, rather than passive service recipients who are denied choice over fundamental decisions affecting their lives, such as where and with whom they live. However, people with disability whether participating in the NDIS or not are to be afforded citizenship by the advent of this scheme that goes far beyond mere consumerism. Therefore it is vital that this is communicated across all communities and sectors within. This would be enhanced by the introduction of a national Bill of Rights, and with the introduction of penalties for offenders.

Identifying the systemic workforce issues contributing to the violence, abuse and neglect of people with disability and how these can be addressed

There are a number of systemic workforce issues that contribute to the violence, abuse and neglect of people with disability.

Key issues are:

- The hierarchical nature of many organisations
- The 'cover-up' culture and incidents of executive misuse of power that were formative parts of Queensland political history
- The historical approach of substituted decision-making taken by guardianship law to people with disability, which disregards the autonomous choice of people with disability
- Industrial conditions for disability workers are generally poor. The lack of status and low level of remuneration which many disability workers are provided contributes to a devaluing to the important care work these workers perform. This is symbolic of the scant regard society places on the work of caring for people with disability and can lead to discrimination and disadvantage for these workers, which feeds into the general disability care culture. This can also result in a high turnover of workers, which can be problematic in terms of continuity of care and of understanding and recognising symptoms of distress
- The wide variation of care availability in institutions and residential care services, with predominantly substandard care dominating the market.

The role of the Commonwealth, states and territories in preventing violence and abuse against people with disability

The Commonwealth, states and territories have a significant role to play in preventing violence and abuse against people with disability. The first step, which should be an immediate priority, is the enactment of a state and federal human rights charter to establish a uniform baseline recognition and protection for human rights throughout Australia, as discussed above. The Australian Capital Territory introduced a human rights charter in 2004 and Victoria followed in 2006. Notwithstanding the conservative approach taken in Victoria, in failing to create standing for a person alleging a breach of the charter without a related cause of action, the charter has had significant benefits including improved outcomes for vulnerable groups (including people with disability). Yet the other states and territories, and the federal government, have lagged to follow suit.

A further and much needed step is the passage of legislation at both a state and federal level that implements the human rights principles agreed to in international treaties within Australian law. Most relevantly for people with disability is the *Convention on the Rights of Persons with Disabilities*, but other humanitarian treaties are also relevant in protecting the rights of this group. Notwithstanding that Australia has agreed to be bound by a number of major international human rights treaties, they do not form part of Australia's domestic law unless the treaties have been specifically incorporated into Australian law through legislation.³⁸ Under the external affairs power of the Constitution³⁹ of the Australian Constitution, the Commonwealth Parliament has power to enact legislation that implements the terms of those international agreements to which Australia is a party.⁴⁰ QAI submits that

³⁸ *Kioa v West* (1985) 159 CLR 550.

³⁹ Section 51(xxix) of the Constitution.

⁴⁰ *Commonwealth v Tasmania* (Tasmanian Dam Case) (1983) 158 CLR 1.

this should be an urgent priority that should supersede political interest or less critical agendas.

The governments must then ensure that the framework is in place to support the translation of many of these values into practice, in a way that benefits both people with disability and the broader population. Relevantly for the present inquiry is ensuring that people with disability have adequate options and the financial and practical support to live outside of residential facilities and institutions in which they may be, or may have been, subject to violence, abuse or neglect. Funding must be provided to ensure the availability of appropriate options.

QAI considers that it is fundamentally important to support people with disability to live autonomously, where desired and possible. Over the past few decades there has been a strong emphasis on deinstitutionalisation and reformation of the social and housing policy framework in Australia and this has resulted in people with disability being moved from institutions into smaller, community-based group homes.⁴¹ While the outcomes of this movement have been generally reported to be favourable,⁴² there remains a significant disparity between the preferences and reality of accommodation for many people with disability in Australia.

Recent Australian research has recognised the desirability of taking an individualistic approach to housing for people with disability, which acknowledges the importance of providing appropriate fiscal and non-fiscal supports to enable people to live independently in the community.⁴³ In 2010, an external evaluation of the delivery and outcomes of the Queensland Government's Housing and Support Program found that people with intellectual and cognitive disability or mental illness can successfully reside and participate in their community of choice, with adequate community support, stable housing and appropriate clinical case management.⁴⁴

For many adults with disability, adequate financial support in the form of rental assistance is but one part, albeit an integral part, of the support structures required. It is noted that the type of financial assistance required to support appropriate accommodation arrangements for people with disability, whether it be a physical impairment or a mental health, intellectual or

⁴¹ Lisa Bostock, Brendan Gleeson, Ailsa McPherson and Lillian Pang, deinstitutionalisation and housing futures: Final report (Australian Housing and Urban Research Institute UNSW-UWS Research Centre, 2001).

⁴² See, for example, doctoral research by Young, which reports on Australia's largest deinstitutionalisation research project, whereby residents from Challinor, a government-run institution located in Ipswich, Queensland, were relocated after the centre was closed. The residents of Challinor was predominantly classified as a most problematic group to deinstitutionalise, as the demographics of this group were mostly older (aged over 40 years), had been institutionalised for an extremely lengthy period (over 20 years), many had severe and profound levels of intellectual disability and many had behaviour problems. However, the deinstitutionalisation of this group resulted in favourable outcomes: Janet Louise Young, *Deinstitutionalisation and Changes in Life Circumstances of Adults with Intellectual Disability in Queensland*, unpublished doctoral thesis, University of Queensland, 2001.

⁴³ Lesley Chenoweth, Natalie Clements and School of Human Services and Social Work, *Funding and service options for people with disabilities: Final Report*, Griffith University, June 2009, reporting on the 2008 meta-analysis by Parmenter and Arnold for the Victorian Department of Human Services.

⁴⁴ The evaluation was conducted by the Department of Psychiatry, University of Queensland, in conjunction with the Queensland Centre for Mental Health Research (known as 'The Park').

cognitive impairment, is higher (and often significantly so) than that required by a person without the disability. However, it is appropriate and necessary that this additional assistance be provided to ensure persons with disability are able to enjoy living conditions on par with others without disability.

The challenges that arise from moving towards an individualised funding arrangement, like the National Disability Insurance Scheme, including the capacity of service providers to identify, respond to and prevent instances of violence, abuse and neglect against people with disability

QAI has made detailed submissions on the consultation paper on the proposed framework for quality and safeguarding under the National Disability Insurance Scheme.

We do not consider that the move towards an individualised funding arrangement like the National Disability Insurance Scheme will pose additional challenges in terms of the capacity of service providers to identify, respond to and prevent instances of violence, abuse and neglect against people with disability.

Rather, if the spirit of the NDIS is properly embraced and achieved, the introduction of the NDIS should, itself, be a form of safeguard against violence, abuse and neglect of people with disability. This is because the NDIS, if the vision is properly translated, should empower people with disability and elevate their status within the service provision realm.

In Queensland, there have been many factors that have historically contributed to a culture that does not properly respect or empower people with disability. People with disability have largely been viewed as passive service recipients, subjected to the practices of the service provider who predominantly enjoys significantly greater power and resources than the person in their care.

As discussed further below, we consider that the implementation of the NDIS offers an opportunity to embrace cultural change in the disability services area, centring on the significant shift in mindset towards viewing people with disability as active participants in a competitive services market, rather than passive, voiceless service recipients.

There is a need to ensure all service providers operating in the marketplace are required to be appropriately trained and skilled, and to operate with transparency and accountability. We consider that significant benefits would flow from the requirement that all registered service providers undertake appropriate training, such as Social Role Validation (SRV) training, and adopt 'right relationship roles' to ensure that their interactions with people with disability are appropriate.

What elements are required in a national quality framework that can safeguard people with disability from violence, abuse and neglect in institutional and residential settings

QAI submits that the elimination of the use of Restrictive Practices on people with disability is at the heart of this issue. Restrictive Practices are imposed upon vulnerable people by those who abuse their power and exert domination over the person. The person viewed as exhibiting the behaviours of concern is restricted, thus exacerbating the problem. Therefore

the perceived solution is to apply more or longer use of the particular restrictive practice or practices, entrenching and sanitising this approach as acceptable for the long term. QAI asserts that the use of Restrictive Practices is a violation of human rights on the grounds that such treatment, if applied as a societal norm, would not be tolerated and would be viewed as criminal conduct. The application of Restrictive Practices on people with a disability is discriminatory, cruel, inhuman and degrading treatment that must be ceased.

Further, the existence of permissive legislation that allows the imposition of Restrictive Practices also implicitly condones the use of violence and abuse as a means of relating to a person with a disability by a service provider as part of their day-to-day interaction. This has significant implications for the culture of institutional and residential settings.

People who live under the imposition of Restrictive Practices are excluded from being able to employ their own staff and self-direct or self-manage their supports and/or funding. While we recognise that this is currently the national position for the NDIA, QAI maintains that this discrimination is unfair and imposes severe limitations on the choice and control available to the most vulnerable people who are eligible for NDIS support yet could potentially have the most to gain. Furthermore, the legislation for the use of Restrictive Practices in Queensland is the most robust and longstanding in Australia, yet it has been amended several times, with each amendment imposing more constraints on individuals while affording more ease for service providers. This would suggest that Queensland's Department of Disability Services and the service sector have not developed the mindset or embraced the culture to be ready for the NDIS.

We understand the need to safeguard people from inexperienced workers or those who may abuse or take advantage of vulnerable people. However, the current system does not safeguard people from the same happening within traditional services. Excluding these people from the same opportunities as others is discriminatory and will exacerbate the denial of autonomy and control for this vulnerable group.

An alternative measure is to support people who live under Restrictive Practices to train or direct their own staff (with their informal supporters as and when required) or to have their own selected staff trained at the Centre of Excellence. QAI believes that a significant number of people who are supported to move towards this level of autonomy will then be enabled to emerge from under Restrictive Practices.

People who live under the imposition of Restrictive Practices are currently confined to the few choices of Service Providers available that are perceived by The Department to have expertise and knowledge of Positive Behaviour Support Plans and how to use Restrictive Practices. This is certainly exacerbated in rural and remote areas of Queensland with few if any choices of services. We point to the model of Kalpana – a small person-centred service geographically located and specifically designed to support 10 individuals deemed 'too difficult' for all other Service Providers. Those people no longer live under Restrictive Practices and self-direct their own supports. The service operates with a coordinator and a governance model.

The Department's own service provider AS&RS has expertise that need not be lost. People who wish could and should be able to hire AS&RS staff as independent contractors as they can any other staff. Clinging to the notion of department owned and run service providers is not conducive to the NDIS and not necessarily enhancing the lives of people with disability.

Furthermore, QAI submits that a supported decision-making approach should be adopted for all matters concerning people with disability. Supported decision-making is about encouraging people with disability and their informal supporters so that guardianship and administration orders are in some cases no longer necessary and informal supporters conduct their support with morality that respects the dignity of risk, and allows people with disability to make mistakes, to learn, and to truly make their own decisions.

As noted above, QAI has made detailed submissions on the consultation paper on the proposed framework for quality and safeguarding under the National Disability Insurance Scheme. We do not propose to repeat the entirety of our submissions here but are happy to forward a copy of that submission upon request. Here, we do wish to outline our consideration of the key elements necessary to safeguard people with disability from violence, abuse and neglect in institutional and residential settings, as follows:

1. There is a need for a significant shift in mindsets, particularly on the part of service providers. Rather than being viewed as passive recipients of care, people with disability should be understood as the key decision-makers and the consumers in service marketplace. This is necessary to deliver services of an appropriate quality and ensure safeguards that reflect the 'choice and control' intended by the inception of the NDIS, while creating safeguards that ensure people are not disadvantaged or harmed.
2. There is a tendency for many service providers to view the NDIS as a threat to their viability rather than an opportunity to change and be more responsive to need. We have witnessed this in interstate trial sites with service providers speaking about 'offering programs to new clients' and 'merging and amalgamating' to remain viable. This approach entrenches the monopoly that existing large service providers already have on the sector and will result in small innovative services struggling if they are not recognised for their excellent support in enabling people's autonomy. Smaller responsive and innovative service models need to be supported and promoted as being geographically ideal and person centred.
3. Safeguards need to be put into place to ensure that instances of abuse are reported via the appropriate channels and properly responded to. At a minimum, this requires:
 - a. Consideration is given to developing more appropriate means of reporting a grievance for people with different types of disability;
 - b. The culture of the service is conducive to receiving complaints – that is, complaints are welcomed as a means of improving service provision;
 - c. People with disability are provided with adequate support, including advocacy support, to express their concerns in safe environment;

- d. Attention must be paid to helping people with disability who lack an adequate support network to build a support base within their community;
- e. Any complaints must be listened and responded to appropriately – it is imperative that people with disability are listened to and their complaint taken seriously, and that they **feel** that they are listened to and their complaint taken seriously.
- f. The onus should not be on the person to know or recognise what avenues for complaints are available. For any service or system that prides itself on excellence this should be offered at any reasonable expression of dissatisfaction;
- g. If a person is experiencing dissatisfaction with either a service or system this should automatically generate a prompt to the internal complaints system and once this is exhausted or rejected for whatever reason is escalated to the independent mechanism;
- h. It is important to ensure any complaints handling process is easily accessible to both complainants and respondents – i.e. it must be available in a simple-to-use format, in a number of forms, and not overly bureaucratic. For people with disability, this can be particularly challenging to ensure. Flexibility as to form is required – there should be no requirement that a complaint from a person with impaired capacity be in a prescribed form or meet certain requirements to be actioned;
- i. The onus must be on the service provider to investigate informal complaints as well. This will obviously require the introduction of safeguards to ensure that complaints are reported and actioned appropriately;
- j. An important component in accessibility for people with impaired capacity is ensuring that they have the support – this includes support to feel empowered to make the complaint, support to provide adequate detail to enable the complaint to be investigated, support to respond to any questions regarding the complaint. To this end, it is integral that their support people are proactively involved from the earliest opportunity;
- k. Further, it is important that proactive mechanisms are put in place to ensure that, to the greatest extent possible, potential problems are detected. It is inappropriate to place the full onus of understanding, identifying, communicating and pursuing a complaint on a person with impaired capacity. In many instances, there are indicators of a problem that are apparent to relevant observers. Protocols must be put in place to aid the identification and reporting of any indications of sub-optimal service delivery;
- l. It is important to ensure that the system does not rest on assumptions such as that complainants will have access to and the ability to effectively use the internet, the telephone, etc., both as a means of accessing information relevant to making a complaint and to communicate the complaint;

- m. It is important to consider the power imbalance that can exist between a person with impaired capacity and a service provider. People with impaired capacity are often in a very vulnerable situation and may fear reprisal for making a complaint. It is essential that they feel supported to voice any complaints without concern about retribution or cessation/reduction of the service. It is important that the NDIS vision of having people with disability empowered as consumers within a disability services market translates into empowerment for people with impaired capacity to feel they have options and can therefore voice dissatisfaction with unsatisfactory service and have autonomy to exercise choice and seek change;
 - n. The investigation of the complaint should be answerable to the person with disability.
4. While QAI asserts that congregate and shared care or work arrangements (not of the individuals' own designs) should be phased out of existence, we acknowledge that for a significant number of people with disability this reality will continue for some time. Therefore, the role of community visitors must continue as a safeguard until the transition to fully inclusive lifestyle is achieved.
5. We also need to be cognisant of the terminology used. We need to recognise that the occurrence of sustained and constant abuse, whether it be physical or psychological abuse, gives important insight into how system is working (or failing). There is a need to address systemic issues where this type of abuse cycle occurs.

Conclusion

In summary, Queensland Advocacy Incorporated submits that people with disability will be best protected from abuse when supports, systems and services are less intrusive, less restrictive and more enabling. In other words, those supports and services must be discreet and be geared towards ensuring the person is 'in charge' and directs a good but ordinary life of their choosing.

Congregation

The sharing of accommodation is fraught with the issues of forced co-tenancies, lack of choice and control about one's life and where and with whom one lives, but the sharing of care is just as (if not more) problematic. Whether one resides in a 'duplex' or cluster housing, a person will be dependent upon the timing of delivery of supports and services to another or others. It is incongruent to believe that anyone can live independently while having to share care. A means of addressing the question of enabling choice and control about lifestyle and accommodation is to find solutions to the housing shortfall. One such solution could be to subsidise access to private rental at the same cost of social and/or public housing.

Advocacy

Individual and systemic advocacy that is well funded, accessible and provided at a local level will ensure that people with disability will not be unheard or alone in their struggle against abuse or neglect.

Far too many people with a disability have nobody in their lives with the exception of those paid to be there – ie, doctors, professionals and support workers who may not prioritise their interests. If people don't have a trusted person in their lives, they will need someone apart from the service system to be there for them. This is a great opportunity to expand Citizen Advocacy. The potential for such relationships to be both informal supports and enduring relationships is both a momentous advantage and a worthwhile opportunity. Citizen Advocacy programs would need expansion in every neighbourhood and advocates would need training to work within the principles of citizen advocacy.

The deinstitutionalisation of people with disability has been a perennial agenda item for QAI. We extend our efforts to promote the long term benefits to individuals, their families, neighbours, friends and local communities when all people are included in the fabric of local life. As people have moved from the harsh and often listless existence of institutional or congregate care arrangements into homes of their own, they contribute to the richness of their communities by being neighbours, employees, employers and customers. These ordinary but important roles are the most appropriate means to safeguard people who were once secluded from the rest of our society.