Violence against people with cognitive impairments
Report from the Advocacy/Guardianship program at the Office of the Public Advocate, Victoria

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EXECUTIVE SUMMARY

The Office of the Public Advocate works to promote the dignity, rights and interests of people with cognitive impairments and protect them from abuse, neglect and exploitation. People with disabilities are more likely than others to be the victims of interpersonal violence and less likely than others to receive proper assistance to deal with it and prevent its reoccurrence.

Through advocacy and guardianship, the Office of the Public Advocate is frequently involved with people with cognitive impairments who experience violence. This report is based upon a project investigating the circumstances of these OPA clients and includes exploration of the involvement of service providers before, during and after the occurrence of violence.

The project examined 86 cases, involving 66 women and 20 men. This report reveals that people of all ages with a range of cognitive impairments are subjected to physical, sexual, psychological, emotional and impairment-related violence, financial abuse and neglect.

Further, this report reveals that the response of service providers, notably from the disability and family violence sectors, is not well co-ordinated and is based on different understandings of violence and disability. The response of Victoria Police and the Justice system also requires improvement.

Few examples could be found of effective cross-sectoral collaboration that works in the interests of clients. When acts of violence are not responded to appropriately, the report shows that further violence is likely to be perpetrated against the person and it is less likely that the person will report it. On the other hand, in those cases where appropriate action was taken, clients benefited significantly.

Recommendations

1. That DHS Disability Services formally recognize and incorporate family violence, sexual assault and intimate partner violence into its range of service needs assessment tools, with the aim of providing an improved response to people with disabilities experiencing violence and greater collaboration between disability, sexual assault and family violence services.

2. That on-going professional development about family violence and sexual assault issues be prioritised for all disability services staff and management. This should involve induction, orientation and professional development that emphasises the importance of building cross-sectoral connections.

3. That a protocol be developed between family violence services, sexual assault services, and DHS Disability Services that incorporates processes for referral, information sharing, case co-ordination, professional development, secondary consultation, data collection, and monitoring of its implementation.

4. That OPA staff members receive education about the range of family violence and sexual assault service options available for people with cognitive impairments, and seek to build connections with these agencies.

5. That capital funding be provided to family violence services for the development of accommodation that suits the needs of people in all family violence contexts, to account for the range of “family members” now formally recognised within the Family Violence Protection Act.
(2008). Accommodation should be universally accessible and employ a model that offers safety and security to people experiencing violence in a range of circumstances.

6. That the state government allocate additional funds to enhance family violence services for people with disabilities who require additional support such as personal assistance.

7. That family violence support workers receive on-going professional development to increase their capacity and skills for helping people in the range of circumstances now covered under family violence and sexual offences legislation.

8. That research be conducted into the extent and prevalence of violence against people with cognitive impairment and older people, and their specific service needs.

9. That Victoria Police members receive education about the particular issues facing people with disabilities who experience violence when they seek justice through the Criminal Justice system.

10. That eligibility for court-ordered behaviour change counselling for perpetrators of family violence be extended beyond domestic partners to other family members.

11. That the court-ordered behaviour change counselling program be available through Magistrates’ Courts across Victoria.
1.0 INTRODUCTION

People with disabilities have a broad range of life experiences— they can experience the full range of relationships from social to intimate, they live in families, independently, use facility-based and home-based support services, work, undertake education and participate in the community. They experience and share gender and cultural issues as well as identifying specific kinds of experiences relating to the interaction between their embodied disability or impairment and the way this impacts in a society that responds less favourably to disability than the non-disabled norm. Therefore, people with a disability can experience family violence, domestic violence, gender specific violence and abuse, elder abuse, hate crimes, and child abuse, as well as kinds of violence and abuse that are specific to living with a disability and using supports and services, such as institutionalised abuse and carer abuse (Frawley and Ballantyne-Brodie 2009, 4).

The Office of the Public Advocate (OPA) represents people with cognitive impairments such as intellectual disability, psychiatric disability and mental illness, acquired brain injury, and dementia. OPA’s mission is to promote the rights and interests of people with a disability and work to eliminate exploitation, abuse and neglect. This mission is met through work conducted in a range of areas including systemic advocacy and research, a community information service, three volunteer programs, and the Advocacy/Guardianship program.

The project informing this report was undertaken in response to broad interest from the Public Advocate and OPA staff in promoting awareness about the violence to which some people with a disability are subjected. This interest stems both from OPA’s mandate, which leads OPA staff to regularly work with people experiencing violence and abuse, and two recent research projects undertaken at OPA. In late 2008 the practice knowledge and experience of OPA staff about violence against people with disabilities was used to inform an internal framework for further policy advocacy, research, education and training at OPA on these issues (Frawley and Ballantyne-Brodie 2009). Around the same time, research for a minor thesis was undertaken within the OPA Advocacy/Guardianship program, on the topic of the effectiveness of guardianship for women with cognitive impairments experiencing intimate partner violence (Dillon 2009).

The initial purpose of the project was to compile a collection of case summaries about people involved with the Advocacy/Guardianship program who were subjected to violence, to be used for further OPA advocacy. In addition, an analysis of this information would be used internally, and as the basis for a presentation at a forum on violence and disability. This report has been written as a consequence of the interest of forum participants in having greater access to data on violence and disability. It is based on the same material compiled for internal use, and has been de-identified for the anonymity of represented persons and to comply with privacy requirements.

The aim of this report is to further knowledge about the circumstances of people with cognitive impairments experiencing violence, including the involvement of service providers before, during and after violence occurs. By providing case examples of the violence to which our clients have been exposed, the report aims to highlight:

- that people of all ages with various cognitive impairments are subjected to physical, sexual, psychological, emotional and impairment-related violence, financial abuse and neglect.
- the good and poor practice of service providers in responding to and supporting a person with a cognitive impairment who has been subjected to violence, and the potential ramifications of inaction.
2.0 LITERATURE REVIEW

2.1 Defining violence

The experience of interpersonal violence is labelled in a range of ways. “Family/domestic violence” is described as

one person exercising power and control over another within the domestic setting (for example, the family home), through the use of coercion, threat and force, subsequently leading to the oppression, disadvantage, and harm of the other person (Mays 2006, 148).

Within the *Family Violence Protection Act* (2008) (Victoria) (*FVPA*), the meaning of “family violence” is defined in section 5:

(1) For the purposes of this Act, *family violence* is—

(a) behaviour by a person towards a family member of that person if that behaviour—

(i) is physically or sexually abusive; or

(ii) is emotionally or psychologically abusive; or

(iii) is economically abusive; or

(iv) is threatening; or

(v) is coercive; or

(vi) in any other way controls or dominates the family member and causes that family member to feel fear for the safety or wellbeing of that family member or another person; or

(b) behaviour by a person that causes a child to hear or witness, or otherwise be exposed to the effects of, behaviour referred to in paragraph (a). (*FVPA* s.5)

Further to this definition, sexual offences are defined in the *Crimes (Sexual Offences) Act* (2006) (Victoria). Victoria Legal Aid (2010, 6) describes “sexual assault” as

any unwanted sexual behaviour that causes humiliation, pain, fear or intimidation. It includes rape, incest, child abuse, and unwanted kissing and touching. It includes behaviour that does not involve actual touching. For example, forcing someone to watch pornography or masturbation is also sexual assault.

A range of people may be considered as perpetrators of family violence. Experienced as violent, abusive or intimidating behaviour, family violence “occurs in a family, an intimate relationship, or former partnership, including same-sex relationships” (Domestic Violence Victoria 2004, 1). In addition to relatives, partners and former partners, the *FVPA* extends the definition of “family member” to include parties “regarded as being like a family member” in regard to a number of circumstances, such as whether the parties live together in a home environment, the provision of any responsibility of care, and the provision of sustenance or support between the parties (s.8.(3)). Therefore, in some circumstances, a co-resident at a supported accommodation facility or a staff member providing support services may meet the *FVPA* definition of family member.

“Intimate partner violence” (IPV) refers to

violence occurring between people who are, or were formerly, in an intimate relationship. Intimate partner violence can occur on a continuum of economic, psychological and emotional abuse, through to physical and sexual violence (Vichealth 2004, 5).

“Elder abuse” is often used to describe violence against and abuse of older people, however, there are concerns that this terminology can mask what is in fact family violence or intimate partner violence experienced by an older person. British organisation Women’s Aid (n.d, 4) note that different categories of intimate partner violence against older people have been identified: “domestic violence grown old,” where domestic violence starts early in life and persists into old age; “late-onset domestic violence,” where there may have been a long-term strained relationship that came to include physical violence as the partners aged; and entering into a relationship later in
life where the new partner is abusive. However, understanding family violence against older people should not be limited to experiences of intimate partner violence but should also include violence against older people perpetrated by adult children or grandchildren (indeed any relative) as well as by paid carers in domestic settings.

Consideration of power is critical when thinking about abusive relationships. For a range of reasons the balance of power can be weighted even more heavily against victims when they have a disability. This can occur because, in addition to having a range of strengths and abilities, a person with a disability may require practical assistance from others that relates to his or her impairment. For example, this may include physical help with showering, eating and shopping, mobility and transport; planning and remembering tasks such as medication administration, or assistance with finances. This reliance on another person for assistance can create a power imbalance in the relationship.

Analysis of both the act of violence and the social context in which it occurs is vital for understanding the difference and commonality of experience of women and men facing this problem, and ultimately will lead to solutions that assist many more people. Feminist scholars have sought to expose the gendered nature of abuse and argue that social norms supporting gender inequality and particularly cultural representations of male domination, such as patriarchal families, create the conditions for this widespread and devastating problem (Dobash and Dobash 1979; Chenoweth 1993; Westlund 1999). This feminist socio-political explanation of family violence provided a basis for later studies that explore how immigrant women, indigenous women and women with disabilities may be even more vulnerable to abuse, because they experience power inequity through multiple circumstances. Some argue that for women with disabilities this vulnerability is compounded by their marginalization within both disability and feminist movements (Nixon 2009, 86; Mays 2006, 50). For a sound policy response to be developed, it is critical to acknowledge that age, ability, race and sexuality are neither pre-conditions for, nor grounds for exclusion from, experiencing violence (Domestic Violence Victoria 2004, 5).

2.2 Prevalence

There are significant difficulties in conducting research in relation to violence against people with disabilities, because of the sensitive nature of the topic and the vulnerability of the subjects. Like all people who have experienced violence and abuse, people with disabilities may feel shame in reporting, and may fear that if abuse is made known to outside parties there will be violent repercussions and other consequences, such as family breakdown. There may also be other obstacles to reporting experienced by people with disabilities, such as a fear that support services will cease, and reliance on abusers for transport or communication assistance that impedes access to support services and police (Carlson 1997; Sobsey and Doe 1991; Martin et al. 2006, 824). In addition, non-disclosure may be attributable to a lack of awareness or education about what constitutes abuse or violence, one outcome of which may be an absence of appropriate language to describe what has occurred (Jennings 2003, 13; Carlson 1997). The failure of disability support agencies to collect data on violence, and the failure of family violence support agencies to collect data on disability, has further limited the potential for understanding the issues around violence against people with disabilities and its prevalence (Healey et el, 2008; Radford et al. 2006, 244).

Despite the challenges in determining prevalence, researchers in Australia and internationally believe there is sufficient evidence to indicate that people with disabilities are more likely to be vulnerable to abuse than their non-disabled peers (Jennings 2003; Brownridge 1999; Gilson et al. 2001). People with disabilities are more likely than people without disabilities to experience abuse by attendants and health service providers (Nosek, Young and Rintala 1995; Sobsey and Doe 1991). Howe (1999,16) provides an important caution that in focusing on vulnerability of women with disabilities, at times the literature is unclear in making distinctions about “the personal characteristics of the victims of abuse and the perpetrators’ perception of increased vulnerability.”
Children and women with developmental disabilities are at particularly high risk of sexual abuse (Carlson 1997). The majority of perpetrators of violence against people with disabilities are male (Sobsey and Doe 1991) and in the overwhelming majority of cases, the perpetrator is known to the victim (Brownridge 2006). Findings in several studies indicate intimate partners are the primary perpetrators of physical and sexual abuse against women with disabilities who live outside of institutional settings (Curry, Powers and Oschwald 2003, 126; Cockram 2003; Brownridge 2006; Martin et al. 2006). Women with Disabilities Australia (2008) report that women with disabilities tend to be subject to violence for longer periods of time, because they “have considerably fewer pathways to safety.” In addition to people with disabilities being more likely to experience violence and abuse, several researchers note that violence may be the cause of cognitive, physical and sensory impairments, and mental illness (Gilson et al. 2001; Jennings 2003; Cockram 2003; Radford et al, 2006; Banks 2007; Healey et al. 2008; Gutman et al. 2004).

2.3 Service sectors

In Victoria, the community services sectors continue to be organised as separate systems (often described as ‘silos’), so that there are distinct sectors for the provision of disability, aged care, mental health, family violence and sexual assault services. In the context of individuals requiring support from specialists across a range of service areas— for example, support for both disability needs and issues relating to violence— there continue to be challenges in moving beyond the individual sector approach to service provision (Healey et al 2008).

The family violence and disability support sectors are known to be based on different theoretical frameworks and this underpins the different understandings of the experience of violence. Radford et al. (2006, 239) explain

Disability agencies described emotional abuse and controlling care as ‘neglect’ rather than through the power and control framework of domestic violence discourse, illustrating a tension between the welfarism of disability agencies and the protection and justice, human rights perspective of the domestic violence discourse.

While these fundamental differences can frustrate practical collaboration, they also create the circumstances for lexical differences which hinder the capturing of accurate data about violence. Frawley and Ballantyne-Brodie (2009, 4) argue that in relation to people with disabilities

Terms such as maltreatment, neglect, victimisation, bullying, abuse, sexual assault, exploitation and, if people are in a service context, being the victims of ‘incidents,’ are all used to describe experiences that are or can be termed as violence.

For example, the DHS Disability Services Division Residential services practice manual (2009, part 1.2-2) refers to “actions of concern” and “harm to people being supported,” but neither in describing what these may entail nor in any part of the document does the manual explicitly refer to violence or abuse perpetrated against residents. In contrast, “occupational violence” (part 3.4) is used numerous times throughout the manual in reference to violence perpetrated by residents against staff. By failing to use the same accurate language in reference to residents, these language choices overtly diminish rather than promote residents’ rights, and signify the privileging of the rights and safety of staff rather than those of the people for whom the residential service is provided.

Many researchers argue for a model of intervention that takes adequate account of the range of disadvantages experienced by women with disabilities so that barriers to service provision are minimized (Healey et al 2008; Chang et al. 2003; Zwieg, Schlichter and Burt 2002; Copel 2006; VWDN 2007). Partnerships and collaboration have been found to be extremely important in helping to provide an appropriate service to women with disabilities experiencing violence. Reporting on a Victorian-government funded project which aimed to improve outcomes for women with mental illness who have experienced sexual assault and/or family violence,
Fernbacher (2006, 11) reports that “participants in the Partnerships Project unanimously agreed on the value of collaboration and partnerships between mental health, sexual assault, and family violence services.” Similarly, in their report on the status of Victorian policy and practice in responding to violence against women with disabilities, Healey et al. (2008, 13) found that “there is strong evidence for encouraging the family violence services to obtain specialist advice, secondary consultation, and education from existing disability and family violence advocacy and peak body services.”

While these reports argue that service collaboration is the goal, other research indicates that in practice, this occurs infrequently at best. Reporting on the barriers to assistance for older people experiencing violence, McDermott (1993, 8, cited in Tually et al. 2008, 22) states

Our enquiries told us that there was very little communication between the professionals and advocates concerned with domestic violence and those concerned with aged care. As a result, the services for women escaping domestic violence are probably seen as irrelevant or inaccessible by many older women.

In a study about sexual assault of adults with disability, Murray and Powell (2008, 10) report that

Anecdotally, sexual assault specialist services report large variation in the number of referrals made from disability services and residential facilities, with some services seemingly very aware of the importance of offering support to victims while other services appear to retain a culture of responding internally.

Consultations in rural and metropolitan Victoria led Healey et al. (2008, 66) to report that

family violence workers interviewed had minimal or no links with disability services or disability advocacy organisations and vice versa. As one put it, “the disability services don’t crop up in the networks.” [emphasis in original]

Finally, in a study into the effectiveness of guardianship for women with cognitive impairments experiencing abuse, the author of the current report found that “the extent to which achieving positive outcomes [for the women] was possible was largely determined by the service system’s ability or willingness to offer support” (Dillon 2009, 45). These examples suggest that despite research recommendations and existing policies, to date there is limited evidence of a consistent practice of collaboration between the specialist services who may support people with cognitive impairments experiencing violence, such as disability, mental health, aged care, family violence and sexual assault services.

This literature review reveals that violence against people with disabilities is a significant problem with considerable consequences. A paucity of quantitative data within Australia has been linked to the disconnected service systems, which still identify as providing services either to people experiencing violence or people with disabilities. The absence of service connections has also been found to hinder or prevent the provision of adequate support to meet the range of needs of people with disabilities experiencing violence.

3.0 METHODOLOGY

In mid-December 2009, the author of this report sent an email to all OPA Advocate/Guardians to invite participation in the project. It was explained that the project involved compiling a collection of cases to be used as a basis for future policy advocacy work. The Advocate/Guardians were asked to consider what advocacy, guardianship and investigation matters they had been allocated
in which the (proposed) represented person was the victim of some form of violence. The Advocate/Guardians who volunteered to participate then met with the writer to discuss the relevant cases. Following this, a summary for each case discussed was written. The summaries were sent to the Advocate/Guardians to check content for accuracy, and once returned the requested changes were made.

An internal working group comprising the author, the OPA Policy and Education Manager, Legal Officer, and five Advocate/Guardians met monthly to discuss the direction of the project. Input was also received from the Victorian Women with Disabilities Network (VWDN), as a presentation of the details of the project was given at a forum co-hosted by OPA and VWDN.

The period of collecting cases was approximately two weeks, with most participant meetings occurring between 4–15 January 2010 and two meetings occurring outside this time. Fourteen Advocate/Guardians participated, contributing 86 cases in total. Participants’ employment at OPA ranged from ten years to six months. The number of cases provided by an individual participant ranged from one to sixteen cases. Participants’ length of tenure was not proportionate with the number of cases contributed, as participants self-selected the cases they discussed. Some participants referred to case lists to prompt their memory about cases, some used their memories only. Some took a sample from across their entire historical caseload, others selected a year of cases on which to draw their sample, and others provided information about only one or two cases which they felt best highlighted the issues and challenges inherent in working with a person with a cognitive impairment who has experienced violence.

Initially cases were relayed to the researcher by memory. The participants were asked to check certain details against the case notes, and the author also verified some details against electronic case notes. In addition, each case summary has been checked for accuracy several times by participants. Through these measures attempts have been made to ensure the accuracy of information used.

The information obtained was analysed using quantitative and qualitative methods. Quantitative analysis focused particularly on frequencies, with information recorded about: the represented person’s gender; age group; ethnic background; disabilities and diagnoses; whether family members had disabilities; what form(s) of violence were reported to have been experienced; the perpetrator(s) of violence; the scene(s) of abuse; the represented person’s accommodation when abused; what services were involved; whether there had been any police involvement in the case; and whether intervention orders had been made. The information obtained has been de-identified in order to observe ethical and privacy considerations.

Qualitative information in relation to issues or factors that repeatedly emerged in cases was also recorded. This included information relating to demography, relationships, service issues, and further details about forms of abuse experienced.

### 3.1 Project limitations

The project is exploratory in nature and was undertaken in 12 weeks. This timeframe limited the potential for a more comprehensive data collection method to be used, such as a case audit. However, the number of cases collected using the chosen method far exceeded the expectations held by the project supervisor. This can be viewed as an indicator of the prevalence of the problem within the matters brought to OPA’s attention, and the willingness of the Advocate/Guardians to help promote awareness about this issue. The cases were self-selected by the Advocate/Guardian participants. No definition of violence was provided, therefore, the cases studied reflect the views of individual Advocate/Guardians about what constitutes violence.

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2 Potential participants were advised that economic abuse would not be an area of focus for the research, because other research has recently been conducted in this area (eg. Loddon Campaspe Community Legal Centre, 2008). However, in the context of people being subject to abuse in multiple forms, some data about economic abuse was collected.
4.0 RESULTS

Power

To illustrate the nature of the power imbalance which is present in all violent relationships, a sample of the cases studied is provided below. Some examples reflect abusive relationship dynamics experienced by people with and without disabilities. However, most of these examples highlight the specific issues about violence against people with disabilities raised in the literature, including: reliance on perpetrators as paid or unpaid carers; reliance on service providers as intermediaries to receiving police assistance; and denigration of the person because they have a disability. Further examples of this power imbalance can be found in the case examples used throughout this report.

- An indigenous woman was not believed by her case manager when she disclosed that her partner was abusive towards her. The perpetrator always presented with a caring persona and was able to say “the right things” to the right people. In this way he was using the woman’s disability against her, as it was her disability that enabled him to be a carer. By being able to present himself in a credible way to people in a position of influence, the perpetrator became even more powerful in the relationship. His story was viewed as more plausible than hers, and this undermined her ability to exert influence on the relationship.

- An elderly woman was socially isolated from her family and friends by her second husband. He was very controlling of her and emotionally abusive. The attempts of service providers to reconnect the woman with her children were intercepted and prevented by her husband, and the woman continued to be alienated from her children until her care needs were so great that she was moved into an aged care facility, where her family and friends were able to visit her.

- A young woman was pressured by her perpetrators to retract a police statement which outlined substantial sexual abuse. The police then charged her with making a false report. One of these perpetrators had previously been imprisoned in relation to sex acts against the young woman. In this context it is concerning that there was not more investigation by police or sensitivity to the potential reason behind the withdrawal of the statement.

- An elderly woman was neglected, physically abused, and financially exploited by her daughter. Her daughter left her on the floor after a fall, withheld medications, and failed to feed her. The elderly woman agreed she was the victim of violence but as she wanted to stay out of residential care and her daughter was the only person who could assist her to remain living in the community, she was prepared to experience abuse and risk losing all of her money.

- An older woman reported she was sexually exploited by the bus driver at her adult day service. After the abuse her behaviour changed and became more challenging for day service staff to manage. The day service manager had a personal connection with the bus driver and did not believe the woman’s report. The change in behaviours was the reason given for the woman being asked to leave the day service.

Fourteen guardians provided information about 86 cases in which the represented person had been subjected to violence. The data has been collected on the basis of allegations rather than substantiation of abuse, as one purpose in undertaking this research is to highlight the difficulties in substantiating abuse against people with disabilities. The Advocate/Guardian participants were not given prompts about potential abuse categories, so it is possible that even within the cases discussed the extent of abuse has been underreported. The absence within this report of qualifiers such as ‘allegedly’ and ‘reportedly’ is a conscious decision made with readability in mind.

The results are presented in three parts. A brief description of the scope of circumstances within the cases studied will be followed by a more detailed analysis of specific categories of violence.
including sexual violence, carer violence, and intimate partner violence. The third part is an analysis of the involvement of specific service sectors, namely disability services, family violence services, and the police. While other sectors (such as mental health and aged care) were mentioned in the cases studied, a detailed analysis of these sectors has not been possible within the current report. Further investigation into how these sectors respond to violence is needed.

4.1 Scope of circumstances

The 86 cases studied related to represented persons aged 16–100+. Consistent with most research into family violence, within this study, the number of cases about women (n=66) greatly exceeds cases about men (n=20). A broad range of cognitive impairment categories are represented within the cases studied. Intellectual disability was the most common primary diagnosis (n=41), including nine cases in which the represented person also had a mental illness. In some cases it was noted that violence resulted in disability or additional impairments, for example, traumatic brain injury and mental illness.

The represented persons were reported to be subjected to a range of violent and abusive acts, including physical and sexual violence, emotional and psychological abuse (including seclusion and isolation), impairment-related abuse (acts of violence specifically related to the experience of impairment), financial abuse and neglect. Fifty of the 86 represented persons were reported to experience more than one form of abuse. Fifty-two of the 86 represented persons were reported to have experienced physical violence. This was the predominant form of violence experienced by men (reported in 18/20 cases) and women (reported in 34/66 cases), with a similarly high reported rate of sexual violence for women (reported in 30/66 cases).

Perpetrator categories included parent/parent’s partner; sibling; adult child; other relative; partner; neighbour; staff; co-resident; and stranger. Overall, there were 64 cases in which perpetrators were categorised as relatives and partners, meaning their actions may be classified as family/domestic violence within the definitions of the FVPA (s.8). As it has not been possible to consider for individual cases the relationship between parties in its entirety (FVPA s.8(4)), within this report the cases studied involving violence by co-residents (n=4) or staff members (n=9) have not been counted as cases which may be classified as family violence under the FVPA.

In ten cases impairment-related abuse was reported. Examples of this included: restraining the represented person in order to administer non-prescribed medications; failure to provide medication or to support the represented person when illness ensued; keeping mobility aids out of reach; and exploiting the represented person in order to access his or her service support. Impairment-related abuse was fairly evenly represented across all age groups among people with a range of impairments that limited physical functioning.

One unexpected sub-category to emerge was violence in the context of war, which was reported in relation to three represented women. In two cases this experience was thought to be a factor relating to their subsequent impairment. In one of these cases, the represented person was also subjected to violence outside of the wartime experience, after arriving in Australia.

**Violence in the context of war**

“Tina” is woman who is a refugee from an African nation, a survivor of war, who was tortured and raped in that context. She has been diagnosed with a mental illness. The violence was not the primary issue for guardianship, but the guardian noted that it had a big impact on how she was diagnosed and how Tina came to have a guardian.

Mental health services became involved with Tina when she was found wandering the street. Because her daughters remained overseas, Tina was saving all her money to send to them, neglecting her own needs while doing so. She was made an inpatient and was discharged on a Community Treatment Order. The guardian made a referral to a community service organisation that could
provide case management support for social issues. Tina was supported to find share accommodation so that she could save more money, and the guardian provided advocacy for her citizenship application. An administrator also assisted with her financial and travel concerns. The guardian believes the intersection between post traumatic stress disorder and mental illness is a complex area. To this end the guardian advocated for the mental health team to consult with Foundation House, to increase their understanding of Tina’s situation so that her wartime experience was not merely pathologized, but considered in the context of post-traumatic stress.

**Impairment related abuse**

“Tracey” is a woman in her 70s who suffered a major stroke and now requires full assistance with her activities of daily living. At the time of the guardianship application she was being supported to live at home with services and case management through an aged care package, but the agency raised concerns about her husband’s ability to care for her. Tracey’s husband would leave her at home in her bed for hours, with her mobility aid out of reach. He started seeing another woman and would have sex with her while Tracey was in the house, unable to move to another room without his assistance. The husband also perpetrated physical violence against Tracey. Although Tracey acknowledged that the violence occurred, her expressed wish was to remain at home.

The care agency were reluctant to provide care and thought Tracey should move to residential aged care, however, the guardian encouraged them to continue to support Tracey at home. The care agency always sent two carers to the house at once because they felt ill at ease around the husband, resulting in Tracey receiving only half as many hours of care as the funding would usually provide. This reduction in hours only made Tracey more reliant on her violent partner.

The husband was claiming a carer’s benefit and the guardian believes this was the major motivator for him wanting Tracey to remain at home. In addition, he believed he would no longer be eligible for public housing if his wife relocated. After some time trying to improve the home environment and support Tracey’s wish to remain at home, the guardian ultimately decided that Tracey needed to move to an aged care facility.

**Sexual exploitation**

“Wanda” is a young woman who is deaf and has a mental illness. She seemed to be targeted in her community as someone who can be exploited; word went around that she was an easy target and men would come to her door asking for sex. Wanda had a case manager from a community service organisation who put some protections in place for her, including safety plans and making agreements with some neighbours about how to support Wanda if she came to their door. The exploitation was not the primary issue of the guardianship application. The guardian advocated for community mental health involvement, and asked a general practitioner to make a referral for this.

### 4.2 Forms of violence

**4.2.1. Sexual violence**

- Sexual violence was reported in relation to 32/86 represented persons. Two of these 32 represented persons were men (each of whom had dual disabilities), 30/32 were women.
- Of the 30 women, 22 had an intellectual disability; of these, four were also reported to have a mental illness.
- Some women experienced abuse by perpetrators in more than one category, some were assaulted by more than one perpetrator within the category (ie. numerous strangers, several relatives). To this end, while there are 30 cases involving sexual assault of women, there are 40 recorded perpetrator types across these cases.
• Strangers were the most common perpetrators of sexual abuse (12 reports), followed by parents/parent’s partner (8 reports).

• Some women experienced multiple abuse events by each perpetrator recorded. For example, some women were systematically abused by family members over several years, others were exploited by numerous strangers.

• Of the ten sexual violence cases in which the police were contacted, five involved women who were reported to have been repeatedly subject to sexual violence. Of these, four women were reported to have been abused by multiple perpetrators.

Six cases involved sexual abuse while the represented person was housed in supported accommodation. In three of these cases, the scene of the abuse was the accommodation facility, and in two of these three cases the alleged perpetrator was a staff member at the facility. For the other three cases, the abuse occurred in the community. Three represented persons were reported to be exchanging sex for money. In one case the liaisons with strangers were occurring at the represented person’s shared supported accommodation service (SSA).

Police were involved in 10/32 cases involving sexual assault. One case involved police taking protective intervention by removing a woman from what was considered to be an unsafe home. The other nine involved reports of sexual assault to the police. Figure One presents the data regarding the outcomes from police involvement in these nine other cases. One of these cases involves reports to police of two separate incidents. For the first incident no charges were laid as there was insufficient evidence, in the second incident the charges were withdrawn when the perpetrator moved interstate (see Nicole’s story in section 4.3 Issues).

Jane’s story is outlined below. Even though Jane was sexually abused over many years, her father faced only one charge involving one incident of abuse against her. This charge was withdrawn (in part due to difficulties with Jane providing evidence), however, Jane’s father continues to face charges regarding the sexual abuse of others.

![Figure One: Outcomes from police involvement in sexual assault allegations.](image-url)
from having contact with her. DHS Disability Client Services is providing case management and other support to Jane. The guardian notes that the depth of difficulty in working with Jane’s situation is considerable.

At one stage Jane was housed with a female who also had a history of being sexually abused, who threatened Jane with a knife. The guardian insisted on new housing for Jane.

The guardian reports Jane’s way of relating to males (particularly older males) is primarily sexual, however, the sex is almost incidental to her—she is relationship driven and wants to please people and have friends. Jane is now prostituting herself. Jane does not understand the risks to herself in doing this; her entrenched understanding of relationships is highly dysfunctional and her mother lacks the ability to communicate useful self-protection skills to her daughter. Jane appears to have no protective instincts and a very poor understanding of risk. The issue for the guardian is how to keep Jane safe from further sexual exploitation given her ingrained attitudes and behaviours, and the increasing number of anecdotes about others within her community who have taken advantage of her sexually. She has been relocated to a new area and now has more time with one-to-one support workers, however, there is concern that the old patterns will re-emerge unless there is an opportunity for Jane to be educated about relationships in an environment where she is not exposed to risk. It is not clear that such a place exists.

4.2.2 Carer violence

Abuse by a person in a care-giving role was reported in 30 cases. These cases were identified by the author of this report rather than the participants, and were determined based on whether the perpetrator was purportedly relied upon to, or in a position to, provide care to the represented person. The details of the types of abuse inflicted by different “care-giving” perpetrators is illustrated in Figure Two.

The most common perpetrators of carer abuse were “parents/parent’s partner.” In 19 cases, violence was perpetrated against the represented person by “parents/parent’s partner,” either in childhood, in adulthood or both. In 15/19 cases, the represented person was subjected to more than one form of violence.

In nine cases sexual violence was perpetrated against the represented person by a parent and/or the parent’s partner. This occurred primarily in childhood and adolescence but for some represented women continued to be experienced into adulthood. In one case the new husband of a frail elderly woman perpetrated sexual violence against his 50 year old intellectually disabled step-daughter. In addition to parent/parent’s partner abuse, in 11/19 cases the represented person was subjected to more than one form of violence.

In nine cases sexual violence was perpetrated against the represented person by a parent and/or the parent’s partner. This occurred primarily in childhood and adolescence but for some represented women continued to be experienced into adulthood. In one case the new husband of a frail elderly woman perpetrated sexual violence against his 50 year old intellectually disabled step-daughter. In addition to parent/parent’s partner abuse, in 11/19 cases the represented person was subjected to abuse by at least one other perpetrator type, including 7/9 cases involving sexual violence.

![Figure Two: Forms of violence & abuse perpetrated by person in a care-giving role.](chart.png)
In several cases it seemed that some aspect of the parent’s personal circumstances influenced their ability to provide support to their disabled child in a way that would be thought to be consistent with current day norms in Australia. These scenarios included restraint and seclusion enacted by newly arrived Australians to subdue the destructive behaviours of their child; psychological abuse and compromising care perpetrated by a parent with longstanding poor mental health; and an elderly carer bruising, bullying, and being domineering towards her intellectually disabled daughter, whom she had raised and supported without service assistance for 70 years. These examples indicate that current efforts to educate parents about how to appropriately support a person with a disability may not be sufficiently far reaching. It also reflects the ways that ideas of parenting are embedded in cultural and generational norms.

There were five cases in which sons were perpetrators, six cases in which daughters were perpetrators and one additional case in which several children were perpetrators of violence. However, in Figure Two “daughter” is identified as a perpetrator category rather than “child” as the sons who perpetrated abuse against their mothers were not reported to be in a care-giving role. In 5/12 cases in which children were violent towards their parents, the perpetrator had a disability.

In eight cases it was reported that staff perpetrated abuse against represented persons. The details of these cases are outlined in Table One. Most of these cases involved staff in residential settings rather than community support workers, the exception being the day service bus driver. The police investigated the two sexual assault cases but did not lay charges.

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<th>Table One: Circumstances in which staff were perpetrators.</th>
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**Carer violence**

“Trevor” is a young man with an intellectual disability and mental illness, who experienced chronic homelessness. Trevor’s lifestyle frequently exposed him to acts of violence in the street. He alleged that he was sexually assaulted by a worker at a supported residential service (SRS). The police investigated this but did not prosecute, as his case was difficult to prove. The worker was stood down while the matter was investigated. The Community Visitors program was notified. The guardianship order was eventually revoked as Trevor was constantly non-compliant with the guardian’s decisions. However, OPA continued to advocate that Trevor have dual disability assessments.
Trevor’s story illustrates how OPA’s Community Visitors program can become involved in matters where abuse has occurred in a residential facility. The Community Visitors program is dedicated to working in residential facilities such as SRSs, psychiatric units and SSAs funded by DHS. As such it is likely that the Community Visitors program is best placed within OPA to identify instances of staff at residential services and psychiatric units perpetrating violence against residents/patients.

4.2.3 Intimate partner violence

Intimate partner violence (IPV) was the most prevalent theme to emerge in the cases studied. In 33 cases the represented persons were reported to be experiencing IPV at the time of OPA’s involvement, or to have a history of IPV. This included 30 women and three men. In two of the cases about men, there was reciprocal violence between the partners. In 21/33 IPV cases, multiple forms of violence were reported. In 12 cases multiple diagnoses were reported, including 8 cases of drug and alcohol addiction.

A family violence support agency was reported to be involved in only 4/33 cases relating to intimate partner violence, including one refuge. In one additional case the represented person attended counselling, in another, counselling was investigated but was not possible due to difficulties in understanding the represented person’s style of communication.

To understand the level of involvement of disability case management agencies, it is helpful to catalogue the prevalence of impairment types within the IPV cases studied. The 33 IPV cases comprised four people with mental illness, eight with dementia, and 21 cases of people aged under 65 with a primary diagnosis of intellectual disability (n=13), neurological condition (n=1), degenerative condition (n=1) and acquired brain injury (n=6). Two people with an acquired brain injury received case management from community service organisations. DHS Disability Client Services provided case management in seven IPV cases (including one in which the IPV was not current). Of these nine cases involving disability case management, two also involved a family violence support agency, however, in one of these cases this involvement was initiated by the guardian not the case manager. Similarly, in a case in which a family violence agency made the application for guardianship, a DHS case manager was engaged only after guardianship commenced.

Aged care case management was provided in three of the eight cases involving people over the age of 65 experiencing IPV (all of whom had a diagnosis of dementia). No family violence or counselling services were reported to be involved in these eight cases.

All four of the people reported both to have a mental illness and experience IPV were no longer in their violent relationships. Mental health services were provided to two of these people, and in one additional case, the mental health service discharged the represented person from its care soon after the guardianship order was made. No family violence services were involved in these four cases.

These figures indicate that within the cases studied which involved IPV, there was very little cross-sectoral collaboration occurring between disability, aged care and mental health sectors, and the family violence sector.

Intimate partner violence

“Nat” is an indigenous woman in her 40s. She has an acquired brain injury post-surgery. She is in a relationship with a non-indigenous man, who comes across as very caring and seems to say the right things. Nat’s disability case manager has not always believed her claims about the partner being violent, and the police have also believed the partner when called to the home by Nat, and did not take action to remove him from the home (leased in Nat’s name) until the guardian advocated strongly for this. The partner received a carer’s benefit but did not take Nat to medical appointments. He received rental assistance but did not contribute to the rent. Nat was largely reliant on him to buy food and for personal expenses. When he did buy food for the household, it would often be in packaging that because of her impairments, Nat was unable to open.
The guardian arranged for a family violence service to support Nat. When she told them she did not want the partner living with her, this service helped her to change the locks. Nat is still in contact with the man, but he no longer has keys to the property, and he no longer receives a carer’s benefit. The guardian believes Nat now has a sense of having more control over what occurs in her life. The family violence service workers and the disability case manager are now communicating better and working together to support Nat.

4.3 Issues: service sector, police and courts
4.3.1 Disability services
Advocate/Guardians provided information about positive and negative impressions of the services supporting represented persons. In 16 cases Advocate/Guardians commented on the involvement of agencies specifically in the context of the represented person’s experience of abuse, most often reporting concern. In some cases Advocate/Guardians commented on instances where the actions of agencies seemed to lead to the circumstances in which abuse against the represented person occurred. In other cases Advocate/Guardians commented on the way the agency responded to disclosure that abuse had occurred. In seven cases specific concerns were raised regarding the involvement of DHS Disability Services. The case studies which follow provide some examples of concern about the actions of DHS Disability Services.

Concerns about the actions of DHS Disability Services.

“Nicole” has an intellectual disability, autistic spectrum disorder and depression. For several years she has lived away from the family home, with varying levels of service support and involvement, including DHS case management. Throughout this time she has been highly vulnerable to sexual exploitation by men in the community. A guardian was appointed (OPA’s second involvement) following Nicole’s reports to police that she had been raped multiple times in the two years prior. The police investigated but did not proceed with the charges as Nicole was unable to particularise the events. However, the police advised the guardian that they believed she was being sexually abused. Later that year, Nicole reported to the police that she had again been raped. The perpetrator was apprehended, and forensic examination provided some evidence. Nicole was interviewed several times by police but had difficulty remembering times and actions. When the perpetrator moved interstate, the police, Nicole and her family decided not to proceed with charges, due to concerns about her ability to provide evidence in court, and the potential trauma she would experience if the perpetrator was not found guilty. For some years concerns have been raised by OPA, numerous medical professionals, Nicole’s family, her Centre Against Sexual Assault (CASA) counsellor, the case manager and the police that Nicole does not have sufficient skills nor protective abilities to continue to live in independent accommodation. For two years OPA has advocated to DHS Disability Accommodation Services that there is an urgent need for Nicole to access supported accommodation. She remains in independent housing. The guardian and others are now concerned that Nicole will not speak out if she again experiences sexual violence, because of the trauma experienced and the outcomes achieved when she has disclosed in the past.

“Theo” has an intellectual disability and autism. For many years he lived at an SSA staffed by DHS. The guardian reported that there appeared to be a tension between Theo and some of his support workers, and that his experience could be likened to domestic violence as Theo had a long-standing relationship with his workers, he was dependent on them for support, and they appeared to neglect their duty of care towards him. The guardian believed Theo was subject to neglect in the form of poor support practices which escalated Theo’s agitation rather than minimising it, and in turn led to him being medicated by support workers to a questionably high degree as a behaviour management practice. The abuse of power by support workers was evident in their resistance to changing work practices and adopting less restrictive approaches to supporting Theo, despite the recommendations of medical practitioners and behaviour management specialists that Theo would benefit from a
reduction in medication. Such changes would be more demanding on the support workers; the guardian believed they sought the easiest option for themselves with little consideration of Theo’s best interests.

On one occasion Theo reacted to the approach used by a worker by hitting out; charges were laid and Theo was taken to remand. Advocacy for Theo occurred at a high level across several departments. Following this, Theo was moved to a new unit and began receiving intensive one-to-one support. He has since relocated to a different unit where he remains supported but has more independence, and is reportedly flourishing there. In addition, it was recommended that the workers at his former home undergo specialist skills training about understanding behaviour management practices, among other things. These workers did not continue working with Theo.

In his new environment Theo is engaging much more with others, and seems to be a different man. He is no longer prescribed any medications.

“Danielle” has autism and an intellectual disability. Prior to OPA’s involvement, Danielle was made subject to an intervention order after assaulting her mother. At this time her mother stated she could no longer cope with Danielle’s behaviours. Danielle went to live at an SRS, the best of two SRS options identified by DHS case management. This placement broke down after Danielle was threatened by a resident, and Danielle was moved to the other SRS, which the case manager had previously deemed unsuitable for her. At this SRS Danielle was sexually assaulted by another resident. She disclosed this to her mother a week after the incidents occurred, during which time her mother noticed her heightened distress. The SRS management did not believe the allegations. DHS case management did not provide an immediate response in relation to Danielle’s lack of safety at the SRS, and two days after allegations were made, rather than having the alleged perpetrator removed, Danielle was relocated to emergency accommodation. The case management team leader then advised that for two weeks Danielle would need to return to live with her mother, as there was nowhere else for her to go. After one night with Danielle home, her mother told the team leader that she did not believe the arrangement would work. Subsequently the team leader reportedly told Danielle that if she misbehaved, either the police would be called or she would be sent back to the SRS where the sexual assaults occurred.

Danielle was at home for more than two weeks. Her mother was advised that she herself would need to seek alternate accommodation for Danielle, as case management did not see this as their role. At home with her family Danielle continued to have nightmares, and her behaviours became increasingly violent and difficult for her mother to manage. OPA’s involvement included advocacy to the police around the follow up to the sexual assault, and to DHS on the issues around accommodation and the inappropriate comments of the case management team leader. Following this advocacy, after several months when the risk of Danielle perpetrating family violence was escalating, DHS found alternate supported accommodation for Danielle, who now enjoys a much better relationship with her mother.

Overall, the cases studied indicate that disability services need a deeper understanding about violence so that better outcomes are achieved for people with disabilities experiencing violence. Areas identified where improvement is needed include:

- Responding appropriately to a client who discloses that abuse has occurred.
- Reporting in a timely manner to police when a client appears to have been subjected to violence.
- Ensuring appropriate referrals are made so that the victim and others affected are supported emotionally and psychologically in the aftermath of violence.
- Considering the other impacts the violence will have on the person with a disability.
  - Is the client or resident being supported by an appropriately trained counsellor?
Can the client’s needs continue to be met in current accommodation, or is support needed to obtain more appropriate housing?

Could behavioural or health concerns be connected to the experience of abuse?

In addition to these points, within both the cases studied and other research, concerns have been raised about the following points, which I will address in turn: disability services’ responses to disclosures; actions about risk factors; and detection of violence.

4.3.1.1 Responses to disclosures

There are reports within the cases studied of people with disabilities disclosing abuse and not receiving an appropriate response regarding the criminal, social and emotional aspects of the disclosure. Murray and Powell (2008, 10) identify that while across Australia state governments have developed policies in the disability service sector for how to respond to the sexual assault of service users, “in practice, disability service providers are left with considerable discretion in defining whether an alleged incident is serious enough to constitute sexual assault and therefore warrant a police report being made.” They note that similar discretion is possible in relation to whether victims are referred to an appropriate sexual assault support agency (Murray and Powell 2008, 9). In relation to the social and emotional aspects of the disclosures, the cases studied demonstrate the further need for training within the disability sector. The need for this to occur is also identified within the Victorian family violence reforms as an important component of strengthening the integrated family violence system (Office of Women’s Policy 2009; 2010).

4.3.1.2 Detection of violent incidents

In a number of cases, disability service staff raised concerns about possible violence following identification of a client’s injuries. In several cases in which no injuries were identified and the abuse was not disclosed for some time, it was reported that the behaviour of the represented person had changed, becoming more challenging for services to support. These cases illustrate that these behaviours that challenge may sometimes be a response to– and therefore an indicator of– the perpetration of violence, whether they are displayed immediately in a retaliatory way or used as an expression of anger, discomfort or fear following earlier abuse that has not been disclosed or addressed. In this context the use of restrictive interventions (including physical, chemical and social3 restraint, and seclusion) may appear to be further punishment for a victim, echoing forms of violence used by perpetrators, and recalling in the victim’s mind the sense of denigration and devaluation imposed by the perpetrator. In the context of restrictive interventions the need for mindfulness about trauma due to abuse has been recognised internationally in the behaviour management field (for example, the Office of Mental Retardation, Pennsylvania, 2006). For these reasons, it is important that behaviour management specialists, such as those with DHS Behaviour Intervention Support Teams and Family Intervention Support Services, and the Office of the Senior Practitioner, are aware both of indicators of family violence and that behaviours observed may be a response to experiences of violence.

4.3.1.3 Acting on risk factors

Within the cases studied it was evident that for some represented persons, risk factors for experiencing further violence had been identified and were not acted upon. There were several examples within the cases studied of DHS Disability Services clients who remain in inappropriate housing, and as a result, experience further violence and/or continue to exhibit behaviours of concern. The provision of appropriate housing and support services to people in these circumstances should be prioritised– they are living with the threat of a raft of potential negative consequences from violence, in addition to the threat of experiencing future violence.

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3 In an article commissioned by the Office of the Senior Practitioner, McVilly (2008,2) defines social restraint as “the use of verbal interactions (which might reasonably be construed by the person to whom they are directed as intimidating or potentially abusive) and/or threats of social or other tangible sanctions (e.g., response cost programmes), which rely on eliciting fear to moderate a person’s behaviour.”
Disability services must develop a greater understanding about the connections between experiencing social isolation and violence. Social isolation is both a risk factor for and a consequence of violence. In several cases, guardians sought the involvement of social programs or new environments where social interactions without violence (and other improvements to quality of life) could be experienced. This was successful primarily in relation to older people through services provided in the aged care system. Despite advocacy for this outcome in several cases involving younger people, this was realised far less often. In the few examples in which it did occur, a reduction in the behaviours of concern displayed was seen as an indication that the person experienced a greater quality of life.

Disability services can play an important role in creating opportunities for people with cognitive impairments to be more involved with their community and consequently to be more empowered. There is potential for substantial improvement in safety for a person with a cognitive impairment experiencing violence if they are given the opportunity to connect to the community. Disability services, including DHS Intake and Response Service, and the DHS Outreach Service, offer programs that could be utilised to provide these opportunities. Employees of these and other disability services should be made aware of the cumulative benefits that can be derived from such programs for people experiencing or at risk of experiencing violence, and policies adapted so that resources are allocated with these benefits in mind.

Intimate partner violence and family violence should be formally recognised and incorporated into the range of DHS Disability Services’ service needs assessment tools, so that in future there are fewer hurdles both for people with disabilities experiencing violence to access resources that can increase their safety, and for family violence services to collaborate with services in the disability sector. With increased access to resources, women with disabilities experiencing violence will be far better able to remain safe in their homes without relying on perpetrators of violence who also have a caring role.

As people with disabilities are at greater risk of experiencing violence than their non-disabled peers, professional development about family violence and sexual assault issues must be prioritised for disability service providers from both the community sector and DHS Disability Services. The cases studied indicate that better education in this area is required for disability service staff in areas including accommodation, case management, behaviour management and outreach services as well as day services. Disability services staff should be encouraged to make connections with local agencies who provide advice and support about family violence and sexual assault. Even when a disability case manager has a reasonable understanding of violence issues, the involvement of another agency can strengthen the support network available to the person experiencing violence. This collaborative approach has been found to be most effective in bringing about positive change for people with disabilities experiencing violence, particularly in relation to intimate partner violence (Healey et al 2008; Fernbacher 2006; Dillon 2009). A protocol between family violence and sexual assault services and DHS Disability Services would provide the foundation for meaningful cross-sectoral developments.

Social isolation

“Nick” is a young man with a mild intellectual disability. He lives with his mother who has a mental illness. Their windows are boarded up, the home is littered with unusual objects, and Nick seems underfed and pale. Nick’s mother inflicts psychological abuse, constantly putting him down, forbidding him to do things, telling him he is not capable of doing things, and attributing this to his disability. Consequently Nick is extremely lacking in confidence, and is socially isolated. The guardian advocated for the allocation of a DHS case manager, however, the case manager appointed was extremely ineffective at supporting Nick to see there was a different way of living. With encouragement from the guardian this changed and the case manager started to assist him to improve his confidence. He was encouraged to spend time with other supportive family members. In time he
started saying he wanted to leave the local area, and the case manager was asked to support him to pursue these options.

*  

“Carolyn” is a young woman with an intellectual disability in a de facto relationship. The couple lived in a regional area and had several children together. Carolyn’s partner would spend days away from the home, during which time Carolyn would often be isolated, being left with no means of transport from the home. She experienced physical, verbal and financial abuse. Her partner used illegal drugs and he often used all their money, which he controlled, solely on drugs so that they did not always have enough money for food. The couple had some service support in respect of parenting issues, and the support workers raised the concerns about the domestic violence. Carolyn fluctuated in her wishes about remaining with him or leaving him.

OPA recommended an independent guardian and administrator be appointed. Once Carolyn’s finances were protected by the administrator, the partner would take longer absences from the home. The guardian believed he lost interest when he no longer controlled Carolyn’s money. The guardian increased services in the home in an effort to build Carolyn’s skills, and to improve her confidence with cooking and home management so that she would see she was capable. During her partner’s absences she would see that she could manage without him. Carolyn’s family were encouraged to be more supportive, and in time Carolyn moved in with a female relative.

**Recommendations**

That DHS Disability Services formally recognize and incorporate family violence and intimate partner violence into its range of service needs assessment tools, with the aim of providing an improved response to people with disabilities experiencing violence and greater collaboration between disability and family violence services.

That on-going professional development about family violence issues be prioritised for all disability service staff and management. This professional development should emphasise the importance of building cross-sectoral connections.

That a protocol be developed between family violence services, sexual assault services, and DHS Disability Services that incorporates processes for referral, information sharing, case co-ordination, professional development, secondary consultation, data collection, and monitoring of its implementation.

4.3.2 Family violence services

The cases in this study revealed a very low rate of involvement of family violence services (4/64 family violence cases, including three outreach services and one refuge). In each of these four cases, the represented person experienced IPV rather than any other form of family violence. One reason for the low rate of involvement may be that the people subjected to violence do not perceive what is happening to them as family violence, or if they do, they may not seek assistance in relation to their experience. However, in most cases services of some description were involved and it may have been possible for referrals or secondary consultation to occur.

It is unclear why guardians and service providers involved with people experiencing family violence did not seek to engage counselling and family violence services more often. One could speculate that this was in relation to the represented person’s level of impairment, and consideration of what could be achieved through engagement with such services. It could also reflect an awareness that different cultural and generational perspectives on family relationships and marriage may accommodate high levels of abuse and violence and sit uncomfortably with referral to and support from family violence services. For example, older persons experiencing violence may continue to hold the traditional view that marital problems are best kept hidden. This raises the question of whether guardians and other
professionals should take a role in encouraging people to see what they have experienced as violence. While not seeking many counselling options, as noted above, guardians did try to engage represented persons in programs and find accommodation that could increase their social options and give rise to a better quality of life.

Historically family violence support agencies were conceived as services to assist a narrow cohort of women experiencing IPV and their young children. However, over the years many Victorian services have developed a more broad interpretation of their client group, for example, recognising the family violence experience of older persons whose adult children use violence, and this is reflected in the *Code of Practice for Specialist Family Violence Services for Women and Children* (Domestic Violence Victoria 2006). In addition, the *FVPA* (s.8) now defines family violence more broadly, to include violence perpetrated by any family member, as well as people in a family-like relationship. However, despite this recognition at the policy level, Healey et al. (2008, 65) report there continues to be some discriminatory attitudes towards disability among family violence workers and services, including discretionary policies which exclude some women with disabilities from using certain services. In addition, there are insufficient supported, accessible refuges and secure, long-term post-crisis accommodation options available for women with disabilities (Healey et al. 2008, 15).

Increased capital funding is required for the development of appropriate accommodation for people experiencing violence by the range of “family members” now formally recognised within the *FVPA*. Family violence services accommodation should be universally accessible and employ a model that offers appropriate support, safety and security to people in a range of circumstances, such as the cluster model housing currently being built on a limited scale in some parts of Victoria (for example, the Eastern Region).

As a consequence of the legislative changes, there may be heightened community expectations that family violence agencies providing outreach services should be equipped to support people experiencing violence from non-partners in the domestic setting. It is unclear whether family violence agencies have the resources and capacity to provide services to this expanded group, however, research indicates that since the implementation of the *FVPA*, family violence agency workloads have greatly increased in relation to supporting the existing client group of IPV victims. For example, Healey (2009, 89) reports that the Mornington Peninsula Domestic Violence Service is funded to respond to 21 police faxback4 referrals per year, but since the change in legislation, the service received an average of 24 faxback referrals *per month*. For this service, the increase in police referrals restricts the ability to be responsive to people whose referrals do not come through police. Additional funding must be allocated to enhance family violence services for people with disabilities.

Further professional development is required for family violence support workers to build their capacity and skills for helping people in the range of circumstances now covered under the *FVPA*. As previously noted, collaboration with the disability (and other) sectors will be important if this is to be achieved. While the minimal involvement of family violence agencies in the cases studied limits the extent to which conclusions here can be made, other recent research indicates that family violence workers would benefit from training in “‘disability awareness,’ learning how to navigate access to disability support services, and building worker confidence in supporting women with disabilities” (Healey et al. 2008, 16).

Finally, investigation is required into areas such as what family violence services are offered to people with dementia, what assistance can be offered to people with disabilities experiencing abuse by carers, and what programs will assist older people being abused by their adult children.

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4 “Faxback” is the term used in the family violence sector for referrals made by police to family violence agencies responsible for providing a crisis outreach response. Services are expected to respond within 24 hours.
Recommendations

That OPA staff members receive education about the range of family violence and sexual assault service options available for people with cognitive impairments, and seek to build connections with family violence agencies.

That capital funding be provided to family violence services for the development of accommodation that suits the needs of people in all family violence contexts, to account for the range of “family members” now formally recognised within the FVPA. Accommodation should be universally accessible and employ a model that offers safety and security to people in a range of circumstances.

That the state government allocate additional funds to enhance family violence services for people with disabilities who require additional support such as personal assistance.

That family violence support workers receive on-going professional development to increase their capacity and skills for helping people in the range of circumstances now covered under family violence legislation.

That research be conducted into the extent and prevalence of violence against people with cognitive impairment and older people, and their specific service needs.

4.3.3 Police and the court system

Police involvement at some level occurred in 24/86 cases. Police were involved in a range of ways, including responding to calls about family violence; making an Intervention Order (IO) on behalf of the represented person; investigating reports of sexual assault, physical assault and fraud; charging represented persons with offences; and chemically restraining the represented person when a mental health Crisis Assessment and Treatment Team (CATT) could not. In relation to the represented persons who experienced violence and were also charged with offences, in three cases charges related to acts of violence. In addition, one represented person was charged with minor offences and lived for an extended period in a remand facility, due to not being provided with appropriate accommodation. While in some cases positive comments about police were reported, concerns were raised regarding some police responses, including:

- Not acting to remove the perpetrator from the home, despite the represented woman requesting this and the home being leased in her name;
- Not investigating allegations of assault by a staff member at a psychiatric facility because the represented person did not make a statement (OPA advocacy led to the matter being investigated, with statements made by witnesses);
- Charging a woman with making a false report after she was pressured by her perpetrators to withdraw a statement, and
- Not following-up on reports of IO breaches.

These cases include examples of police believing the perpetrator rather than the victim. This suggests that police need better education about the issues facing people with disabilities experiencing violence, the potential difficulties they may have in communicating what has happened, and the additional power issues that may be present if the perpetrator is in a caring role. Police must also be alert to the need to refer women with disabilities to family violence services through the fax-back process.

In 12 cases an IO was made, including six where police involvement was reported. In one case it was reported that an elderly woman was unable to stop her son entering her home, despite the IO that was in place to prohibit this. The guardian reported that while the police were aware the order
was being breached, as they had no evidence of this, no action could be taken. However, in another case it was reported that the police had not always followed up when IO breaches were reported. This failure to act on IO breaches was also reported in the study of long-term service users of the Mornington Peninsula Domestic Violence Service programs, which suggests this is not a problem limited to people with disabilities:

The women also experienced multiple breaches of the intervention orders, which were not necessarily prosecuted by police either for lack of evidence or a failure to act, for whatever reason (Healey 2009, 111).

These breaches occur even though the Victoria Police Code of Practice for Investigating Family Violence\(^5\) (the Police Code) outlines the likely consequences of a lack of police response:

Ignoring the breach conveys to the defendant and the aggrieved family member that the order is not taken seriously. An outcome of this could be continued abuse, further police involvement in subsequent breaches and possible harm to victims and/or their children (Victoria Police 2004, 4.6.1).

An additional consequence of this inaction may be increased fearfulness:

Women want to feel safe at home but often do not, especially when they feel that ex-partners can breach intervention orders with impunity. When they feel unsafe, they are more fearful of denying their ex-partner entry into the house, even if they have an intervention order (Healey 2009, 85).

Arguably, when not enforcing breaches contributes to fearfulness, the objective of minimising the trauma experienced by police interventions (Victoria Police 2004, 1.2) is not met: the absence of intervention can also add to traumatisation.

The question of whether a person with a disability will be a sufficiently reliable and competent witness for a case to be prosecuted is an often-cited barrier to the attainment of justice for people with disabilities who have experienced violence (Goodfellow and Camilleri 2003; Heenan and Murray 2007, 35). The cases studied provide further evidence of this scenario. Both the perceived issues regarding the reliability of people with cognitive impairments as witnesses, and the potential difficulties for a person with a cognitive impairment to enforce the conditions within an IO, should elicit greater investigation by police into matters where these issues may be present.

The Police Code (2004, 2.1) acknowledges “the deterrent effect” that “a strong and effective criminal justice response” can have in relation to family violence and also promotes working in partnership with other agencies. These points reflect a key finding in research into guardianship for women with cognitive impairments experiencing IPV undertaken at OPA. In this study, when the guardians’ advocacy to police resulted in increased police presence and response to reports of violence, the represented women experienced less violence (Dillon 2009, 36). However, in the same study guardians reported frustration at the slow rate of change and initial unwillingness of police to work with them in providing an integrated response to the violence experienced by the represented persons.

While the \textit{FVPA} enables the Family Violence Court Division to direct perpetrators of violence to behaviour change programs and counselling, currently there is only approval for current or former domestic/intimate partners who use violence to be directed to counselling, and only in the Ballarat and Heidelberg jurisdictions (Magistrate’s Court of Victoria 2009). There may be some value in extending the approval for this program so that counselling can be ordered for other people who use violence, particularly adult children who are violent towards an ageing parent.

\(^5\) Sixteen of 86 represented persons had an OPA file pre-dating the implementation of the Police Code in August 2004, however, in six of these cases, the issues discussed within this report relate to more recent periods of OPA involvement (post-August 2004).
**Intervention orders**

“Lesley” is a young woman with a moderate intellectual disability. A family violence support worker made an application for guardianship, due to concerns about Lesley’s vulnerability to exploitation and abuse by her partner. When that relationship ended, new concerns arose about sexual violence by her subsequent partner. The new partner has forced Lesley to have sex when she does not wish to and to have sex without a condom; he has photographed and filmed their intercourse without her consent; and he has made her watch him have sex with other women, which causes her distress. These are often other women with disabilities that she introduces to him. In addition, Lesley is exploited financially by the partner, who controls the money she has access to, and has pushed her to seek bank loans for his use.

An IO against the partner was taken out by the police, however, the police have not always followed up when the order has been breached. Therefore, despite numerous breaches, neither party has experienced any consequences over the order being breached. The Sexual Offences and Child Abuse Unit and Family Violence Unit remain involved. The guardian sought DHS Disability Services case management and this was allocated to Lesley. Initially the case manager was reluctant to accept direction from the guardian, and would seek to undertake only what was requested by Lesley, which was very little. This situation improved when a more pro-active case manager was assigned to work with Lesley. The family violence support worker remains involved.

**Recommendations**

That Victoria Police members receive education about the particular issues facing people with disabilities who experience violence when they seek justice through the Criminal Justice system.

That eligibility for court-ordered behaviour change counselling for perpetrators of family violence be extended beyond domestic partners to other family members.

That the court-ordered behaviour change counselling program be available through Magistrates’ Courts across Victoria.

**5.0 CONCLUSION**

This report establishes that people of all ages with various cognitive impairments are subjected to physical, sexual, psychological, emotional and impairment-related violence, financial abuse and neglect. An additional aim has been to highlight the good and bad practice of service providers in responding to and supporting a person with a cognitive impairment who has been subject to violence, and the potential ramifications of inaction.

The 86 cases studied included people aged 16 to 100+ who were subjected to a wide range of violent acts, perpetrated by family members, strangers and staff. The circumstances of cases involving sexual violence (n=32), carer violence (n=19), and intimate partner violence (n=33) have been outlined in more detail. Women comprised 76% of the study, and were reported to experience physical and sexual violence more than other forms of violence.

The details of the involvement of disability services, family violence services and the police were discussed in order to identify examples of good practice, and areas of practice requiring improvement so that the most beneficial response is provided. The cases studied contained examples of good practice by each sector and the police, however, several issues of concern were also raised.
A range of disability services were involved in the cases studied, including case management, day services, accommodation services, home carers, and behaviour management specialists. However, family violence services were involved in only 4/86 cases. To this end, within the cases studied there were very few examples of cross-sectoral collaboration. While the range of relationships now covered within the FVPA were represented within the cases studied (including violence perpetrated by adult children, other relatives, and people in family-like relationships) family violence services were found to only be involved with people experiencing intimate partner violence.

The disability services sector must ensure that workers increase their knowledge about responding appropriately when disclosures of violence are made, as well as improving their skills in relation to the identification of, and action regarding, risk factors of violence. If this action included providing appropriate supported housing that meets the needs of people at risk of, or currently, experiencing violence, and increasing the opportunities for people socially isolated due to violence to build skills and engage with the community, it would seem (based on the case examples provided) that a significant increase in safety and quality of life could be achieved.

Police were involved in a range of ways within the cases, including both taking protective actions for and arresting the represented persons, investigating crimes, and seeking intervention orders. The difficulty in prosecuting crimes perpetrated against people with disabilities has been raised in other studies (eg., Heenan and Murray 2006), and many of the cases studied in which police were involved provide further evidence of this. Concerns were raised about the failure of police to respond to reports of IO breaches and to investigate reports of violence made by people with cognitive impairments.

5.1 Recommendations

1. That DHS Disability Services formally recognize and incorporate family violence, sexual assault, and intimate partner violence into its range of service needs assessment tools, with the aim of providing an improved response to people with disabilities experiencing violence and greater collaboration between disability, sexual assault and family violence services.

2. That on-going professional development about family violence issues be prioritised for all disability services staff and management. This should involve induction, orientation and professional development that emphasises the importance of building cross-sectoral connections.

3. That a protocol be developed between family violence services, sexual assault services, and DHS Disability Services that incorporates processes for referral, information sharing, case coordination, professional development, secondary consultation, data collection, and monitoring of its implementation.

4. That OPA staff members receive education about the range of family violence and sexual assault options available for people with cognitive impairments, and seek to build connections with family violence agencies.

5. That capital funding be provided to family violence services for the development of accommodation that suits the needs of people in all family violence contexts, to account for the range of “family members” now formally recognised within the Family Violence Protection Act (2008). Accommodation should be universally accessible and employ a model that offers safety and security to people experiencing violence in a range of circumstances.

6. That the state government allocate additional funds to enhance family violence services for people with disabilities who require additional support such as personal assistance.
7. That family violence support workers receive on-going professional development to increase their capacity and skills for helping people in the range of circumstances now covered under family violence and sexual offences legislation.

8. That research be conducted into the extent and prevalence of violence against people with cognitive impairment and older people, and their specific service needs.

9. That Victoria Police members receive education about the particular issues facing people with disabilities who experience violence when they seek justice through the Criminal Justice system.

10. That eligibility for court-ordered behaviour change counselling for perpetrators of family violence be extended beyond domestic partners to other family members.

11. That the court-ordered behaviour change counselling program be available through Magistrate’s Courts across Victoria.

If these system improvements occur, the rights of people with cognitive impairments experiencing violence may be far better protected. In addition to better justice outcomes, for Advocate/Guardians and other professionals there may be a better chance of achieving outcomes that are both in keeping with the wishes, and protective of the rights and dignity, of the people with cognitive impairments whom they support.
6.0 REFERENCES


Loddon Campaspe Community Legal Centre (2008) *Responding to the financial abuse of older people – understanding the challenges faced by the banking and financial services sector*, Advocacy and Rights Centre Ltd., Victoria.


Women with Disabilities Australia 2008, ‘*Shut out, hung out, left out, missing out’*, WWDA response to the Australian Government’s green paper *which way home? A new approach to homelessness*, Women with Disabilities Australia, Tasmania.


**Legislation**

*Family Violence Protection Act* (2008) (Vic)
*Crimes (Sexual Offences) Act* (2006) (Vic)