

Rapid Evidence Assessment: Family and Intimate Partner Violence against Women with Disability

Dr Morag MacSween, for Engender Equality, March 2021

Introduction

This paper explores four questions:

1. What does the data tell us about disability and domestic, family and intimate partner violence?
2. What models, theories and concepts are used to explain disability and violence, abuse, neglect and exploitation?
3. What does the research tell us about responding to people with disability experiencing domestic, family and intimate partner violence?
4. What does the research tell us about the prevention of domestic, family and intimate partner violence against people with disability?

The paper defines evidence as including: the best available research evidence; evidence from practice; and evidence from lived experience. It highlights where the evidence aligns with Engender Equality's insights into core issues for people with disability experiencing family violence in Tasmania. Where the research focusses on women and girls, women with disability rather than people with disability is used. It is likely that relevant evidence and research has been missed in this rapid assessment.

The paper also:

5. Summarises emerging themes in relation to domestic and family violence from, and future directions for, the Royal Commission.

Terms of Reference, theoretical underpinnings, definitions and language adopted by the Royal Commission are at Attachment A. Emerging themes from the Royal Commission are at Attachment B.

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Section 1: The Data

Key messages

- People with disability make up 18% of the Australian population, but 38% of First Nations people.
- The percentage of people with disability increases across the life course.
- People with disability disproportionately experience violence of all kinds, including intimate partner violence and sexual violence.
- Some forms of abuse are unique to people with disability.
- This includes forced contraception and forced sterilisation of women and girls with disability.
- People with disability who are members of other marginalised groups experience multiple disadvantage and complex experiences of violence.
- Violence varies with disability type. People with intellectual or psychosocial disability appear to experience higher rates of violence than people with physical disability.
- Domestic and family violence is itself a leading cause of disability, particularly for women and children.
- The data is limited, and currently is not helpful in evaluating prevention and response initiatives.
- First Nations people with disability are likely to be underrepresented in the available data.

We looked at three sources of quantitative data: The Royal Commission's Interim Report, published in October 2020; the World Health Organisation; and the Centres for Disease Control Violence Prevention Division.

Royal Commission Interim Report

Disability:

- in 2018 there were around 4.4 million people with disability in Australia, representing 18% of the population'
- percentages of people with disability rise across the life course:
 - 8.2% of children and young people
 - 12.9% of adults 18 – 64
 - 49.6% of adults 65 and above';
- in 2019, 38% of First Nations people had disability, considerably more than the general population; and
- the difference is particularly stark for First Nations children and young people, 22.8% of whom had disability.

Violence:

- almost two-thirds of people with disability have experienced violence in their lifetime;
- people with disability are twice as likely as people without disability to experience violence in a 12-month period;ⁱ
- 32% of women with disability aged 18–64 experience sexual violence in a 12-month period, twice the rate of women 18-64 without disability; and
- First Nations adults with disability experience high rates of violence.ⁱⁱ

Invasion and the dispossession resulted in drastically increased rates of disability among First Nations people; today, 38% of the First Nations population have disability, which is more than twice that of the nonindigenous population (18%).ⁱⁱⁱ

World Health Organisation

The World Health Organisation cites two systematic review published in 2012 as providing *the strongest available evidence on violence against children and adults with disabilities*.^{iv}

Children with disability are:

- 3.7 times more likely than non-disabled children to be victims of violence;
- 3.6 times more likely to be victims of physical violence; and
- 2.9 times more likely to be victims of sexual violence

Children with intellectual or psychosocial disabilities are at 4.6 times the risk of sexual violence.^v

Adults with disability are 1.5 times more likely to be a victim of violence than non-disabled adults. People with psychosocial disability are 3 times more likely to experience violence.^{vi}

Centres for Disease Control: Division of Violence Prevention

The National Intimate Partner and Sexual Violence Survey finds that:

- 1 in 4 (25%) of women in the United States have a disability, but 2 in 5 (39%) female victims of rape had a disability at the time of the rape;
- 1 in 5 (20%) of men have a disability but nearly 1 in 4 (24%) of male victims of sexual violence had a disability at the time of the victimization;
- women and men with a disability are at increased risk of sexual coercion and unwanted sexual experiences;
- women with a disability are more likely than women without a disability to report physical violence, stalking, psychological aggression, and control of reproductive or sexual health by an intimate partner; and
- men with a disability are more likely than men without a disability to report experiencing stalking and psychological aggression by an intimate partner.^{vii}

The limitations of quantitative data in Australia

A review by the Centre of Research Excellence in Disability and Health for the Royal Commission of available data concluded that:

- *the historical omission of people with disability from national data collections, and the lack of up-to-date analyses where data on violence and disability are available, means there is limited empirical evidence to inform governments, institutions and the community about best practices in prevention and response.*^{viii}

In addition, First Nations people are likely to be underrepresented in the available quantitative data, for a variety of reasons including the absence of a word for disability in many First Nations languages, different concepts of what constitutes disability in First Nations culture, and reluctant to adopt an additional label which attracts discrimination and prejudice.

Violence-induced disability

The data focuses in the main on disability as a risk factor for violence, abuse, neglect and exploitation. Domestic and family violence is, in addition, a leading cause of disability. We looked at two studies:

- *Getting Safe Against the Odds* cites data from a 2004 VicHealth study demonstrating that not only is domestic violence the biggest single health risk factor for women 25-44, it is also the leading cause of disability, including acquired brain injury, disability arising from violence-related substance misuse, and psychosocial disability.
- *Violence-Induced Disability: the Consequences of Violence Against Women and Children* argues that domestic violence both causes disability and increases the severity of existing disability, cerebral palsy, behavioural and learning disabilities in children, and acquired brain injury and the effects of depression and anxiety for adults.^{ix}

Both papers argue that disability is usually understood as a risk factor for experiencing violence and that disability cause by violence is *an almost un-navigated backwater* in the literature.

The Australian Institute of Health and Welfare reconfirmed the data in 2018, finding that domestic and family violence continues to contribute to *the burden of disease* - illness, disability and premature death – more than any other single risk factor for women in this age group.^x

More positively, in the intervening years, the links between domestic and family violence and acquired brain injury has been the subject of research and awareness raising.^{xi}

Qualitative data

Qualitative data adds depth and specificity to quantitative data. Key findings from qualitative data, including evidence from practice and lived experience, are:

- Some forms of abuse are unique to women with disabilities:
 - sexual abuse of a woman with a disability may include forced sterilisation or forced abortion; and
 - physical abuse may include taking away a woman’s wheelchair, denying personal care, rough handling, withholding medical treatment, women who are visually impaired having their physical environment rearranged.
- Psychological abuse includes:
 - women with physical disabilities having essentials such as house keys or medication kept just out of their reach;
 - women who are reliant on communication aids having access to aids restricted;^{xii}
 - perpetrators *explaining away* disclosure by women with psychosocial or intellectual disability as inaccurate memory, confusion, fantasy, misunderstanding or lies, both to the victim and to people around her ^{xiii} and threatening institutionalisation^{xiv}; and
 - for people with high support needs, when the abuser is the main carer, individuals suffer neglect, isolation and intense vulnerability to abuse and insurmountable barriers to support.^{xv}

Forced sterilisation of people with disabilities, in particular women and girls with disabilities, is a subject of enduring concern and advocacy by people with disability in Australia. For example, in *Forced sterilisation of people with disability and people with intersex variations* Disabled People’s Organisations Australia note that Australia continues to allow forced sterilisation where a person is assessed as not possessing the capacity to consent. They argue that *the prior, free, full and informed consent of the person* should be in place to ensure that the rights of women and girls with disability to *sexual and reproductive autonomy, self-determination and sexual expression* are not denied through *forced treatment, forced sterilisation, forced contraception, and restrictive practices*.^{xvi}

ANROWS also argues in seeking justice, the legal capacity of women with disability *was routinely denied or inhibited; reproductive and sexual autonomy were compromised; women’s decisions about treatment and desired outcomes were not respected; appropriate communicative methods and approaches were not offered; and therefore, agency to act as full citizens before the law was not accorded them*.^{xvii}

The Australian Supported Decision-Making Network have made representations to Government to develop a national framework to enable the replacement of substitute decision-making for people with disability to supported decision-making with people with disability.^{xviii}

We found helpful resources for parents of children with disabilities approaching puberty from the Royal Children’s Hospital Melbourne and raisingchildren.net.au.^{xix} These resources recognise the greater fears parents may have about their children’s capacity to manage menstruation, understand puberty and be safe from sexual abuse and unwanted pregnancy. For example: “Can’t we just stop the periods?”

Many parents feel it would be ideal to stop the periods. Periods are a normal, healthy part of being female and an important biological function, good for bone health and cardiac function. For most parents of girls with a disability periods are much easier to manage than expected and there is no reason to stop menstruation.^{xx}

These resources are not explicit on the much greater risk of sexual assault for women and girls with disabilities.

Section 2: Models and Concepts

Key messages

- Models of disability have moved through the charity model, to the medical model, to the social model.
- The social model is internationally influential. It distinguishes impairment and disability, arguing that disability is caused by inaccessible environments and systems.
- People with disability do not have uniform views. Models, theories and concepts are contested and evolving.
- The issue of capacity to consent to treatment and to participate in society are particularly fraught issues.
- Professor Shane Clifton argues that models, theories and concepts used by people with disability share two fundamental premises:
 - *disability is an expression of human diversity, vulnerability, and strength; and*
 - *disability theory is a criticism of ableism and paternalism, a deconstruction of hierarchies of power, and an effort to transform attitudes, values, and systems*
- Ableism - the conflation of normality with able bodied and fully functional - is central to the way disability is constructed.
- Ableism allows individual and collective privilege, privilege which is usually invisible, unconscious and thus harder to challenge.
- Sexual objectification, dehumanisation and the normalisation of violence against women is intensified for women with disability.
- Framing domestic and family violence as occurring in the home and from partners and family excludes the violence women with disability experience in institutions and from service providers.

The Royal Commission has published a research report which sets out and summarises the theories and models that influence how disability is understood and the social response to disability.^{xxi}

The paper identifies three main models of disability: the charity model; the medical model; and the social model.

The report also identifies key theories and concepts which intersect with these models to inform, enhance and challenge our understanding of disability, and of violence, abuse, neglect and exploitation:

- ableism and abled privilege
- embodiment
- disabled and crip identity
- feminist disability theory
- intersectionality theory/theory from the Global South
- First Nations concepts of disability
- concepts of independence, interdependence and vulnerability
- social role valorisation
- care and support for people with high support needs
- reconceptualising capabilities
- the concepts of justice and human rights.

It is, of course, impossible to capture the richness and complexity of the paper in summary, in particular its exploration of theories and concepts.

The charity model of disability and social welfare

Paternalism is often subtle in that it casts the oppressor as benign, as protector, and enables people in power to express sincere sympathy for people with disability while keeping them socially and economically subordinate. The paternalism people with disability are subjected to throughout the course of their life sustains hierarchical power and makes them vulnerable to direct and systemic violence, abuse, neglect, and exploitation.

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The charity model *understands disability as tragedy to be ameliorated or erased by generous giving*. Key aspects of the model are found across the current mixed market of disability services:

- paternalism: interaction where capacity, superiority and benevolence characterise the ‘giver’ and dependency, lesser status and lack of voice characterise the ‘receiver’;
- charity complemented by social welfare: the intent of distributive justice often transforming in practice into seeing recipients as a burden and reinforcing dependency and unequal status; and
- services largely run for people with disability by people without disability.

Disability advocates argue for a cultural transformation of the attitudes underpinning the charity model:

- interdependency: all (or most) of us will all need social welfare and services at some point in our lives;
- co-production: service users have expertise in their lives, are not passive users, and should shape the services they receive; and
- the cultural humility practice paradigm: where non-disabled providers recognise and work in genuine partnership with those with lived experience.

The medical model of disability and eugenics

When the difficulties attending to disability are perceived to be medical, they are solvable by increasing funding for research on cures and therapeutic interventions, rather than other more systemic reforms, such as removing barriers to employment, human rights protection, and other social transformations...sorely needed by people with disability in the community.

The medical model builds on and encompasses the paternalism of the charity model. Sustained critique has not *shaken its primacy*. The medical model understands disability as individual impairment which requires cure and/or treatment. Key aspects of the model are:

- diagnosis: classifying the (perceived) impairment in terms of divergence from (accepted) norms of biology and functioning; and
- treatment: medications and therapies which relieve negative symptoms and manage (or contain) vulnerabilities and behaviours.

Disability advocates do not argue against the positive impacts of medical science, and recognise that a diagnosis allows access to helpful treatment. However, they do argue that:

- diagnosis shifts the balance of power towards medical professionals and policy makers and has negatives as well as positives;
- negatives include people with disability being contained in institutions where they are often *captives of care...disempowered, controlled, restrained, and at risk of violence, abuse, neglect, and exploitation*; and
- although explicit eugenics disappeared after the end of World War II, *new eugenics* or *neugenics* legitimise non-consensual treatment, including physical and chemical restraint, and for women and girls with disability, forced sterilisation, contraception, restrictions on sexual freedom and *growth attenuation therapy*.

The social model of disability

The social model of disability was developed by disability rights advocates in the UK but is now internationally influential, having a significant impact on how people with disability understand their circumstances, and on public policy. Key aspects of the model are:

- distinguishing impairment and disability: the built environment and social systems have not been constructed as accessible, and disability is the resultant social exclusion, rather than the impairment itself;
- disability is about social justice rather than personal tragedy: universal design principles and systemic reform will increase agency, power and choice for people with disability and better equip them *to resist personal and systemic violence*; and
- a *calculated overstatement* intended to challenge entrenched thinking.

The impact of the social model on access and empowerment are recognised by its critics. However, they argue that the social model:

- *ignores the bodily limitations and pains that many people with disability wish could be ameliorated, whether through medical treatment, technological advance, or social transformation; and*
- *forgets or underplays the fact that disability is always a complex interaction between the functioning of our bodies and the physical and social environments in which we live*

One example of this difference of view is illustrated by many in the Deaf community arguing for *social settings where sign language is common, deafness is not disabling, and Deaf culture can be preserved*, and others choosing to use hearing aids or have cochlear implants.

Another example is the critique by carers of people with high support needs of the emphasis of disability theory on independence and autonomy, arguing that for some people, autonomy and independence are not possible.

Disability theory

Key concepts in disability theory include:

- Ableism is central to the way disability has is constructed. Ableism is based on an *imagined standard* of the able bodied and fully functional as normal e.g., *assumptions in civic planning that all citizens are normatively mobile, or by employers about the necessity of a 9-to-5, office bound, five-day workweek*. Ableism allows individual and collective privilege, privilege which is usually invisible, unconscious and thus harder to challenge;
- Sexual objectification, dehumanisation and the normalisation of violence against women is *heightened for women with disability, for whom the male 'gaze' is often replaced by the 'stare'*;
- Framing domestic and family violence as occurring in the home and from partners and family excludes the violence women with disability experience in institutions and from service providers; *these experiences of violence are typically downplayed and detoxified as workplace issues rather than crimes, and may justified on the grounds of 'managing behaviours'*; and
- The capabilities approach has identified a list of human capabilities which are argued to be the minimum basis for human rights; the list includes being able to *experience bodily integrity, such as security against violence, and the opportunity for sexual satisfaction and choice in matters of reproduction*

The author concludes by noting *the multifaceted nature of the causality of violence, abuse, neglect and exploitation against people with disability*. Because of this, thinking, theory and evidence are neither uniform nor static.

Disability is not abnormal, and people with disability are not inevitably *powerless and vulnerable to systemic violence and neglect*.

Disability is an expression of human diversity, vulnerability, and strength. In all its varieties, disability theory is a criticism of ableism and paternalism, a deconstruction of hierarchies of power, and an effort to transform attitudes, values, and systems. It intends to empower our personal and collective thinking to help us resist violence, make choices about our own future, and flourish in our own way.

Shane Clifton

Section 3: Responding to people with disability experiencing violence, abuse, neglect and exploitation

Key Messages

- The literature notes significant physical, systemic, skills-related and attitudinal barriers for people with a disability experiencing violence in accessing services.
- Partial knowledge is held in the disability, violence and legal sectors; partnerships are successful, but rare.
- Lack of progress in tackling barriers to physical access and securing women's basic safety from violence is a critical issue in Tasmania.
- There are excellent resources for increasing access in women's services.
- The social response to violence against people with disability is critical:
 - most women who have experienced intimate partner violence do not seek help from specialist services, but do talk to someone they know
 - a positive social response is correlated with better outcomes.
- Community attitudes to domestic and family violence, and to disability shape the social response people with disability experiencing violence will receive. Current research shows a mix of positive and negative attitudes.
- The literature notes a set of barriers which can prevent people with disability:
 - recognising that they are experiencing violence, abuse, neglect or exploitation
 - disclosing domestic and family violence.
- Fear of having children removed if they disclose domestic violence is an issue for women with disability, particularly women with intellectual disability.
- The available research confirms that parents with intellectual disability are over-represented in child protection services.

This section explores the barriers that too often prevent people with disability experiencing a helpful and supportive response to the violence they have experienced. We consider: barriers to accessing services; barriers to accessing informal or ‘natural’ supports; and ‘barriers before the barriers’ – limits to awareness and disincentives to disclosure.

The service response

The literature notes significant barriers for people with a disability experiencing violence in accessing services. We were struck by the consistency of messages and findings across decades.

Triple Disadvantage: out of sight, out of mind reports on a project run in Victoria between 1997 and 2003. The project piloted a local partnership to address the relative invisibility of disability in domestic violence services, and the relative invisibility of domestic violence in disability services.

Among the project’s key messages and findings were:

- if sexual assault and family violence organisations were to target the population facing the highest risk of violence, that group would be women with disabilities;
- the definition of domestic and family violence needs to change; for women with disability *the perpetrators are not just intimate partners, but may also include those who provide personal care*;
- interventions that work for abled women cannot be assumed to work for women with disability; and
- partnerships between the disability and family violence sectors, including training, ongoing networking and shared advocacy are needed.^{xxii}

Twenty years on, the ANROWS research report *Women, disability and violence: barriers to accessing justice* made similar points in its key findings:

- common sense, inaccurate and untested assumptions about the experience of violence for women with disability are common in the specialist disability, specialist DFV and legal sectors, including assumptions about what they need, what they want, how they understand violence, safety and security, their legal capacity and rights, the barriers they experience, the types of violence they experience and what responses they need;
- partial knowledge, insight and skills are held in different sectors...this is...a key risk for women with disability affected by DFV...(and)...there has been limited progress towards integrated knowledge and skills; and
- not only has there been inadequate progress towards effective access to justice for women with disabilities experiencing violence, there has been inadequate progress towards securing their basic safety from violence.^{xxiii}

Against this depressing background, the literature includes targeted guidance on tackling barriers to access - physical, systemic, skills-based and attitudinal:

- *Triple Disadvantage* includes a detailed description of cross-sector training between the women’s and disability sectors;^{xxiv}
- *Women with Disability and Domestic and Family Violence: A Guide for Policy and Practice* sets out steps domestic and family violence agencies can take to increase access to their services for women with disability;^{xxv}
- *Getting Safe Against the Odds* outlines strategies that domestic and family violence agencies have used to better respond to women with disabilities, including adapting interventions to better fit their needs^{xxvi}; and

- The National Symposium on Violence against Women and Girls with Disabilities identified and workshopped eight key areas for enhancing good policy and practice from the Stop the Violence project evidence base, Including education and training for service providers and service sector development and reform.^{xxvii}

Lack of progress in tackling barriers to physical access and securing women’s basic safety from violence is a critical issue in Tasmania. As the CEO notes:

Appropriate crisis accommodation for women with disabilities is extremely limited in Tasmania, and, in many places, non-existent. Long-term accommodation that is tailored to people with disabilities is also an issue for Tasmania. When women with disabilities experience abuse, they are extremely limited in their options to access safety and stability. This is even more difficult when women have pets.

The social response

Most women (84-91%) who have experienced intimate partner violence do not seek help from specialist services. Most women do talk about partner violence to someone they know (74-93%).^{xxviii}

Against this background, the social response to domestic and family violence is of critical importance. The Centre for Response-Based Practice argues that:

- both victim/survivors and perpetrators of domestic and family violence are *constantly mindful* of the response they are likely to receive from their social networks;
- a positive and helpful social response is *strongly correlated* with better immediate and long-term outcomes, including lower levels of distress and the confidence to disclose again; and
- the reverse is true for a negative social response.^{xxix}

Community attitudes to domestic and family violence, and to disability, shape the social response people with disability experiencing violence will receive:

- The available evidence on community attitudes about inclusion of people with disability suggests that they are positive, but paternalistic. Attitudes towards people with more severe disability and towards people with psychosocial disability, particularly schizophrenia, are more negative, and include stigmatising views, anxiety and discomfort. People with intellectual disability are often seen as less capable than they in fact are.^{xxx}
- Community attitudes to violence against women are improving overall. ANROWS reports that most Australians have a *good understanding* of violence against women, support gender equality, policies enabling violent partners to be removed from the home, understand that domestic violence is more than physical violence and reject violence-supporting attitudes.^{xxxi}

However, ANROWS also reports that:

- some Australians continue to believe that *women cite violence to gain tactical advantage in their relationships with men*;
- 40% believe that women make up false reports of sexual assault in order to punish men;
- 1 in 8 believe that if a woman is raped while she is drunk or affected by drugs, she is at least partly responsible;
- many Australians are willing to excuse violence as part of a ‘normal’ gender dynamic in a relationship

- 1 in 5 Australians believe domestic violence is a normal reaction to stress, and that sometimes a woman can make a man so angry he hits her without meaning to; and
- 1 in 3 Australians believe that if a woman does not leave her abusive partner responsible then she is for the violence continuing.^{xxxii}

Barriers before the barriers: awareness and disclosure

The literature notes a set of barriers which can prevent people with disability recognising that they are experiencing violence, abuse, neglect or exploitation. There are additional barriers for disabled people disclosing domestic and family violence. For example:

- inadequate or limited education may mean that women with disabilities have not been informed about the different forms of violence, abuse, neglect and exploitation they may encounter^{xxxiii}; researchers noted that Women with disability participating in the ANROWS study of barriers to justice had *a growing understanding of what they were experiencing as “violence”* and impacting on their *everyday security*;^{xxxiv}
- information about services may not be available in formats required for some disabilities^{xxxv}
- perpetrators may deliberately withhold information;^{xxxvi}
- care workers can be reluctant to raise violence as an issue with their clients, and this *can operate as a form of gatekeeping, preventing them from making informed decisions and taking control of their lives*;^{xxxvii}
- women with disabilities are frequently not believed when they disclose, have their experiences minimised, or are held responsible for the violence;^{xxxviii}
- in common with women from other marginalised groups, women with disabilities disclosing family violence fear losing their children if they come to the attention of child protection^{xxxix}
- there is also fear that leaving violence may mean the available accommodation cannot support the required level of care and support;^{xl}
- high dependence on support also reduces the opportunity to disclose or report violence;^{xli}
- segregation or isolation in residential support, and social isolation because of discrimination reduces access to networks of support that could provide support to seek help or leave^{xlii}; and
- the concepts of carer fatigue or carer sacrifice can obscure, minimise or excuse violence from carers.^{xliii}

Disability, family violence and child protection

Fear of child removal as a barrier to disclosing family violence is an issue for many Engender Equality clients. As the CEO notes:

Women with intellectual disabilities often tell their counsellor about the fear - and the reality - of having children removed. The literature talks about parents, but it is mothers with intellectual disabilities who are having their children removed who are having their children removed - not fathers with intellectual disabilities.

The Royal Commission is currently hearing about the removal of children from Indigenous women with intellectual disability who are victim/survivors of family violence. Evidence submitted by Thelma Schwartz, the principal legal officer at the Queensland Indigenous Family Violence Legal Service has received media attention. Ms Schwartz told Commissioners that the child protection system is broken, in crisis and stacked against First Nations women with disabilities. Women in violent relationships who reach out to police or services can then find themselves reported to child safety. Ms Schwartz said:

- *She's already on the back foot because of her disability...by coming forward and making the disclosure that you've been a victim ... this is now used as a catch 22 for this mother and used against her to remove her kids.*

The available research confirms that parents with intellectual disability are over-represented in child protection services and Court proceedings. The Australian Institute for Family Services argues that assumptions about people with intellectual disability, the erroneous reliance on IQ as a measure of parenting capacity, and the use of inadequate assessment tools combine to make it very likely that children are being removed from parents who can, or could with supports, care for them.^{xiv} The Victorian Public Advocate, commenting on this over-representation, notes that:

- *There is considerable knowledge available about how to work successfully with parents who have cognitive disabilities in order to reunify families or enable families to stay together; and*
- *Women with disabilities are more likely to be the victims of domestic violence and are frequently perceived by child protection as likely to attract men who prey upon them and to be unable to keep their children safe. When this happens, parents are, in effect, being held personally responsible for the systemic social evil of domestic violence in our community.^{xiv}*

Section 4: Prevention of violence, abuse, neglect and exploitation of people with disability

Key messages

- We could find no information on preventing violence against people with disability specifically.
- The World Health Organisation and the Centres for Disease Control Violence Prevention Division argue that effective and promising prevention strategies need to be tested for their efficacy in relation to people with disability.
- Women with Disabilities Australia argue that the National Plan to Reduce Violence against Women and their Children 2010-2022 does not adequately address violence against women and girls with disability.

We could find no information on violence prevention related specifically to people with disability. The World Health Organisation has identified programs which have been evaluated as either effective or promising in preventing violence against non-disabled adults and children, and argues that these programs should be implemented for children and adults with disabilities, and their effectiveness evaluated as a matter of priority. The Centres for Disease Control similarly argues that the strategies and approaches in their packages on preventing sexual violence and preventing intimate partner violence may help reduce violence among those with a disability.

The National Plan to Reduce Violence against Women and their Children 2010-2022 is Australia's key response to violence prevention, and includes women and children with disabilities. However, Women with Disabilities Australia argue that the National Plan:

- includes little emphasis on women and girls with disabilities;
- does not address forms of violence that women and girls with disabilities experience which non-disabled women do not; and
- does not include strategies addressing violence and abuse of Aboriginal and Torres Strait Islander women with disabilities or culturally and linguistically diverse women with disabilities.^{xlvi}

Section 5: Findings and Themes about Domestic and Family Violence to date

The interim report of the Royal Commission includes a section on domestic and family violence. The key points are:

- people with disability experience higher rates of domestic and family violence than people without disability;
- people with disability can experience particular forms of domestic and family violence, including the withholding of food, water, medication or support services, the use of restraints, reproductive control and forced isolation;
- the Commission has been told about violence or abuse by other family or kinship network members and support workers.;
- women with disability experience much higher rates of violence by a current or previous partner than women without disability, as do men with disability compared with men without disability;
- the same pattern exists for sexual violence experienced by women with disability compared with women without disability, and men with disability compared with men without disability;
- during the COVID-19 pandemic, people with disability may have had less access to support networks and been less able to report and escape domestic and family violence; and
- the Commission has been told about a range of experiences that people with disability have had with police. These include being disbelieved when they have tried to report violence and abuse and being treated as the offender, rather than the complainant.^{xlvii}

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The Interim Report outlines the future focus of the Royal Commission. The areas of focus with most direct relevance to family violence and intimate partner violence are:

- how homes and living arrangements can support the independence of people with disability and their right to live free from violence, abuse, neglect and exploitation;
- how to prevent people with disability from experiencing violence, abuse, neglect and exploitation in the context of relationships; and
- experiences of people with disability in the justice system, including access to justice.

Attachment A: The Royal Commission

Terms of reference

- to inquire into what governments, institutions and the community should do to report, investigate, respond to, prevent and better protect people with disability from experiencing violence, abuse, neglect and exploitation.
- to inquire into what should be done to promote a more inclusive society that supports the independence of people with disability and their right to live free from violence, abuse, neglect and exploitation.
- to have regard to the multi-layered experiences of people with disability, and the particular situation of First Nations people with disability and culturally and linguistically diverse people with disability.

Definitions

Disability is an evolving concept that results from the interaction between a person with impairment(s) and attitudinal and environmental barriers that hinder their full and effective participation in society on an equal basis with others.^{xlviii}

People with disability are people with any kind of impairment, whether existing at birth or acquired through illness, accident or the ageing process, including cognitive impairment and physical, sensory, intellectual and psychosocial disability.

Violence and abuse include assault, sexual assault, constraints, restrictive practices (physical, mechanical and chemical), forced treatments, forced interventions, humiliation and harassment, financial and economic abuse and significant violations of privacy and dignity on a systemic or individual basis.

Neglect is made up of physical and emotional neglect, passive neglect and wilful deprivation. Neglect can be a single significant incident or a systemic issue that involves depriving a person with disability of the basic necessities of life such as food, drink, shelter, access, mobility, clothing, education, medical care and treatment.

Exploitation is the improper use of another person or the improper use of or withholding of another person's assets, labour, employment or resources, including taking physical, sexual, financial or economic advantage.

Language

The Royal Commission uses people-first language, referring to people firstly as individuals i.e., people with disability. The Commission recognises that some people prefer identity-first language, recognising disability as a core part of their identity and as arising from social barriers i.e., disabled people.

Theoretical approaches

The Royal Commission has adopted four theoretical approaches:

- human rights: people with disability are entitled to full rights and freedoms
- the social model of disability: it is social structures, barriers and attitudes that disempower and exclude people with disability
- intersectionality: discrimination based on ableism intersects with other forms of oppression
- the life course shapes individual pathways of people with disability.

Attachment B: Royal Commission Interim Report, October 2020

Emerging themes

The interim report identifies a number of key themes which have emerged in the Commission's work to date:

- choice and control
- attitudes towards disability
- segregation and exclusion
- restrictive practices
- access to services and supports
- advocacy and representation
- oversight and complaints
- funding.

Themes emerging from community forums include:

- the need for better regulation, oversight, transparency and accountability
- barriers to self-advocacy
- control, autonomy, disempowerment and discrimination
- the role and recognition of families
- the accessibility and responsiveness of service systems.

Each of these themes has direct and/or indirect impacts on violence, abuse, neglect and exploitation. As Professor Sally Robinson told the Commission:

People with disability are subject to stigmatising and discriminatory social, cultural, and structural 'rules' about their place in society. These are about being damaged, 'other', less than human, and needing to be in 'their place'. This leads to oppression, isolation, and dehumanising of people with disability – all conditions which substantially increase the likelihood of abuse occurring and recurring.^{xlix}

There is additional vulnerability to violence for people with disability living in group homes and closed environments where they are isolated. For example, the Commission has been told that some women with disability in group homes are subjected to forced contraception.

Reliance on carers and perceptions of credibility create additional barriers to reporting violence, abuse, neglect and exploitation for people with disability.^l

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